Under pressure and ‘the whole umbrella’s going to have to grow’:

Capturing the voices of NHS workers

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Introduction

The NHS continues to come under pressure to accommodate a sustained budgetary squeeze, while at the same time endeavouring to deliver world-class health care in a context of growing demand for its already stretched service. This paper draws on in-depth interviews with NHS staff to illuminate the current lived realities of those who work so hard to provide this service. Its purpose is to give a voice to these NHS workers about their views and insights around a range of interlocking debates concerning their pay and working experiences. The context to the research is the NHS Pay Review Body 2015/16 call for observations on the barriers and enablers within Agenda for Change for delivering health care services seven days a week in a financially sustainable way. It was felt that a useful way of providing such evidence lay, among other sources, in seeking to uncover the views and experiences of those who actually work on the NHS front line. This research sought to do just that. The findings of detailed semi-structured interviews with thirty NHS workers across a range of occupations broadly defined here as domestic, nursing, and ambulance workers, has sought to capture these voices in a form that illuminates in detail their present-day working lives.

The paper begins with a brief background to the research and the research methods employed. It then presents a thematic analysis of the extensive data derived from the interviews. The key themes to emerge from the data include pay issues; workload and stress; feeling valued and supported; staff morale and lastly, commitment to patients and to the NHS. These themes best reflect the key and current concerns of those interviewed. The findings reveal a complex and deeply worrying mix of pressures concerned with pay, and with feeling under-valued, demoralised, over-worked and under-staffed. Juxtaposed with this general picture is the immense commitment that all of these interviewees felt towards the NHS in general, and the patients in particular. The paper concludes
that, as far as these workers are concerned, they are already giving their all to their jobs. They feel that their pay does not adequately reflect their contribution and they place a heavy reliance on unsocial hours payments; any reductions in these payments would undoubtedly negatively impact on already low levels of morale and staff retention. It is clear that these staff already feel under-valued and under-supported – and sometimes bullied. All of this said, the same staff express enormous commitment both to the general NHS ideals and perhaps most important, to their patients. It is perhaps this aspect of the research that has loomed large. These interviewees were very clear in articulating their deep-seated frustrations while at the same time, making clear that they wanted to do the best they could for “their patients”.

**Background to research**

The NHS Pay Review Body (PRB) Remit 2015/16 has been asked by the Department of Health to make observations on the barriers and enablers within the Agenda for Change (AfC) pay system, for delivering health care services every day of the week in a financially sustainable way. The wider context to this are the significant and sustained budgetary pressures across the whole of the public sector services as public spending continues to be squeezed as part of the austerity measures that have prevailed since 2010\(^1\). While these financial pressures are evident across the public sector, they are particularly acutely felt in the NHS service as a result of multiple pressures bearing down on the service derived from increased demand, public and political scrutiny of any ‘mistakes’, the sheer scale and complexity of service provision and perhaps, most important of all, the role of the NHS in providing free, ‘cradle to grave’ health care.

There is an abundance of evidence that bears testimony to the dedication and hard work of NHS staff\(^2\). The purpose of this research was to provide an opportunity for some of these workers to contribute their views, in their own words to the larger body of evidence. Therefore the research was undertaken within the qualitative tradition and within this, interviews were utilised for their potential to reveal feelings and attitudes that are often otherwise hidden in written responses\(^3\). This meant having an opportunity to gain detailed insights into the daily lived realities, experiences and concerns of those workers who were interviewed. The interview schedule followed a semi-structured approach although the questions were open-ended, to allow for interviewees to highlight

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1 Mather, K. (2014) Evidence to independent review of terms and conditions for operational staff in the fire and rescue service (Thomas Review).
issues of importance to concern to them. The interviews were therefore conducted in a context of allowing interviewees to speak freely but within a general framework of general questions related to the research focus. This approach afforded opportunities for exploring the lived realities of these workers and for generating a richness of data that had not initially been anticipated, much in line with earlier commentaries on the benefits of such an approach in qualitative research.

The research, commissioned by UNISON, involved a series of in-depth semi-structured interviews with thirty NHS workers from across three broad occupational categories: ambulance workers; nurses/clinical support; domestic/porters. A complete list of interviewee occupational and pay banding details is provided in appendix (i) at the end of this paper. All interviewees have been anonymised, as have their locations. The research included those working in several regions including the North East, North West, East and West Midlands and London. The interviews lasted between thirty minutes and one and a half hours and in twenty six cases were face to face and recorded with the permission of the interviewees. The remaining four interviews were conducted over the telephone and were not recorded. The interview data has provided a rich stream of data that has been organised thematically around the issues of pay issues; workload and stress; morale; feeling valued and supported; commitment to the NHS. These key themes frame the discussion of findings that follows. It is important to note that the focus of this research is with capturing the views of a range of NHS workers and to give their voice to current concerns.

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Findings

1. Pay issues: “This is the breadline”

Debates about the potential for provision of seven day service provision cannot be disentangled from how work is currently organised and incentivised. There are already a range of complex shift patterns that taken together, would appear to offer the flexibility required for operating seven day services. These include rolling rotas; overtime; alternating shift patterns and on call availability. Perhaps unsurprisingly then, all of the interviewees expressed the view that in effect, their part of the service was already offering 7 day provision. In return for such flexibility, there is a clear expectation that this needs to be financially incentivised. It is difficult to overstate the impact of the myriad working hours arrangements on these workers’ home and family lives, let alone the impact on their work-life balance. For them, there is a quid pro quo that is beyond question -- in return for weekend working, disruptive working patterns, night working, finishing late, starting early, they provide an extremely compelling case for being compensated appropriately through their pay. A number of interlocking concerns surfaced when interviewees were asked for their views on pay and specifically, the unsocial hours or ‘enhanced’ pay elements of their pay. First there was universal discontent over their absolute levels of pay and in particular the fact that they had been denied a decent pay rise for the last five years. There were many complaints about the adequacy of the pay band they were on in relation to the work they are required to do and this cuts across “felt-fair” principles:

“For the responsibility that I’m expected to take, that I don’t feel that my banding is adequate” (Clinical Support Nurse, Band 3).

Such comments do not reflect any sense of being worth more than those on other bands, but rather, a general sense across the board of pay levels being low in comparison with jobs in the wider labour market, especially in light of the responsibility attaching to their roles and the consequences if the job is not performed well. This general discontent with pay has undoubtedly been deepened by the decision to ignore the most recent PRB recommendation. Many of the interviewees explained in detail how they were struggling to cope financially, using terms such as “it’s a real struggle” and “I’m feeling the pinch”. Second there was real anger around any possible suggestion of losing unsocial hours payments, or even having them reduced in anyway. This anger was rooted in the fact that they were all reliant in some way on being able to access enhanced pay as a means for managing financially and personally with childcare/family commitments. The following commentary surfaces some of their key concerns around these issues.
The ‘unsocial’ element to their working hours was raised across all of the interviews and several were highly critical of the terminological sleight of hand when referring to ‘unsocial’, with several interviewees commenting that there seems to be a view among senior NHS decision-makers that ‘unsocial’ simply means not being able to socialise with friends at the weekends. This, they argued is a superficial framing of the concept that ignores the rather more severe across a broader spectrum of home, family and personal health matters. This suggests there needs to be a far more nuanced and well-informed understanding of precisely how ‘unsocial hours’ is conceptualised and understood. For example,-

“There is some evidence that you may have a shorter life span, so there is a reward for doing this unsocial behaviour” (Nurse, Band 6).

“Night working can take four or five years off your life and shortened life expectancy needs to be paid for. So what about the impact on health? What about the impact on your cognitive abilities? This all needs compensating for. It is only right that extras burden is compensated. Plus they [USH payments] have already been reduced. It’s unfair and very harmful and we would certainly fight to protect it” (Community Health Support Worker, Band 3).

“I’ve read some research recently about shift work and it being extremely bad for you, we’ve known that for ages” (Nurse, Band 5).

The most fundamental issue however is the reliance of these workers on the extra money they earn through unsocial hours payments. While all interviewees expressed their fears about any prospect of reductions/changes in these payments, it was particularly acutely felt among those on lower pay bands (notably bands 1 and 2). Put simply, they rely on these enhancements in order to live. As a ported commented, “we are already low paid workers”. Typically, there was a clear view that hourly pay is poor and therefore enhancements are crucially important:

“If we lost our enhancements and... oh, and unsociable pay, we’d be on virtually minimum wage” (Domestic, Band 2).

“I’ve never any money, let’s put it that way. Your cost of living – council tax, gas, electric – that takes up the big bulk of your wage, basically” (Car Park Attendant, Band 2).

“I wouldn't be able to manage on a Band One wage without the enhancements, no.” (Domestic, Band 1).
“I think our basic wage without the enhancements, when you take off your tax and you take off your pension, it’s not a lot … I couldn’t live off that anyway… If it ever come to [reducing USH payments] it I’m not sure what I’d do” (Domestic, Band 1).

“It’s important, very important, because without it the wage would not be enough. It would be a financial struggle” (Domestic, Band 1).

“I’d lose about £150 a month but also, because my husband works here and works weekends as well, we’re probably looking at about £300 to £400 loss a month… I’d have to increase my hours or even get a second job because it’s a lot to lose” (Domestic Band 1).

“This is the breadline, but if it’s taken away, most of the good people who are there who are doing a good job in the NHS, will leave, it’s as simple as that” (Porter, Band 2).

“I’m really worried about this. It is vital because you can’t under-estimate the impact on already low paid workers”, (Community Health Support Worker, Band 3).

“If you are in one of the lower-banded jobs, then unsocial hours become a significant part of your salary” (Nurse, Band 6).

“I get away with the bare basics. I’d probably have to move to somewhere cheaper to rent because I probably couldn’t afford the place I’ve got at the moment” (Call Handler, Band 3).

“Without my unsociable hour payments, I’m stumped. I’m really… I would be on the bones of my backside” (Ambulance Care Assistant, Band 3).

Worryingly, one of the nurses explained how qualified and unqualified nurses were now having to use a local food bank to manage until they get paid each month. Another interviewee working as a domestic on band 2 explained in detail how she was struggling to manage financially and had recently resorted to using candles instead of putting the lights on during the evening.

These problems are then exacerbated by the need of many of these interviewees to juggle their work and their childcare arrangements. Any reductions in their pay would mean having to either increase the hours worked within the NHS or their having to take a second job outside of the NHS. As one noted, “The added problem then would be that this would increase childcare costs” leaving her in a “catch-22” (Domestic, Band 1). This is particularly worrying as she is already struggling to cope financially. The juggling of work and childcare commitments was a real concern for many of the interviewees across the range of bands. For example, a nurse explained:
“I work mainly night shifts, often weekends. I prefer to work nights currently because I've got a small child who doesn't like being left if I do long days, because I have a choice of long days or long nights. So it's 7:30 until 8:00 either way” (Nurse, Band 6).

There was evidence that many of these workers, particularly nurses and ambulance workers regularly work beyond the end of their shift and this is often unpaid overtime. The common response to working unpaid hours was “I can’t walk away leaving jobs unfinished”. The magnitude of unpaid overtime is variable but commonly equates to at least 15 minutes before/after shifts. It depends on staffing pressures and how busy the staff are at any one time. An Emergency Care Assistant (Band 3) commented that “we never finish on time”. As another put it, “Late finishes are the norm. We barely ever just do the 12 hours. We're always doing in excess of the 12 hours in a shift” (Paramedic, Band 5). While there may be scope for claiming overtime he explained that it is seldom worth it on account of all the paperwork that has to be completed after finishing a long, busy week. Another noted,

“For instance, I need to finish work on time tomorrow… I need to finish work, more or less, on time, more or less, you know. ..I’ve spoke to my team leader, but I haven’t got the greatest confidence that I will be able to finish work, more or less, on time” (Operating Dept. Practitioner, Band 5).

Another explained, “I actually rarely go home on time, because I don’t feel like I can leave because I haven't finished everything. So I don't feel like I can go home until I’ve completed because otherwise I still think about it” (Critical Care Nurse, Band 6). For this worker, these extra hours, often amounting to between half an hour and an hour should theoretically be taken as TOIL, but this is rarely taken. This was supported by the comments of a nurse who stated that: “most; a lot of people have got loads of toil. Well, if you don’t take it within three months, they are supposed to pay you, but unfortunately, obviously they don’t want to pay it. And in a lot of cases, I’ve had staff come to me, and say that their toil’s just been wiped out” (Nurse, Band 5).

A related finding across the interviews is the tendency to miss breaks. For example,

“Staff won’t take breaks because they’re too busy. My argument has always been, well, if you are that busy, that’s when you most need a break, and you need that break away from the ward so you’re less likely to make a mistake, but they use the argument that, you know, if it... if I’m not doing it, then it won’t get done. You know, Mr Jones is waiting to go home and, you know, if I have half-an-hour break, then Mr Jones is not going to be ready when his transport comes” (Nurse, Band 6).

Implicit within these comments is a lot of unpaid good will and desire to see a job well done.
Any reductions in pay enhancements would also have negative consequences for staff retention and this appears to be particularly felt among ambulance service workers who observed that staff turnover was already a problem:

“We lost five paramedics last month who have gone into the private sector, which is a big loss for us who are already short staffed... And they’re just doing a nice nine until five Monday to Friday role assessing disability patients, you know, and they get just about the same amount of money as what they were on as a paramedic” (Emergency Care Support Worker, Band 3).

Another noted that “there’s a massive shortage of paramedics. They’re leaving in their droves because of the working conditions and all the added stress” (Ambulance Care Assistant, Band 3). He went on to note “If they decreased, or got rid of, the unsociable hour payments, then I would be looking for other employment. There’d be absolutely no incentive to stay”.

The retention problem also extends to call-handling/control room staff. The interview findings point to major problems with staff turnover --- while such issues are a widely reported feature of most call-centre work⁵, there are particularly serious consequences in the NHS context. One call handler explained, “this is a not a normal call centre, we’re dealing with people’s lives. And it’s very difficult to get them to realise that it’s not a normal call centre” (Call Centre Handler, Band 3). The argument may be put that call handlers (call centre staff) are relatively easy to replace but as was highlighted, this is a potentially dangerous strategy as valuable skill is lost in high labour turnover. This is deeply concerning when these people are tasked with handling calls from members of the public who are anxious about the well-being of a potential patient. This is then exacerbated by increased reliance on agency /short-term staff and this carries consequences, so “half of them couldn’t care less. They’re like, I don’t want to work here for more than six weeks; I’ll do the training and then I’ll leave” (Ambulance Care Assistant, Band 3).

Nurses also expressed concerns about retention, especially in light of recruitment difficulties and an aging nurse workforce profile. It was felt that any detrimental changes to pay enhancements would undoubtedly add to the existing set of problems:

“I’m extremely worried, that we’re going to put the NHS at risk, if we decide not to give enhanced payments, because I honestly do believe, that that will cause people to walk” (Nurse, Band 5)

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One interviewee, an Accident and Emergency Receptionist worked night shifts only because it enabled him to earn just enough to live on and he explained that any changes in his night working enhancement would deter him from working nights and to contemplate leaving the NHS altogether:

“The way I look at it that night enhancement is, for me, giving up my night time, my evening times, which I could spend with friends, family, to come here. Whereas, if we didn’t have any allowances I might as well just do a 9:00 till 5:00 for the same money” (Accident and Emergency Receptionist Band 2).

Others drew similar conclusions:

“They cannot recruit. Who’d want to work in here? Who wants to work Christmas Day? Who wants to work Christmas night? Who wants to work Saturday night? You know, you’re 21 years old, you want to go down town with your mates. So, you know what I mean, and bearing in mind that most people could earn, a lot of people could probably earn the same amount of money for doing decent hours working in an office in town, you know” (Operating Dept. Practitioner, Band 5)

Several interviewees expressed similar views that highlighted how a withdrawal of financial incentive for night/weekend working would also spill over into more general concerns around increased dependence on agency workers. This would be potentially costly on financial and quality of care grounds. A nurse threw light on these issues:

“If I don’t get paid extra for doing nights, and I might as well do days, who is going to end up doing nights, will this be more agency nurses? We already have a large proportion of staff that are agency. Some of them are our own staff that work the extra shifts to help prop up their income. If they no longer have incentives does that mean that we get agency staffs that aren’t our staff, which weakens our care? So it’ll have an impact on care. If our staff don’t get paid unsocial pay, and then they have to do more agency to fix the breach in income disparity, does that mean that we’re going to have more people that are working too hard? And that has an impact on sickness and the well-being of the team. That would mean that I would perhaps be doing more nights with people that I’m not familiar with, more agency workers. So maybe I will then start thinking, this is getting more difficult, So I might start thinking, do you know what, I could do three days, perhaps, rather than doing nights, and earn the same now. And I might change. (Critical Care Nurse, Band 6).

She was not alone in suggesting that in the event unsocial hours payments were abandoned or “attacked”, then far fewer people would be willing to work weekends and night shifts:
“If they took the 24 hour stance, where it was a flat rate pay, nurses and everybody else, that are on these, would refuse point blank to do them. Why would I want to not have a life, I mean, we promote people to look after themselves, and to have an outside life, if I could do that, and not have to do the special duties, like weekends, and nights, then obviously I would choose not to” (Nurse, Band 5).

“Saturday, Sunday is precious time when you’re already a full-time worker, to give up more time with your family, to come to work, to, well, to provide a service for people that really need it, to have it go unnoticed by just being paid a flat rate of pay, so I think it would be quite selfish of them if that were the case. So I definitely wouldn’t be doing it. I’d definitely put my name down for a change back, back to Monday to Friday, which I think most people would.” (Senior Supervisor, Band 4).

The issue of agency workers raised more general questions as to the financial sense of relying on what are essentially more expensive staff to cover internal staff shortages. Most of the interviewees explained that their workplace currently had a recruitment freeze in place on many posts. This meant that under-staffing on wards led to a reliance on agency staff, which is costly:

“Because the staff who are leaving, they’re not replacing them. But the thing is that wards that have quite a number of staff that have left, that they’re using agency, NHS professionals agency staff - they’re using them and paying more money when they could quite easily use that money to employ someone to do that job” (Clinical Support Nurse, Band 3).

Another commented on how this played out in practice:

“Sometimes you can be the only trained nurse on a late shift who knows that ward, with staff that don’t work on that ward generally, and your time is spent exclusively making excuses, and that’s what it is, making excuses to people, basically, and grovelling apologies on behalf of the organisation just to try and prevent concerns escalating into complaints, and that really isn’t helpful you know?” (Nurse, Band 5).

It is important to emphasise that all of the interviewees accepted the need to undertake night and weekend work as well as the need for bank holiday cover. Nevertheless such ‘unsocial’ work was understood to be provided in return for a pay incentive – if this were taken away then the generally held view among those interviewed was that staff simply would not work these hours: “People would be saying, no, I’m not, why should I do those horrible shifts, or lates, even” (Nurse, Band 5).

It is clear from the interview data that any attempts to reduce pay enhancement opportunities would be strongly resisted and this view was expressed by all of those interviewed.
“You can’t remove the unsocial hours element of Agenda for Change that’s in there now because staff won’t allow it. I know we’re in a pay battle at the minute and whilst we’re not seeing masses and masses of people taking action, if you start taking away their unsocial hours, if you start taking away what they’ve got rather than not giving them what they’re entitled to, it’s different.. so taking that away from them, they’ll defend that.” (Nurse, Band 6).

It would also be problematic if different terms were introduced for new starters, not least the problems of managing a two-tier workforce on different terms and conditions, but also the very real potential for a series of Equal Pay claims.

This genuine anger over pay is undoubtedly exacerbated by the perceived inequities of the continued pay freeze in the NHS at the same time as MP salaries are going up:

“I think it was a bit of a kick in the teeth to a lot of staff to say that our increments and our bands were pay rises... we’ve had a pay freeze for, you know, going on five years, and, you know, costs... the cost of living, when you take into account energy bill, fuel prices, the cost of groceries and all of that, you know, it costs you 25% more to live – just live, not in any sort of luxury – than it did, you know, before the coalition came into power. And to say that we’re not worth 1%, which to most of us works out as about £20 a month, is just... it’s absolutely diabolical. To say that staff that give so much aren’t worth so little. And I think that is complete... I think that was the final nail in the coffin for most staff. I think it was just... you know, people were shocked they were thought so little of by the government. ” (Ambulance Care Assistant, Band 3).

In summary, pay is a major source of frustration and deep-seated grievance among these workers. It cuts across several related areas of their working lives including their ability to cope financially, their sense of injustice around the sustained pay squeeze they are experiencing and importantly, the perceived inequity arising from increasing workload and associated work pressures and stresses.

2. Workload and Stress: “it’s unrelenting”

It is difficult to capture the sheer scale of workload pressures being experienced by these workers. Workload pressures emerged as a major theme across all of the interviews and the data point to a group of workers who feel close to breaking point. This in turn is triggering intense feelings of demoralisation and this does not bode well in a context of mounting patient demand on an already stretched NHS. In the words of respondents:
“I was thinking of just winding it down because my health is deteriorating as well, I’ve never seen my health was so bad .... high blood pressure, too much stress” (Porter, Band 2).

“You feel under so much stress and pressure most of the time that you're almost, you're only seconds away from sometimes lashing out with a verbal kind of, like, you know?” (Nurse, Band 5).

“Sometimes it’s got to the point where I don’t want to come to work. I was diagnosed with acute anxiety two years back, you know, the feelings you get before you get somewhere and your stomach’s all churning and you feel sick....it's just non-stop.... So, it does get stressful” (Accident and Emergency Receptionist, Band 2).

“Sometimes I only get 30 seconds in between calls – just to have the one extra member of staff would take the pressure personally off me so I could delegate the jobs rather than having to work on my own, try to run the team and try to do beds. ... I mean sometimes it’s quite stressful especially when we’re under bed pressure – it’s a bit full-on sometimes. It was so full-on one night I couldn’t find my car in the car park, I just... I couldn’t, I was so stressed I couldn’t find my car” (Domestic, Band 2).

“It’s unrelenting .... It’s very physical, very demanding... but, you know, there aren't enough hours in the day, quite frankly” (Nurse, Band 5).

“It’s just constant. One job after another, after another, after another... . So it's exhaustion as well. Totally exhausted.” (Paramedic, Band 5).

“The workload has increased, I would have said 90%. It's horrendously busy....” (Paramedic, Band 5).

“It's a bit like a train station in the afternoon” (Critical Care Nurse, Band 5).

“A lot of them are becoming disenchanted, and a lot of them are actually saying that they, for all the hassle, and for what they’re paid, they’d be better off doing a nine till five job” (Nurse, Band 5).

“Everyone’s stress levels are through the roof.... And the road staff, every crew seems to think that control is out to get them, and I think, in reality, they realise it’s everyone getting shafted, for want of better words, and not just us picking on one crew to chuck all the jobs out because the demand is just astronomical and the supply doesn’t exist”. (Ambulance Care Assistant, Band 3).
“It’s more intense now, definitely. The job has definitely changed to be more demanding... I think it’s because of the lack of staff that we have so it’s additional... like, it is more strain on the workforce, it’s running... because, as I’ve said, you know all the time as soon as you’re clear you’re going to get a job...all of this has a knock-on effect on your personal self, you know, you get... I’ve only just... In September I had to take a week off sick through stress, through having acid reflux, terrible acid reflux, not even helped by antacids” (Emergency Care Support Worker, Band 3).

“Everybody is so stressed and busy and domestic services do come in for a big brunt of, you know, if we’ve got a lot of infections, we tend to get the blame for it, you know” (Domestic, Band 2).

All of these responses paint an extremely depressing picture of these workers being under constant pressure. Worryingly, they feel that this has negative consequences not just for their own well-being, but also for patient care. This is particularly apparent in the ambulance service where targets are perceived to be used in a pernicious way and with paradoxical outcomes for the patients. Target response times are the bedrock of ambulance service organisation and delivery. It is a fact that the ambulance service is in many ways driven by call handling and the allocation of jobs from call control. This part of the service is responsible for communicating with crews on the road, using radio. Overall control is the sphere of the control dispatcher. The working of the control room is therefore central to the organisation and delivery of ambulance service, buttressed by target response times that are underlined by traffic light systems intended to delineate emergency situations and therefore, emergency response times. These targets have become all-important so “we’re not, sort of, left to give the proper care that we should be giving, it’s a case of: you must meet this target, you must get these patients here” (Ambulance Care Assistant, Band 3).

When asked about the consequences of failing to meet target response times it would appear that there is a largely punitive regime in operation and this is hardly helpful: “, if we’re not doing our job to what we’re expected to do, obviously we get the stress, you know, from management” (Ambulance Care Assistant, Band 3). The same respondent went on to emphasise how stressful the job had become, and how widespread this stress was across the service. These workers acknowledged that this is a stressful job by its very nature, that is, having to deal with sick (and sometimes badly injured people) but above and beyond this, “staffing levels are a real issues, because we haven’t... you know, ... there’s not enough of us on the ground (Ambulance Care Assistant, Band 3). He went on to emphasise the link between staff shortages and current pressures:
“that workload just increases, you know ... you know, I mean, we could meet public demand if we had the staff, absolutely” (Emergency Care Assistant, Band 3).

Several interviewees went on to explain how this general pressure spills over into sometimes antagonistic working relations that are triggered by frustrations with workload and lack of staff:

“You’ll get the nursing staff that are frustrated, they’ve got all these patients coming in, they’ve got nowhere to put them. We can only clean that bed as fast as we can clean it - sometimes it’s never quick enough regardless of how hard we try. I have to prioritise, you know which ward do we go to first.... They do get a bit gnarly with you sometimes” (Domestic, Band 1).

An important, but often overlooked aspect of these workers’ lives is the emotional resilience and indeed the emotional intensity associated with having to cope with extremely difficult situations – death; sick and injured children; traumatised relatives and so on. It is difficult to fully capture the impact on these workers of having to deal with these experiences and this side of NHS working needs to be carefully reflected upon – this is not solely the preserve of so-called “front-line workers” as it was raised by many of these interviewees. For example,

“It’s when you get the relatives here that’s when the emotional side starts because you see them all being put into the relatives room if it’s, you know, a really bad one. They’ve just been in and told by the doctor and the nurse and they’re, sort of, out of the waiting room in a state of shock and that. And they’re, sort of, walking around, you know, crying, screaming, shouting, sometimes, you know, smashing things.” (Accident and Emergency Receptionist, Band 2). His comments are also helpful when thinking through the rather unhelpful “front line/back room” delineation that dominates political discourse when contemplating the (re)organisation of the public services.

Coping with these emotional and sometimes highly-charged situations is made even more difficult by the sheer pace of the work. When asked how they coped with this sort of pressure, one commented:

“... one of my colleagues put it quite well when he said, you clock on and switch off. I thought that was a good phrase, because you don’t have time to, sort of, think, take it all in, you know, there’s no... there’s no... some shifts, there’s no recuperation, you know, you don’t have time to, sort of, get things right in your head, it’s just: next job. And it... I think it does take a toll, especially when you’ve worked a long week. It takes you, you know, two, three, four days sometimes, just to pull yourself round” (Ambulance Care Assistant, Band 3). His comments underline the uniquely intense nature of this job. Unsurprisingly then, perceived attacks on pay are deeply felt.
Lack of time is also seen to be impacting on patient care and the way the job is done:

“It seems much more intense ... you used to go on the ward with an expectation that you'd actually get time to, you know, talk to patients, and, you know, it sounds like a bit of a cliché, doesn't it, a nurse just sitting on the edge of the bed talking to patients or whatever, but, you know, I think that's pretty much gone out the window now” (Nurse, Band 5).

“I used to be able to talk to the patients, now though, we haven’t got time. You haven’t got time to actually sit down, and have a conversation. And sometime, that’s what the patients need. It’s all very well giving them a tablet, and making sure you do the tablet properly, but sometimes you find out, that actually, they don’t need that tablet, they don’t need that sleeping pill, they just need somebody to talk to” (Nurse, Band 6).

A critical care nurse explained in detail the lived daily pressures and how these impact:

“We all get busy with our own patients so the phones keep ringing. We have got more clerics but they have to have a break. So when they go on their breaks the phones go mad. So it starts costing up more in another way. The doorbell: the relatives are trying to visit their loved ones and we haven’t got time to get to the door. So this starts to impact on your delivery because when the first thing you have to say to a relative is, I’m really sorry, and they say to you, well, I’ve been waiting out there for half an hour. And you didn't know because you hadn't heard the bell, you were in a faraway bed space. And you’re already starting to apologise, but you’re trying to deliver decent care. And they’re already now in a position where they don’t feel as confident in you, which is the worst thing that can happen in an ITU. You want to know that your loved one is being cared for. ... it wasn’t... it didn't used to be like that” (Critical Care Nurse, Band 6).

There are also increasing pressures rooted in patient and in particular, relatives’ expectations:

“It’s... out there at the front is chaotic, and that’s when you’re get all the abuse and getting shouted at, literally, all the time” (Car Park Attendant, Band 2).

“People are upset and they do take it out on us because they’ve been waiting five hours. You’re knocking on the door and they’re going [unclear], I’ve been waiting, and you go... But it’s not me personally, it’s not me that’s made them have to wait from there, but you do. So, you see, it is quite stressful” (Emergency Care Support Worker, Band 3).

There are specific issues within the ambulance service that appear to arise from spreading these staff very thinly across a service under enormous pressure to deal with increasing call volume, and with the ways in which calls are allocated. Paramedics noted with extreme frustration that they are
often “stood down” from a call when they were minutes away from a patient and felt they might actually be able to help the patient, but are told they need to be “kept free for emergency calls” (or the ‘8 minute call’). As one put it, “I can’t, morally, and happily, go back to sitting in a car park waiting for the next eight minute emergency, knowing that somebody’s lying on the floor” (Paramedic Band 5). She knows that she would, to use her words “get hauled over the coals” for using her discretion and attending the job. So as she summed up, “so yes, it is, it's a crap job at the minute. It could be an awful lot better. The workload is an awful lot more than when a lot of us joined”.

The comments of another ambulance worker summarise the general mood:

“You know, we join the job not for the massive salaries, because there aren’t, we join the job because you’re a type of person... you’re the type of person that wants to care for people, and I think, you know, the stresses of pay and terms and conditions and targets, it’s just... it’s really, really affecting the job” (Ambulance Care Assistant, Band 3).

Thus far, these findings have raised fundamental concerns about pay and workload. They also reveal profound feelings of injustice – put simply, these workers do not feel valued.

3. Feeling valued and supported:”We can get any plonker to do the job”.

It is something of a sin qua non that the NHS relies on well-motivated staff who feel valued. Caring for patients and doing a worthwhile job is perhaps the embodiment of what is traditionally termed the “public service ethos” and this is being damaged. When asked about feeling supported and valued by managers the responses were fairly unequivocal:

“Absolutely not. Absolutely not. You know, you’re just... you’re just a number. I think immediate line managers, yes” (Ambulance Care Assistant, Band 3).

““A total lack of support from management” (Paramedic, Band 5).

Most felt valued by their colleagues and perhaps their immediate line managers but less valued by the wider public and certainly not by their senior managers. One rather surprising finding was the aggression faced by some of these workers from members of the public (and at times, colleagues/managers). In highly-charged situations, working relationships within teams/units are therefore important and help these workers to deal with the daily pressures. This has ramifications

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for when people are moved around to cover staff shortages. Typically, interviewees felt valued by their immediate work colleagues:

“By the people I work with, yes, management wise I’m not too sure” (Accident and Emergency Receptionist, Band 2).

“We’re a good team. We get on well together. We all work as a team, and we help each other out, and I do like that” (Domestic, Band 1).

A key issue is the sense of being under-valued by government as evident in the lack of commitment to the 1% pay rise:

“I know that people are going on about the 1% pay rise and things like that, you know, and it, I think it's wrong, you know. I mean, footballers and stupid get ridiculous amounts of money for kicking a ball around, you know, and Britain's supposed to be a wealthy country. And, you know, it's just you find it annoying and frustrating that, you know, you're constantly having to be told, you know, you've got to make cuts, you've got to do this, you've got to do that, you know? It's the NHS, for goodness sake. The money should be there. It shouldn't be an issue.” (Domestic, Band 1).

One notable point is that outsourced workers do not feel at all valued and as a band 3 clinical support nurse commented, why would they? He went on to explain:

“Some of these people have worked for the Trust for 20 and 30 years and they've given their whole lives to the Trust, and the Trust's just sold them down the line, and for what -to save a few pence? That's someone's life”.

An issue that emerged from the interview data related to a clear ‘pecking order’ within the hospitals and this led to administrative and clerical workers feeling particularly under-valued. Examples were given of administrative staff being verbally castigated and ‘put down’ in front of staff and at times, in front of patients. This cuts across any clear concept of ‘front-line staff’ and is undermining to staff, while also undermining the confidence of patients and their relatives. One interviewee explained how a manager claimed that there was no need to invest in Accident and Emergency “because we can get any plonker” to do the job (Nurse, Band 5). This suggests that attempts are made to keep clinical staff happy while perhaps regarding the lower band ‘support’ staff as rather more disposable. Nevertheless, these workers engage directly with patients and accrue a vast amount of terminological, computer and hospital-specific skills that take time to acquire. As one nurse put it, “without good backroom staff, you’re knackered”. Perhaps more importantly she went on to
observe, “if management aren’t valuing them, then you’ll find that there’ll be the same contempt out there, for them” (Nurse, Band 5).

This feeling of being under-valued by ‘the Trust’ was a feature of many of the interviews:

“The Trust don’t value their staff - they’ve never valued their staff” (Nurse, Band 5).

This general view was echoed across all interviewees, for example:

“Time and time again, you’re, sort of, told, well, you should think yourself lucky you’ve got a job, and I don’t think that’s right, you know” (Ambulance Care Assistant, Band 3)

“We don’t feel valued at all. It’s just like, you know, we’re going to put some extra things onto you. Each year there’s more and more things put on to you. We’re not going to pay you any more. Everybody’s fed up with it, you know” (Paramedic, Band 5)

“No, we’re not valued as a service…. I feel that the domestics are under a lot of pressure because they’re expected... I sometimes feel that they’re expected to do far more than they’re paid, to be quite honest. The majority of the domestics are keen and hardworking and proud of their area” (Domestic, Band 2).

There is a real danger of this becoming ‘just a job’. One commented that she felt her colleagues were “close to breaking down” (Paramedic Band 5).

These workers did not generally feel at all supported by their senior managers. There was widespread criticism of the expanding numbers and hierarchies of management that were not perceived to be involved with front line issues and who had little understanding of the day to day pressures:

“Ground floor you’ve got less staff, on the top you’ve got more staff, that’s the trouble with the NHS now. They are having more and more (job) titles, nothing more than that. And you can’t do anything, you know, (when) you need to do something, nobody is taking the responsibility” (Porter, Band 2).

One consequence is that these workers feel under-supported and this cultivates a regime wherein they feel they do not have a voice and, therefore, much value:

“We say it’s like a joke in our place, but we think our management run the place like a regime. You know, it’s a, do this, do that, you will do this. What's the term I usually use? The put up and shut up” (Accident and Emergency Receptionist, Band 2).
“You’re guilty no matter what. And the service is not very supportive, I find. As I say, they want to punish you more than help you at times, yes” (Emergency Care Support Worker, Band 3).

This general feeling of being unsupported surfaced across the board but was again particularly noteworthy among ambulance service workers. One explanation lies in the traumatic and emotionally intense aspect of their work, but nevertheless they reported a general worsening in their working experiences with regard to feeling supported to do their job. For example, they explained that they had no meaningful access to sufficient counselling /debrief opportunities after a difficult incident:

“It used to be the case if you got a really particularly nasty job, you’d be sent back to the station after you’d finished the job, have a cup of tea, have a debrief. We used to have a service called care support and a peer support, which ring you, see if they were needed to come and sit and go through things with you. And control would leave you alone, and you weren’t sort of harassed by any more jobs until you were ready. It doesn’t happen anymore…. And it’s almost like you’re being bullied to hurry up at the hospital and finish your paperwork and get back on the road. And it’s horrible. And then when you do go back, you’re feeling pretty crap, and then you get another nasty job. It is, it can be really awful” (Paramedic, Band 5).

References to bullying were alarming. A number of interviewees expressed concerns about an emergent bullying culture, so “there’s been bullying, there has been victimisation, I could go on” (Domestic, Band 2). This is indicative of managers bearing down on staff as they too come under pressure from targets. In similar vein, another recounted a recent event that he had come across:

“This other housekeeper came to me, he said, my missus has passed away, what can I do? And management are just bombarding him with letters, when are you coming back to work” (Porter, Band 2). Likewise, the ambulance service call centre environment was described as “a very, very intimidating atmosphere” (Call Handler, Band 3) and “a very bullying culture” (Paramedic, Band 5). It seems that there are similar problems on the wards too: “there is a lot of bullying” (Nurse, Band 5).

This culture is hardly likely to improve staff well-being and patient care, which when coupled with staff shortages and daily work pressures, may well trigger more stress-related illness and absenteeism. At best, people may feel under pressure to come to work when they are feeling unwell and this is hardly beneficial to themselves, their colleagues or indeed the patients.

Perhaps unsurprisingly in light of this, and most concerning of all, levels of morale among these workers appears to be “rock bottom” (Paramedic, Band 5).

A depressing picture emerges of extremely low levels of morale:

“It’s very low at the moment, right through, yes. Everybody’s tired, yes, tired, mentally tired. Yes. Morale is low. Again, it’s because you know you’re going to come to work. You know you’re not going to finish on time” (Emergency Care Support Worker, Band 3).

“Rock bottom. I have never known it to be as awful as it is now. Horrendously low. Everybody's just fed up with the job. You don't speak to anyone that says, oh, I love it. You know, because nobody does anymore ... I always used to say, well, if I win the lottery, I'd still work. I wouldn't now. I'd be off like a shot” (Paramedic, Band 5). She also added that she was trying hard to dissuade a friend’s son from contemplating a career as a paramedic. She went on to comment that “the people are just existing in the job rather than coming in and enjoying their job”.

Others made similar observations:

“Horrific. It’s... I know people always say morale is at an all-time low, but compared to when I first started five and a half, nearly six years ago, to now, there’s no trust in the service. No one wants to come to work. No one has any trust in the organisation, in each other, or in the government, to help us sort things out. We’re constantly lied to. We’re constantly blamed and it’s just a horrific place to work at the moment. That’s it, horrific” (Call Handler, Band 3). When asked what kept him motivated to stay in the job, he commented that:

“The hope; the hope that it will change. Also, the knowledge that the people I work with at all levels, down from management, work bloody hard. We’re making the best of a bad situation and if we all left things would be even worse, so even though things are really very poor now, in terms of the service for providing the support we’re giving to our staff we feel if we all left it would be ten times worse again. That’s what’s keeping most of us in the job”.

Likewise,

“It’s not like we’re cleaning just a few products; it’s the training and the pride that we give with our jobs. And it’s just getting broken down now, ...they seem to be wanting more and more and more so, you know, the standards are going down, and I’ve noticed ... Pride seems to have left ... morale’s so poor at the moment”(Domestic, Band 1). She went on to comment that she perceived a general worsening in morale.
Worryingly, it seems to have become just a job for some of these workers: “Just frankly having a job. But it’s extremely negative. I’ve never known morale to be so low. And the sickness levels to be so high. It’s a lot more stress-related” (Paramedic, Band 5).

Work pressures relating to being understaffed were also a source of stress and demoralisation: “extra duties is causing stress and the morale in the hospital is at rock bottom because of the pressure of extra duties we’re doing, you know, every day you come there is something... anything management do is a cost cutting exercise” (Porter, Band 2).

Likewise, “I feel that I’m on this treadmill, of trying to find a bed, and which one can I kick out? And that, when you’re doing it on a conveyor belt, you don’t feel like you’re giving them the care.” (Nurse, Band 5). This sense of despair was an alarmingly frequent feature of the interview data:

Staff spoke of being disaffected and “picked off individually and isolated” (Nurse, Band 5). The same interviewee spoke of “battle-hardened veterans” who chose to stay in the NHS, especially in the more deprived, socially diverse areas. He went on to acknowledge that “There are openings and individuals can get on and get out of that kind of hell that the rest of us are in”. The reports of demoralisation and at times, wanting to quit, littered the interview findings:

“So, for me, morale, sometimes, I just feel... sometimes, I feel I’d love to just give it all up, and if that tells you morale is low, yes, it is morale. It is poor morale, and if it’s poor from me, it must be from other people who’ve been doing the job for a long time” (Operating Dept. Practitioner, Band 5).

“Morale’s quite low because, you know what I mean, they put so much pressure on us to do all different things and we’re expected to remember things that you’re constantly under pressure. It’s very stressful.” (Clinical Support Nurse, Band 3).

An overwhelming feature of these workers’ responses was a deep sense of injustice juxtaposed with an equally strong sense of commitment to the broader ideals of the NHS, and to their sense of contribution to what they perceived to be an important role in patient care. This came across in all of the interviews and regardless of the job role.

### 5. Commitment to the NHS: “Everyone really, really does care about the patients”

It is important to note that across the board there is a huge commitment to doing the best possible job for the patients, notwithstanding the pay and workload pressures. Arguably this commitment to the patients and to the wider NHS only deepens their sense of injustice and grievance around the
same pay and workload pressures. The following comments exemplify these views and embody the sense of commitment to patients and indeed to the NHS, and this is regardless of job position:

“I’ve given 30 years of my life to the NHS, and proud to work for the NHS, not necessarily proud to work for this Trust ... because my respect for this Trust ended when they started outsourcing. But I’m proud to work for a company, I’m proud to work for the NHS because of what the NHS stands for” (Clinical Support Nurse, Band 3).

“I love the NHS, I don’t want it to be privatised. I know some of it has gone. I think it’s more beneficial for the country as a whole if it stays in the public sector. But the thing I’m proud of about the NHS is, it’s not interested in your financial circumstances outside these walls. It’s just interested in what condition you’ve got, can we help you? (Critical Care Nurse, Band 6). Her comments reflect more than twenty years of experience of working in the NHS.

“I mean you get to chat with them [the patients]... And that is what matters you know, and it takes seconds but it makes that patient feel a whole lot better that somebody is actually paying them a bit of attention” (Domestic, Band 2). Likewise another domestic commented: “We do try and, sort of, keep them happy. In there... we’re in there straightaway, as soon as we can, and then we get out, rather than disturb the patients” (Domestic, Band 2).

“We just chat to them. Some of the people that are on there don’t get any visitors and we might be the only people that they speak to that day so... you know... Obviously you can see them coming in and obviously they’re quite poorly and then you see them a few weeks later getting discharged or a few days later getting discharged and it’s nice. You know, you think, well, you know, we’re actually doing a good job collectively, because we are getting people better, which is what it’s all about” (Domestic Band 1). There is therefore enormous importance attaching to the ‘caring’ aspects of the job.

“I’m a strong believer in the NHS. I’m hoping, if we cause enough fuss and make enough noise, that they will turn themselves around and I can start to be proud to be a member of staff in NEAS rather than embarrassed. And I think, across the board, no one wants the patients to suffer, no one wants the patients to wait an inordinate amount of time. Everyone really, really does care about the patients and does care about the organisation. It’s just everything else that seems to be screwing them over, for want of a better word at the moment, which is ruining things. But I am a very strong believer in the NHS, “(Call Handler, Band 3).

“I mean, the patients ... I still love my job, no matter for all of this I do love my job. I do love chatting to people. I love, you know the contact that you have with them, so that side of it is still, yes, I still
do like that. It’s just that you just know that after everything else” (Emergency Care Support Worker, Band 3).

“Face-to-face with the patients, knowing that you can... you can, sort of, make a difference to someone, even just having... on a small level, you know. Yes, definitely get job satisfaction from that aspect of the job” (Ambulance Care Assistant, Band 3).

“I love my colleagues, the patients” (Domestic, Band 1).

“Well, you’re helping people... just nice to know that you feel needed, and you’re doing a good job” (Domestic, Band 2). This pride in the job is exemplified by an account of a group of domestics who were concerned about proposals to move some of the cleaning team onto the wards: “it needs eight of us to clean our theatres to the standard that we can hand them over clean and ready on a Monday”. As one of them explained, these are band one and band two cleaners, but they take enormous pride in their job.

On the one hand therefore, these workers spoke with pride, passion and commitment about caring for the patients, while at the same time expressing disillusionment and despair about how they feel under-valued, poorly paid and over-worked. A major consequence of all of this is that these workers may well begin to regard this as ‘just a job’, rather than as a commitment to the NHS:

“For the last two or three years the workload has increased exponentially, it feels. What I quite often say when people ask me if I like working for the ambulance services, I say when I first joined five and a half years ago I was proud as punch to be working for the ambulance service. I thought we were providing a good service, the time scales we got people help to were appropriate, and now I’m almost embarrassed” (Call Handler, Band 3).

There is widespread commitment to the ‘cradle to grave’ principles underpinning the NHS and very real concerns that this is in danger of being dismantled. Several commented that they used to feel proud but in light of the ongoing demonization of NHS workers, particularly by the media, they felt that this was being challenged. There was also widespread condemnation of outsourcing both for quality and cost reasons. Some examples were given to demonstrate how the overall cost of some provision/services had increased since being outsourced. “When we tell people we try to save their lives, how can you save their life with these things” (Porter, Band 2). As a result, a majority of these workers were extremely worried about the future:
“There’s no good news coming out ... it used to be a first-class pride thing to have, but it’s not there anymore. It’s just not there, and you see it with the nurses as well. So I just think it’s... I do, in my heart, believe it’s the beginning of the end; I do” (Domestic, Band 1).
Conclusions: “the whole umbrella is going to have to grow”

This paper has attempted to capture the voices of a fairly typical group of NHS workers employed in a variety of roles in different parts of the country. These voices are unequivocal in their condemnation of any attempt to reduce any aspect of their pay and in their reliance on unsocial hours payments in order to live. There was a clear view that they already provide sufficient flexibility through complex shift-working patterns that included nights, weekends and bank holidays – and that this flexibility needs to be adequately rewarded. So, “for us it’s a seven-day service. It’s not any different for us. We are a seven-day service, 24 hours a day, seven days a week. We don’t stop. So for us it’s just the normal… it’s the norm” (Supervisor, Domestic Service, Band 4).

It is crucially important to take full account of the workload and work pressures that these people are currently experiencing. They feel over-worked, under enormous pressure, under-staffed and under-valued. It is therefore worrying to hear them speak of instances of bullying and of feeling so unsupported. Juxtaposed with all of this, the research paints a picture of an extremely dedicated, hard-working group of people who demonstrate enormous commitment to patients. Despite being deeply demoralised, they continue to speak with pride about how they try their best to make a positive difference for “their” patients. This perhaps explains the enormous amount of good will, unpaid overtime, and desire to stay with the NHS, as was revealed in the findings.

The so-called front-line and back-room debate seems to be deeply ambiguous when reflecting on the comments and insights of this group of workers. Regardless of their individual job roles, they all demonstrated the same degree of commitment to doing their best for the patients. It would be a real pity to lose sight of this in any endeavours to further trim spending in this service as the key to flexibility in the NHS will ultimately depend on having a highly motivated, committed workforce. Unfortunately, this research has revealed a group of workers who feel far from motivated and valued.

It is also the case that these different occupational categories are mutually dependent on one another. It is a pity that they appear to have to draw their support from among their colleagues and indeed from their patients, rather than feeling able to look to their managers for support. It is clear from these interviewees that for them, the major barrier to any expansion in seven day services is the continued squeeze on the NHS budget at a time when service demand continues to expand. One domestic worker summed it up succinctly when concluding that there need to be more staff, more clinics, more wards, more money: “Then you’re getting into the realms of well the whole umbrella is going to have to grow to, you know, and yes it would be very expensive”. Her concluding remarks
offer a salutary reminder of the importance of maintaining decent terms and conditions for those who work so hard to deliver the best possible NHS for their patients:

“\textit{I’m a big believer, you know, if you treat staff right then, you know, the better you treat them the more you get back.}” (Domestic, Band 1).

\textbf{Acknowledgements}

I would like to thank all of those who gave their time to participate in the interviews. I would also express my sincere thanks to them for their willingness to speak so freely about their working lives, views and experiences.
## APPENDIX (i): LIST OF INTERVIEWEES

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### REGIONS:

- **WEST MIDLANDS**
- **EAST MIDLANDS**
- **LONDON**
- **NORTH WEST**
- **NORTH EAST**