UNISON submission to the NHS Working Longer Review

September 2013

Introduction

UNISON welcomes the opportunity to submit evidence to the NHS Working Longer Review. We are the major trade union in the National Health Service and the largest public service union in the UK. We represent more than 450,000 healthcare staff employed in the NHS.

Our members work across a broad spectrum of jobs in the NHS and include senior managers, cleaners, nurses, occupational therapists, ambulance staff, admin staff and porters.

Many of our members are extremely concerned about the impact that the Public Service Pensions Act 2013 will have on their long-term health and their ability to do their jobs as they approach their retirement.

Our submission is based on research that we undertook through our branch structures and UK-wide occupation-specific groups to identify the particular issues that are likely to arise for groups of staff within the NHS as they begin to work longer. We also conducted online surveys of our health membership to help us to identify members' concerns about working longer. Finally, we requested a huge amount of data from the Health and Social Care Information Centre, who provided us with an incredibly useful and detailed breakdown of sickness absence rates within the NHS according to age, job roles and also the reasons for sickness absence. We would be more than happy to share the detailed spreadsheets with the Working Longer Review if it would help further work into the impact of working longer.

What makes working longer more difficult and why?

In this section we aim to highlight the issues that affect a large cross-section of staff within the NHS and that are not specific to one particular occupational group.

A public service

Staff working in the NHS face unique challenges. The service runs 24-hours a day, 365 days of the year and staff have the knowledge that the service they provide will ultimately have an impact on patients and their health.

The demands of providing a 24-hour service mean that many NHS workers find they must compromise their family and leisure time in order to meet the requirements of their job. This may be exacerbated by having to work longer.

Currently, many staff are faced with the consequences of job cuts and understaffing, which have left them struggling to find enough time to provide safe and compassionate care for patients [1].

However, staff not only face the challenge of working with increasing workloads and the threat of cuts hanging over their heads, but also they must deal with the strain of working for an organisation that faces many wider political challenges.

NHS workers have faced huge organisational change with almost every successive government in recent years with the latest change representing the most fundamental reorganisation of how the NHS operates since its inception. When changes are enforced on organisations from government level it means that staff have very little opportunity to feel they can contribute to the process of change – something that will increase stress levels through the disempowerment of staff and the uncertainty this places on their future [2].

UNISON believes that increased stress and uncertainty will lead to staff feeling less secure and potentially feeling less committed to the NHS. **UNISON believes that in order to ensure that we can retain highly-trained and experienced staff and that the NHS remains an employer of choice there needs to be a real commitment to engaging with the views of all NHS staff in major structural change. Staff should not be used as a political football without regard for them as employees.**

Age-related ill-health

UNISON obtained data from the Health and Social Care Information Centre to get a picture of the sickness absence rates by age for NHS staff. The tables below show the average full-time equivalent (FTE) days lost per person due to sickness according to main staff group.

Average FTE days lost per person due to sickness absence for all professionally qualified clinical staff by age group 2012-2013[17]

Under 25	25 to 29	30 to 34	35 to 39	40 to 44	45 to 49	50 to 54	55 to 59	60 to 64
8.57	10.20	11.61	12.92	13.85	15.08	16.19	16.11	16.40

Average FTE days lost per person due to sickness absence for all support to clinical staff by age group 2012-2013 [17]

Under 25	25 to 29	30 to 34	35 to 39	40 to 44	45 to 49	50 to 54	55 to 59	60 to 64
12.68	13.22	14.40	15.82	16.79	18.28	18.54	19.18	19.32

Average FTE days lost per person due to sickness absence for all infrastructure support staff by age group 2012-2013 [17]

Under 25	25 to 29	30 to 34	35 to 39	40 to 44	45 to 49	50 to 54	55 to 59	60 to 64
8.69	8.89	8.83	9.61	10.65	11.31	12.71	14.08	16.00

In each staff group, the data shows an unequivocally clear correlation between sickness absence rates and the age of staff. **UNISON is extremely concerned about the effect that working till 68 years old will have on the health of NHS staff and would press for continued monitoring of the situation to ensure that an increasing number of staff are not being made redundant for reasons of capability.**

Across the NHS in England, in 2012-13, 15,243,104 full-time equivalent (FTE) days were lost to sickness absence. Of these, 1,617,311[1] FTE days were lost due to musculoskeletal or back issues [17].

The average number of FTE days lost per person, according to age, due to musculoskeletal and back problems within the NHS in England are shown in the table below [17].

Under 25	25 to 29	30 to 34	35 to 39	40 to 44	45 to 49	50 to 54	55 to 59	60 to 64
1.14	1.33	1.6	2.00	2.42	2.75	3.06	3.42	3.64

[1] Of the over 15 million FTE days lost to sickness absence, approximately one quarter do not have a stated reason attached to them, so the scale of a particular sickness absence reason may be significantly greater than figures suggest.

Again, the table shows a clear correlation between the number of sickness absence days and the age of staff.

Musculoskeletal problems are the most common cause of early retirement due to ill health for NHS staff in Scotland, being responsible for 38 per cent of ill health retirements [34]. In England and Wales they are responsible for 49 per cent of ill-health retirements among all NHS staff, including 68 per cent of ambulance staff retirements and 50 per cent of nurses and midwives [35].

Other studies have indicated that musculoskeletal disorders are amongst the most frequently reported occupational illnesses in older workers [3] and older people take steadily longer to recover from musculoskeletal injuries after muscular performance peaks at around 33 years of age [4].

However, the UK Health and Safety Executive (HSE) considers that age itself is not a risk factor for musculoskeletal disorders provided that employers make employment flexible for their staff. This can include making adjustments such as modifying tasks, providing retraining, allowing staff to change working hours and job content, and providing regular health checks for all employees [12]. Thus, employers should fit the job to the worker and take account of reduced physical capability of their older staff members.

However, contrary to the HSE guidance, UNISON's own research among nursing staff [1] and responses we received for this submission show that many members working in healthcare are not receiving flexible consideration from their employers. Some staff members are not currently able even to take the meal or toilet breaks that they are entitled to under EU legislation, let alone receive offers of redeployment or retraining to accommodate the degenerative effects of ageing.

As the working age is extended in the NHS, many older workers will need to take additional time to recover from musculoskeletal injuries. While younger workers tend to have more frequent bouts of sickness leave lasting only a day or two, older workers take fewer periods of leave that last for longer periods of time [5]. For example, in their study of occupational and physical therapists, King et al found that older and younger workers "have similar injury incidence rates, however, days away from work due to injury were higher among older workers." [6]

Furthermore, most studies conclude that the functional capability of older adults is less than that of younger people. Leaviss et al presented data to demonstrate that the physical work capability of a 65-year-old is around half of the capability of the 25 year old [7], and Welch et al showed that ageing was correlated to reduced physical functioning [8]. Aerobic capacity has been found to decline at a rate of about 10% for each decade of life, which is thought to be linked to reduced ventilation rates, reduced maximal cardiac output and reduction in peak heart rates associated with ageing [9,10]. It is clear that the majority of older people have a more limited physical capability than they did earlier in life.

Studies have also shown that older workers are more likely to work closer to their individual maximum capacity than younger workers, as typically the physical demands of a role do not decline over time [11]. This may help to explain why musculoskeletal disorders have been found to increase in both prevalence and incidence with age [9], and indicates that older workers are attempting to work to the same physical demands as their younger colleagues.

UNISON heard from members whose employers offered rapid access to physiotherapy and occupational health services to help staff to remain in work without time off for injury or to return to work more quickly after an injury.

However, we also received responses from staff who had been injured at work, but felt they "had to really fight" to get their injury taken seriously and others who felt "let down" that they were not given adequate time off to recover from injury or to attend hospital appointments.

NHS staff must feel supported when they are injured and employers should help them to return to work as soon as possible, whether through rapid access to services such as physiotherapy or occupational therapy, without making staff feel as though they need to 'work through' injuries and illnesses for fear of losing their jobs.

As the NHS workforce begins to age, there is also likely to be an increase in diseases where age is a risk factor.

Conditions such as latent autoimmune diabetes, where an important risk factor is an age greater than 60, [13] or Type 2 diabetes, which is more common in people over 40 [14] are likely to become more common.

Indeed, by 2025 it is estimated that five million people will have diabetes [15] and in order to manage the condition in NHS staff it is vital that staff have the opportunity to try to lead healthier lifestyles. A paramedic that we spoke to told us: "It's really difficult to eat healthily when you don't have a chance to take a meal break at a station", but instead have to carry snacks or meals in the ambulance. Meanwhile, nursing staff we surveyed told us that it was impossible to take a break if they were the sole registered person on duty for a night shift and that there was limited access to out-of-hours catering services, often meaning that staff had to rely on vending machines or a microwave for their meals; neither of which are particularly conducive to healthier eating.

It is essential that staff are able to take their breaks in order for them to have a drink of water, to monitor their blood sugar levels, visit the toilet or just to sit down.

UNISON would like to see the promotion of healthier lifestyles in the NHS and a commitment from employers to provide opportunities for staff to undertake more healthy eating or more exercise should they choose to do so. Minimum staffing levels will become even more important with an ageing workforce in order to ensure that staff are able to take breaks and have adequate rest during their working day.

On-call

For some staff within the NHS, working on-call is a necessary part of their job. On-call has been used to ensure that the NHS can operate as a 24-hour service. However, for staff who have to work erratic shift patterns, on-call can take its toll on physical and mental health. [16]

Staff working on-call are required to be ready to respond at a moment's notice, often having already worked a full shift. This, along with the lack of a regular working pattern, will have a significant impact on their family and social life as well as stress levels. [16]

Variable shifts have been shown to cause more stress than regular shifts [16] and, given the cumulative effect of stress on health, this may cause an increase in problems and health issues for older workers.

A paramedic working in a rural part of Scotland provided an outline of a two-week stretch from the on-call shift rota, which highlights the extreme demands on the physical and mental health of staff:

Day	0000	0100	0200	0300	0400	0500	0600	0700	0800	0900	1000	1100	1200	1300	1400	1500	1600	1700	1800	1900	2000	2100	2200	2300
Wed	Not working																Working							
Thu	Oncall								Not working								Working							
Fri	Oncall								Not working								Working							
Sat	Oncall								Working									Oncall						
Sun	Oncall								Working									Oncall						
Mon	Oncall								Not working								Working							
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Mon	Not working																Working							
Tue	Oncall								Not working								Working							
Wed	Oncall								Not working															

The rota presents a clear picture of an extremely demanding work schedule, where, over one weekend, staff are either working or on-call, without any non-contactable time, from Friday at 4pm until Monday at 8am.

The paramedic explained that there is a policy for when staff are called out when they are on-call but have another shift starting immediately after their on-call shift: "We have what's called a 'lie-in policy' so if you go home after midnight you can say 'I'm having a lie-in' but you decide what time you lie in until and you don't have to do that – the service doesn't enforce it.

"We also have a 'fatigue' policy. If you think you're too tired to work safely you can go 'fatigued' and if you're fatigued you are not contactable. But by doing that you are either leaving your crew mate singlehanded or you're leaving the area with no vehicle. It feels a bit like emotional blackmail."

UNISON would welcome more research into the effects of working on-call on health workers and its likely impact on workers' health as they age. There is already a number of studies about the effects of working rotational shifts, but there seems to be more limited information available on the effects of on-call.

UNISON would also welcome a review of policies such as 'lie-in policies' or 'fatigue policies', as mentioned above, and to consider how these should be enforced to ensure that there is not a pressure on staff to work when they feel they are too tired to be able to perform their duties or make clinical decisions safely.

The main groups of staff (other than doctors) to receive on-call payments are midwives, radiography staff and healthcare scientists, though small numbers of staff in other job groups also receive on-call payments [17].

The effects of on-call on the performance of staff are brought into sharp focus by a quote from the paramedic:

"Cat's eyes on the road are marvellous because they wake you up when you hit them. We have all at one point dozed off. Fortunately, because there's two of us, you hope that at least one of you is compos mentis enough to do the job."

Shift work

There is evidence to suggest that the cumulative effect of a number of years spent working shifts will have a detrimental impact on health. For example, women who work rotating night shifts over a long period are more likely to develop breast cancer [18].

Older people may be more sensitive to the influence of the circadian system, time of day, or sleep disruption during a 12 hour shift rotation than are younger people [19] and may find it difficult to adjust to afternoon and night shifts [18]. This will have an impact on older people's ability to continue working in roles that require them to work rotating night shifts.

This is reinforced by research which suggests that there is a significant difference between the performance of older and younger people working 12-hour rotational shifts.

Researchers found that in a simulated 12-hour shift rotation, "performance for the older subjects was consistently lower than for the younger subjects. There was a significant difference in performance across the shift between older and younger subjects. There was a significant change in performance across the shifts in the older subjects, such that performance significantly increased across the day shifts and decreased across the night shifts. By contrast, the younger subjects were able to maintain performance across both day shifts and the second night shift." [19]

This has huge implications for staff required to work longer and who are given no choice in whether to work day or night shifts as well as staff working 12-hour rotational shifts.

A solution to give night shifts or rotating shifts only to younger workers would potentially place an unfair burden on younger, newer and less experienced staff and may be a factor that would put off many new entrants into any roles affected.

As staff work to an older age, it is reasonable to assume that their partners, parents and other dependents will age as well and will require increased care. With increased carer responsibilities outside of work, many staff members will find the current practices of rotational shift working, twelve hour shifts and inflexible working hours to be in conflict with their other responsibilities. **UNISON recommends that, at a minimum, carer's leave and flexible working practices be strengthened and made available to all staff members.**

Also, UNISON believes that if the impact of shift work is greater for older workers there needs to be serious consideration given to how staff can adjust their working patterns as they get older without an unfair burden being placed on new or younger staff.

Occupation specific issues

Ancillary and maintenance

Staff employed in ancillary and maintenance roles are likely to experience increasing difficulty in working to a raised retirement age. Roles with a distinct physical component will be challenging for many staff as they age. As referenced elsewhere in this submission, muscular performance peaks in a person's early thirties [4] and an individual's physical capability is reduced as they age [7], although the demands of a job are not necessarily reduced in tandem.

The table below shows the sickness absence rate of staff working in hotel, property and estates services.

Average FTE days lost per person due to sickness absence for all hotel, property and estates service staff by age group 2012-2013[17]

Under 25	25 to 29	30 to 34	35 to 39	40 to 44	45 to 49	50 to 54	55 to 59	60 to 64
10.4	12.72	13.12	13.62	14.66	14.96	16.19	16.96	19.31

As with all other job groups there is a huge difference between the average number of days lost through sickness absence for staff under 25 compared to staff 40 years old and over.

For this group of staff the most common reason for sickness absence when a reason was identified was due to musculoskeletal or back problems as shown in the table below.

The average number of FTE days lost per person, according to age, due to musculoskeletal and back problems for staff working in hotel, property and estates services within the NHS in England [17].

Under 25	25 to 29	30 to 34	35 to 39	40 to 44	45 to 49	50 to 54	55 to 59	60 to 64
1.37	2.13	2.45	2.63	3.05	3.35	3.85	3.88	4.79

This occupational grouping includes staff in catering, porters, laundry, cleaning, caretakers, builders, security and porters. Their responsibilities vary greatly and include many known workplace hazards: porters are at high risk of musculoskeletal and repetitive strain injuries due to manual handling of patients and unwieldy equipment; catering staff suffer burns, stress from mealtime rushes and frequent slips, trips and falls from spilled foods and cleaning staff are exposed to harsh chemicals that cause skin disorders and other reactions, as well as physical strain from bending and crouching. Some of these roles, such as porters, will experience emotionally traumatising events which they witness when they deal with patients and their families.

In a survey, 68% of security staff said they had personally been verbally abused or physically threatened in the previous 12 months [20]. This type of abuse affects the health of staff through anxiety or stress and, if experienced repeatedly, can also lead to depression, reduced morale and increased sickness absence [21]

Current figures [17] show that 54% of ancillary and maintenance staff work shifts, which has been discussed earlier in this report in relation to the increased incidence of work-related ill-health.

A large number of jobs within this category fall within the lowest Agenda for Change bands. Staff within these bands will receive a lower pension than staff in higher bands – lower pensions have been linked to higher mortality rates [22]. Deaths in service of male and female manual workers, as a percentage compared with expected deaths, have been shown to be the highest compared with males and females, respectively, from eight occupational valuation groups. [23]

The data also showed that male and female manual staff have the second highest and the highest average age of retirement, respectively, at 63.6 for men and 62.7 for women. [23]

UNISON is concerned that as manual workers perform physically demanding roles, which will have a cumulative negative effect on their health, yet many will be unable to retire early due to their low pay. UNISON believes that further work needs to be done to look at the reasons behind the high mortality rates within manual workers and what can be done to address it. As with all job roles there needs to be more work done to address limited redeployment opportunities within the NHS. Also given the large percentage of staff who work night shifts within this group, there needs to be further consideration given to the ill-effects of shift working on older people and manual workers [19].

Administrative and clerical staff

Although the workplace hazards faced by administrative and clerical staff may not be as initially obvious as for other roles, these hazards are just as real and just as damaging to the individual. Administrative and clerical staff face a variety of difficulties that range from emotional to psychological to physical issues, and unfortunately, as with many roles within the NHS there are limited redeployment opportunities for staff who wish to transition to less demanding roles.

Admin and clerical staff are often the first point of contact between the NHS and a patient. They must deal with patients and members of the public as part of their everyday responsibilities and often find themselves held accountable for outcomes over which they have no control, such as delays in a waiting room or long waiting lists. The lack of control over elements of their role can be a cause for stress [2]. Responses that we received included statements that the pressures of work are worsening as employers implement cuts to staff and services that result in busier staff and longer waits for frustrated patients. Indeed, the most common reason for sickness absence (where a reason was stated) among staff working central functions within the NHS was anxiety/stress/depression/other psychiatric illnesses [17].

Furthermore, some roles in this group such as medical secretaries witness extremely traumatic materials. Medical secretaries may have to type notes for cases involving the deaths of children or clinical notes concerning sex offenders and are prone to experience trauma as a result. **It is important that as staff work longer they have access to any necessary counselling or therapy services that may be required to prevent them from 'burning out'.**

Many administrative and clerical jobs require intense concentration and the highest levels of accuracy. This is necessary because a data error can result in a genuine matter of life or death. For staff experiencing fatigue associated with ageing, roles that require such a high level of precision can be stressful and exhausting. Adding to the mental strain and fatigue of such roles are the regular changes in technology that require staff to learn new processes and systems.

In answering our call for evidence, one medical secretary wrote: "I am 63 at present and quite happy working, but then I only do 24 hours per week. I think I would find my job difficult at my age having to work full time as the concentration levels tend to diminish a little and the job does require a good degree of concentration."

The vast majority of admin and clerical staff have desk-based roles that require long periods of computer use. Musculoskeletal symptoms and upper limb disorders are common among computer users and the risk increases with addtional time spent at a computer [24]. With a raised retirement age, we are therefore likely to see a rise in upper-limb disorders among this group of staff.

Furthermore, most staff in this occupational group do not draw high salaries that would allow them to retire early. The majority will need to continue working until the raised retirement age, regardless of the difficulties they encounter due to ageing.

Sitting for long periods of time has been linked to an increased risk of cardiovascular disease and a higher mortality rate [25]. **UNISON therefore recommends that there needs to be more work done to ensure that staff take breaks from sitting at their desks and that health and safety measures regarding breaks from computer screens need to be more rigorously encouraged rather than left to individual members of staff to undertake.**

Meanwhile, rapid access to services such as counselling or physiotherapy will help to reduce the numbers of staff who face redundancy following a capability procedure.

Nursing and midwifery

UNISON represents staff working across the whole nursing family. This staff group encompasses a wide range of roles and responsibilities including healthcare assistants, midwives, health visitors, registered nurses, student nurses and nurse managers in an equally wide range of care settings. The experience of a mental health nurse in an urban medium-secure facility will differ greatly from the experience of a health visitor in a rural community, but both will face difficulties in working to an increased pension age.

In her examination of the stress faced by nurses and midwives, Sonya Wallbank, associate professor at South Warwickshire Foundation Trust, found that nursing staff have a typical score of 43.35 on the internationally recognised Impact of Event scale, which was around 1.5 times higher than the average for soldiers surveyed after a military trauma in a warzone [26]. A score of 44 is considered to be severe and may affect the ability of the individual to function.

UNISON's own research has revealed that stressors for nursing staff are increasing [1]. Members are reporting that due to austerity measures:

- their workloads are increasing as vacancies are left unfilled
- they have fewer friends on their shifts due to an overuse of rotating bank and agency staff who they never see again
- patients and families who are forced to wait for longer treat staff less pleasantly
- many are forced to leave some aspects of care undone due to a too-heavy workload, making them unable to do their job as well as they would wish
- many work unpaid overtime and miss meal breaks due to this heavy workload

These stressors are added on top of a role that is already emotionally stressful. As has been highlighted in the Francis [27], Berwick [28] and Keogh [29] reviews, nursing staff are expected to deliver a high level of emotional care and support alongside physical care.

The NHS trade unions undertook a survey of NHS staff as part of the Working Longer review call for evidence. When asked: "[Would you] find it useful to be deployed into a less emotionally demanding environment", the occupations most likely to find this very useful were nurses, midwives and emergency medical technicians.

The detrimental impact on patient care when nursing staff become burnt-out and when morale is low has been highlighted most recently in the Francis [27] and Keogh [29] reports, where examples of care left undone are shown to have huge ramifications. Any attempt to increase the strain already placed on nursing and midwifery staff, such as making them work for longer, needs to be approached with care and consideration, and needs to be fully risk-assessed to determine the potential outcomes both to staff and patients.

Other specialist areas of nursing such as in neonatal intensive care units can see nursing staff experience high levels of psychological and physical stress, and eventually burnout [30].

Because they work at the frontline, providing direct patient care, nurses face high levels of abuse from patients or members of the public. When surveyed, 78% of A&E nurses reported that they had personally been verbally abused or verbally threatened in the previous 12 months. Meanwhile 21% of hospital/inpatient nurses reported they had been physically assaulted by a patient or member of the public in the previous 12 months [20]. This type of abuse affects the health of staff directly when an actual physical assault takes place and indirectly through anxiety or stress. If experienced repeatedly this can also lead to depression, reduced morale and increased sickness absence [21].

Figures from the Health and Social Care Information Centre highlight the extent of the problem.

Among qualified nursing, midwifery and health visiting staff 5,234,102 FTE days were lost to sickness. Of these by far the greatest number, 953,250, was due to anxiety/stress/depression/other psychiatric illnesses. Over 70% of these FTE days were taken by staff aged 40 or over [17]. Staff aged 40 or above on average took 4.5 days for these reasons, compared to 2 days for staff aged 39 and under.

The data also suggests that across the nursing family the average number of days lost to sickness absence increases with age.

The average number of FTE days lost per person, according to age, due to sickness absence for qualified nursing, midwifery & health visiting staff and support to doctors and nursing staff within the NHS in England [17].

Under 25	25 to 29	30 to 34	35 to 39	40 to 44	45 to 49	50 to 54	55 to 59	60 to 64
11.57	12.81	14.11	14.82	15.63	17.17	18.03	18.3	18.88

In actual terms, 9,874,696 FTE days were lost due to sickness among this group of staff.

As discussed elsewhere in this report, the cumulative effects of stress can be as damaging to the individual as a major trauma [31]. Raising the retirement age may mean that this damage is compounded through additional years of stress. UNISON recommends that strong provisions be set in place for nursing and midwifery staff to access emotional support, receive transfers and training into less stressful roles where necessary and to receive time off work to recover from any work-related stress incurred. Managers must be trained to spot the signs of stress and to operate a positive and promoting attitude regarding looking after the mental health of staff.

Nursing and midwifery roles are not merely psychologically stressful; there are distinct physical requirements that take their toll on staff as well. Many caring roles are physically demanding: patients need to be lifted, turned, washed, helped to the toilet, as well as countless other physical tasks.

Mental health nurses may be required to restrain and control patients, which can be very challenging if the patient is strong and/or large.

One UNISON branch secretary responded to our call for evidence by writing: “In particular mental health nurses [will have difficulty working longer] due to the lack of suitable alternative positions for staff no longer able to undertake restraint when necessary. Our employer is already looking to displace staff who are unable to participate in restraint training.”

It is important that the additional stress placed on staff through so-called ‘efficiency savings’ or job cuts are recognised. An increased workload will have an effect on the physical and mental health of all staff, and nursing staff in particular are at the very frontline of such cuts and see the effects on patient care, first hand.

As nursing and midwifery staff age, many suffer musculoskeletal disorders and upper limb disorders caused by their work [32]. It needs to be recognised that although there is manual handling guidance, there are situations where such guidance is not appropriate, such as when equipment is unavailable or broken; where staff are responding to an emergency and must, for example, lift a patient as quickly as possible or when a patient is uncooperative.

After anxiety/stress/depression/other psychiatric illnesses, the next most common reason for sickness absence (where a reason was stated) among nursing staff was due to musculoskeletal or back problems, with 1,690,390 FTE days lost in 2012-2013.

The average number of FTE days lost per person, according to age, due to musculoskeletal or back problems for qualified nursing, midwifery & health visiting staff and support to doctors and nursing staff within the NHS in England [17].

Under 25	25 to 29	30 to 34	35 to 39	40 to 44	45 to 49	50 to 54	55 to 59	60 to 64
1.31	1.56	1.89	2.24	2.68	3.06	3.41	3.81	3.90

Another aspect of nursing work that needs to be taken into consideration is the time available for nursing and midwifery staff to take their breaks. As with most aspects of healthcare, nursing staff must respond to a patient's needs, which will affect when they are able to take breaks.

Often, a nurse may be the lone registered staff member working a night shift so will be unable to take a break or leave the area [29]. As stated in the section on age-related ill-health, this will become increasingly significant with an increase in diabetes and other age-related diseases among staff, with the need for breaks to enable staff to have a drink of water, monitor blood sugar levels, eat, visit the toilet or sit down becoming even more important.

Many nursing staff members work rotating shifts and over 60% [17] of nursing staff work night shifts. The figure for midwives is 80%. As discussed earlier in the report, shift working has a detrimental impact on health and on an individual's ability to perform their duties.

There is also the practical issue of night working where staff have little or no access to out-of-hours catering, so may have to purchase their meals from a vending machine or use a microwave to reheat meals, neither of which encourage healthy eating among staff.

Given that the NHS faces a decline in the number of registered nurses over the next few years [33] and that the workforce is ageing, it will become increasingly important to examine more closely factors such as shift working that have a detrimental impact on the long-term health of nurses and to look at what can be done to mitigate the effects.

Scientific, therapeutic and technical

NHS staff working in science, technical and therapy roles cover a wide range of fields including psychologists, physiotherapists, dental technicians, hospital scientists, occupational therapists, pharmacy assistants and cardiology technicians. These staff members work in an equally wide range of settings, from hospitals to community practices to laboratories to learning disabilities.

The average number of FTE days lost per person, according to age, due to sickness absence for qualified scientific, therapeutic & technical staff and support to ST&T staff within the NHS in England [17].

Under 25	25 to 29	30 to 34	35 to 39	40 to 44	45 to 49	50 to 54	55 to 59	60 to 64
8.05	8.12	8.73	9.55	10.83	11.83	12.7	13.85	13.82

Each of the roles in this group requires a high level of specialist knowledge. Intense concentration is intrinsic to many of the job descriptions and all staff are required to keep their knowledge up to date with the leading research and technology in their field.

For example, activities performed by these roles can include:

- researching and developing techniques and equipment used by medical staff to diagnose and treat patients
- monitoring equipment (like x-rays and ultrasound) to make sure they are accurate, safe and well-maintained
- training hospital staff in the use of new equipment and complex procedures
- helping to plan treatment programmes as well as explaining procedures to patients
- carrying out complicated procedures and analysing test results
- using computer simulations and mathematical modelling techniques during research and development work

Roles that require specialist knowledge and prolonged intense concentration carry two additional burdens for older staff. Firstly and perhaps most obviously, staff are placed under intense mental strain as part of their role. High levels of attention to detail and concentration are required for hours at a time. Staff will be required to process complicated information that has serious consequences if it is misjudged. For older workers who suffer from an increased tendency toward mental fatigue as part of their natural ageing process, this aspect of the role will quickly become exhausting.

This is reflected in data from the Health and Social Care Information Centre which suggests that anxiety/stress/depression/other psychiatric illnesses are the most common reason for sickness absence among this group of staff.

Secondly, it is in the nature of a specialist role that few people can perform it. This high demand for staff with specialist skills risks severely limiting opportunities for flexible working such as reduced hours. Where managers do not have a strategy in place to replace highly skilled staff, staff may suffer. One UNISON member stated during our call for evidence: “I do a highly specialist job; there are only three others in the NHS doing similar work. Hence it is hard to find staff with specific skills and experience. My colleague is of retirement age, although his manager wants him to continue working part-time as he will be very difficult to replace. However, he is being offered a lower pay band to do the same job, and he is worried that he may be expected to cram his full-time job into three days per week!”

Furthermore, there will be staff in this occupational group whose roles are very physically demanding. Inpatient mental health/forensic therapists may be required to use control and restraint as part of their job. Paediatric therapists may be bending, crouching and kneeling all day, often sitting on furniture designed for children. Community-based work may require significant amounts of driving, especially in rural areas.

Others will experience eyestrain from computer screens and diagnostic and scientific equipment. Meanwhile moving burdensome equipment, performing manual handling or working with patients in small spaces in their homes may lead to musculoskeletal disorders, upper limb disorders and fatigue, which are likely to increase with the raised retirement age.

Ambulance

Ambulance staff provide healthcare in emergency and non-emergency situations.

When emergency situations take place, ambulance staff, like police and fire staff, have to cope with overwhelmingly stressful situations and often have to make split-second life-or-death decisions within the course of their duties.

The unique nature of their role means they are required to put themselves in physical danger as part of their everyday role. This isn't only when 999 emergency responder staff are called to a car crash or running into the scene of a major incident, but also as part of the day-to-day routine call-outs where they must attend to patients who have fallen in awkward positions, where lifting equipment isn't available or cannot be used.

A paramedic does not often have the luxury of a controlled environment where they can use the necessary equipment to protect themselves. They must respond in the same way as a fire fighter or a police officer would and put their own health and safety aside.

As part of our research for this submission, UNISON undertook an online survey of all our members working in ambulance trusts across many different roles. The responses highlighted the physical and psychological demands that ambulance staff experience on a frequent basis as part of their role. In order to highlight issues particular to the work of 999 emergency responder staff (ERS), where necessary, we filtered the results of our survey to look at only those staff that responded to emergency calls.

Physical demands of ambulance work

The work of ambulance staff is often physically and psychologically demanding, which increases the risk of illness and injury. This is borne out by statistics [17], which show that ambulance staff consistently have the highest sickness absence rates across the NHS.

The average number of FTE days lost per person, according to age, due to sickness absence for qualified ambulance staff and support to ambulance staff within the NHS in England [17].

Under 25	25 to 29	30 to 34	35 to 39	40 to 44	45 to 49	50 to 54	55 to 59	60 to 64
11.26	14.96	18.03	21.47	22.83	24.64	25.54	28.49	28.17

In 2012-2013, 6.55 per cent of qualified ambulance staff were ill on an average day - the highest rate of any staff group.

The tables below show the annual sickness absence rates for all staff in all ambulance trusts in England by age.

Annual sickness absence rates for all ambulance staff by age group 2012-2013 [17]

Under 25	25 to 29	30 to 34	35 to 39	40 to 44	45 to 49	50 to 54	55 to 59	60 to 64
3.33%	**4.14%**	**4.73%**	**5.97%**	**6.34%**	**6.67%**	**6.88%**	**7.57%**	**8.15%**

For paramedics the sickness absence rates are even higher and the increase with age is even steeper.

Annual sickness absence rates for paramedics by age group 2012-2013 [17]

Under 25	25 to 29	30 to 34	35 to 39	40 to 44	45 to 49	50 to 54	55 to 59	60 to 64
3.40%	**3.68%**	**4.76%**	**5.83%**	**6.59%**	**6.84%**	**7.43%**	**9.34%**	**9.41%**

The Job Evaluation (JE) process used as part of Agenda for Change to evaluate jobs within the NHS highlights that there are only 12 roles that score five out of five for physical effort. Four of these roles are ambulance staff.

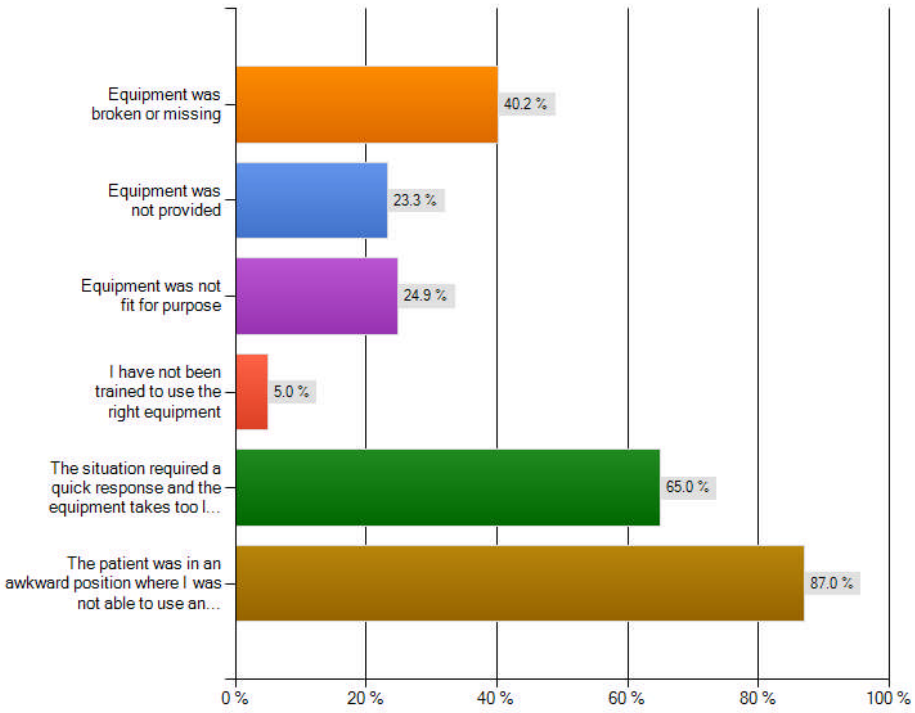
The Working Longer Review is likely to make recommendations about how the physical health of staff should be protected with a raised retirement age. However, there are already health and safety procedures in place for ambulance staff, but the unique and urgent nature of the work of 999 emergency responder staff (ERS) mean staff are often unable to follow them.

In UNISON's survey of ambulance staff 94% of ERS respondents replied that they are 'frequently' required to lift patients. The remaining 6% replied that they 'sometimes' lift patients.

When respondents were asked whether they ever lifted patients without using the appropriate equipment, over 90% replied that they do so either 'sometimes' or 'frequently'.

This is a worryingly high figure. Studies on physical health associated with ageing discussed earlier in this submission suggest that ERS will struggle to cope with these tasks as they age. The unpredictable and emergency nature of their work makes it very difficult to make adjustments to their role to account for the physical difficulties.

ERS were asked to tick all the reasons that applied to situations they had experienced when they were required to lift patients without the appropriate equipment. The graph below shows their responses.



87% of ERS said they had to deal with patients who had been in an awkward position and so they were not able to use the appropriate equipment.

65% said the situation required a quick response and the equipment would have taken too long.

When asked for specific details about these two points, the UNISON survey was inundated with hundreds of responses in which ERS described scenarios where they were unable to use their health and safety equipment. The vast majority provided details of everyday situations, rather than major incidents, where they were unable to use appropriate lifting equipment.

A small cross-section of responses is included below:

- "In a small alleyway on a cobbled street, the patient had fallen behind bins and a wall and I was unable to get any equipment in the street";
- "A cardiac arrest in a tight bathroom";
- "The patient was found lying between the toilet and bath in a small bathroom. The patient was unconscious and had bradycardia. The patient was pre-arrest. It was not suitable to use lifting equipment due to the limited space within the bathroom."
- "Patients do not fall flat on classroom floors [as occurs during training] so frequent use of sheer body strength is required";
- "The patient was too large to move even with the correct equipment provided";
- "I work as a solo on a RRV [rapid response vehicle] and if no back-up is available I need to move the patient for further examination/treatment and/or the patient's comfort. This is a regular occurrence."

Many others also backed up this last statement that they work alone and have to lift patients because of the urgent nature of the situation.

Amount of equipment paramedics must carry

As well as lifting patients, paramedics must also carry a huge amount of equipment with them. This is particularly noticeable with paramedics working alone in rapid response vehicles.

One paramedic that we spoke to weighed the average equipment that would be used for a typical callout.

For a common scenario of a patient with one or more of the following conditions: chest pains, difficulty breathing, collapsed or unconscious, the kit needed would be:

- Personal issue responder bag containing basic and advanced life support items plus some other monitoring tools such as a manual BP/BM kit and dressings
- A "Shock-Box" portable AED Defibrillator with baseline ECG monitoring capability
- Portable Oxygen cylinder in carry bag
- Drugs bag and possibly morphine
  Total equipment weight is 27kgs

If the Shock Box is replaced with a defibrillator with full ECG monitoring capability the weight of the equipment rises to **42.5kg**.

The paramedic added: "Some people would argue that you shouldn't carry all that equipment into a job, but I'd say that you can't be with a patient for an hour and a half, especially if you're in a block of flats and keep going backwards and forwards to the car – it just might not be practical."

The average number of FTE days lost per person, according to age, due to musculoskeletal or back problems for qualified ambulance staff within the NHS in England [17].

Under 25	25 to 29	30 to 34	35 to 39	40 to 44	45 to 49	50 to 54	55 to 59	60 to 64
2.89	2.76	4.75	6.18	6.57	7.65	8.41	9.42	10.81

Given the increased prevalence of such problems with age, without preventive intervention it is likely that the continued employment of an older workforce will result in people in their sixties retiring early due to musculoskeletal problems or being made redundant on capability grounds. Some of this will reflect the inevitable worsening of these types of problems due to injury earlier in life, but people whose jobs require them to do lifting, for example, may continue to compound earlier injuries.

Ambulance emergency response work is consistently documented as more physically demanding than almost any other profession. In their analysis of forty-nine studies on the health of ambulance workers worldwide, Sterund et al [36] found that ambulance staff have a higher likelihood of dying from heart disease, all cancers or fatal accidents than the general population. Ambulance workers have the same rate of fatal accidents as those working in the fire or police services. The review also highlighted that ambulance staff have a higher rate of early retirement on medical grounds. It was also found that in the UK ambulance staff have a higher standardised mortality rate compared with the national average, as well as higher blood pressure.

As outlined above, it is the cumulative effects of the everyday physical requirements of the job that will have a long-term detrimental impact on the physical health of ambulance staff. However, there are also the less frequent but still common major incidents and accidents that require ERS to put themselves in dangerous situations.

The case study below provides details of a road traffic collision attended by a paramedic in a rapid response vehicle.

Case study of a paramedic working solo in a rapid response vehicle at a road traffic collision

I was first on the scene. I drove past the scene and had to come up the opposing carriageway. I could see from the other side that the car had rolled down a ditch. I called up at that point and said 'Have you got the fire brigade running, have you got the police running? They need to attend.'

Another five minutes passed before I could actually get to the scene.

I grabbed my bag and I had to get down the bank by the side of the carriageway and try to work out where the hell the patient might be.

The car was on its side in a ditch and he was in the driver's seat suspensed by the seatbelt. The seatbelt was what was keeping him from falling into the footwell of the car.

I went over on my arse twice when I was going up and down [into the ditch] when I first got there.

I could see he was breathing and had a pulse but I couldn't do anything to help him. Until you start peeling the car apart you can't see what you're dealing with.

There was a gap in the window with the radio going at full pelt because the engine was still on and all I could do was reach down and touch this lad's nose, his face and I could just about reach his throat to check it.

For about 15 minutes I was on my own, then I had a manager and then the fire brigade – who are fantastic because they get on and do their bit and then they send people to help me.

They took the windscreen out and I was able to crawl in and lie on the bottom. I couldn't wear my helmet because it was too bulky so the firemen were there to protect me. I've got firemen working around me and I'm trying to put a monitor on.

I was able to do what I had to do eventually – I could get an access line into him, I decompressed his chest, I got oxygen on him, I assessed him and I was monitoring him.

When a person has a traumatic chest injury they will over-breath. I said to the first fireman on the scene – if we can't get him out within 30 minutes there's nothing we can do for him and even then that was being generous, unfortunately.

It took a good 20 minutes before I was able to get any real access and he was trapped in the car for 90 minutes before we got him out. We were there for two and a half hours.

I just felt helpless because the outcome was a foregone conclusion really – just because of the nature of his entrapment.

The ambulance crew arrived, by which time we had a doctor, a paramedic and a basics doctor. We called it by the side of the road.

We had an ambulance awash with blood. I had to go with the crew because the crew said they didn't know the whole story.

I got the call at 12.30am and I booked green and available again at quarter to six in the morning. My allocated break time had been 1am, but you don't notice it because your adrenaline is clearly going like the clappers.

My shift was 7pm to 7am.

There is evidence to indicate that ambulance emergency responder work is more detrimental to the individual than either police or fire service work. In Johnson et al's study of occupational stress levels, ambulance work was the only occupation to score in the top four rankings of the three factors that contribute most to stress – the damage done to physical health, psychological well-being, and one's job satisfaction [37]. Twenty-six occupations, including ambulance, fire brigade and police, were ranked according to the work's toll taken on physical health, psychological well-being and job satisfaction. Below are the rankings for ambulance, fire brigade and police work. Higher rankings indicate worse than average health and well-being and lower than average job satisfaction.

Physical Health	
Rank	*Occupation*
1	Ambulance
9	Police
21	Fire brigade

Psychological Well-being	
Rank	*Occupation*
3	Fire brigade
4	Ambulance
11	Police

Job Satisfaction	
Rank	*Occupation*
2	Ambulance
3	Police
12	Fire brigade

As shown in the tables above, ambulance work was rated as the most detrimental to workers' physical health, the fourth most detrimental to psychological well-being, and as having the second least job satisfaction. The scores for police and fire brigade work are shown here for comparison, and the full tables can be found in the original article. From the evidence in these tables, it is clear that ambulance work is as detrimental to staff, if not more, than work in the police force or fire brigade.

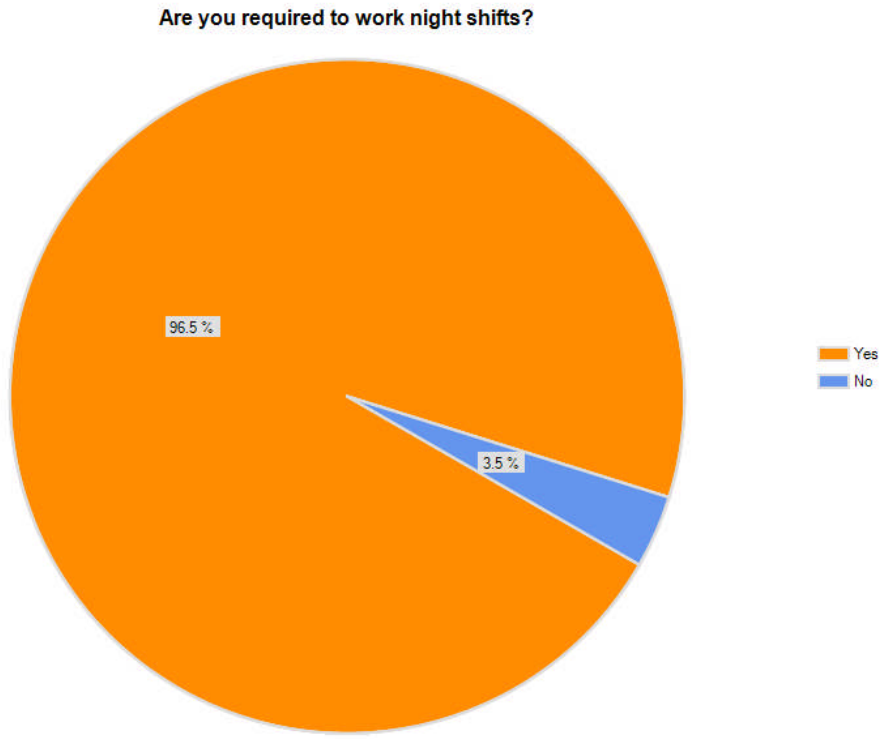
It is not only the type of work that ERS do but also the sheer volume of calls that they must attend that have an impact on their physical health.

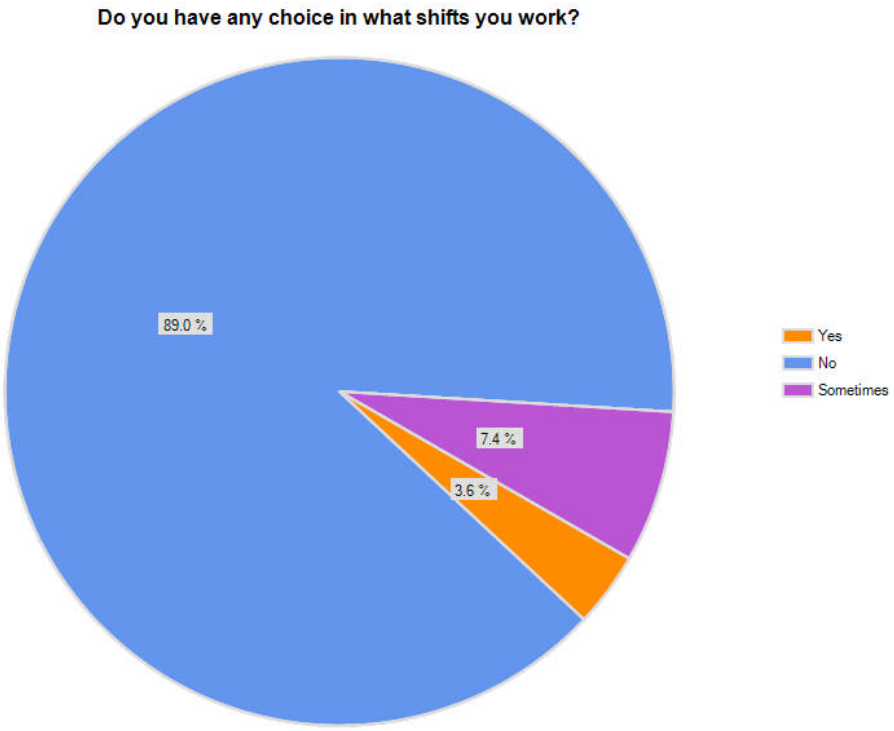
"If you're part of a [double ambulance] crew you're run ragged: you book on duty and you can literally go from job to job to job. Your only stand down time is the time you're waiting in A&E to handover or doing your paperwork or tidying up. If you're lucky you might get back to base for your break but if not you'll end up having it at the nearest station at whatever time or you just keep going", one paramedic told UNISON.

Ambulance shift work

Over 96% of qualified ambulance staff work nightshifts as part of their work [38].

Of the ERS in our survey, 89% said they do not have a choice in what shifts they work.





Given the research on the effects of rotational shift working on older workers [18] this is likely to have a negative impact on the health of workers as well as the service they provide.

One paramedic described the impact of rotating shifts as "a constant feeling of jetlag... I'm so tired all the time. All the vehicles are breaking down because they can't cope and it won't be long before all the people start breaking down too. It's relentless."

Working late afternoon and evening shifts has been linked to an increase in stress for workers and their families while variable shifts have been shown to cause more stress than a regular shift pattern [16].

If workers are less able to adjust or cope with night shifts and rotating shifts as they get older, the impact will be not only on the individual's health but may also affect the quality of service they are able to deliver.

Emergency responders are also expected to drive under blue-light conditions, with the added stress factor of patients being treated and transported in the vehicle at the same time.

Research conducted on medical residents working long night shifts found that 75% of road accidents among this group occurred after they had worked a night shift, while a similar study on paediatric residents indicated that residents fell asleep at the wheel significantly more than other professionals, with 90% of these events occurring after a night on-call [16]. These results have potentially worrying implications for ambulance drivers working shifts and on-call. UNISON would welcome more research into the effects of working long shifts and on-call on ambulance drivers ability to drive safely.

Emotional impact of ambulance work

Unlike police vehicles or fire engines, ambulance drivers have to take into consideration that in the back of the ambulance there may well be a paramedic or technician working on a patient whilst the vehicle is travelling. This can place a huge amount of strain on the driver as well as the crewmate in the back of the ambulance.

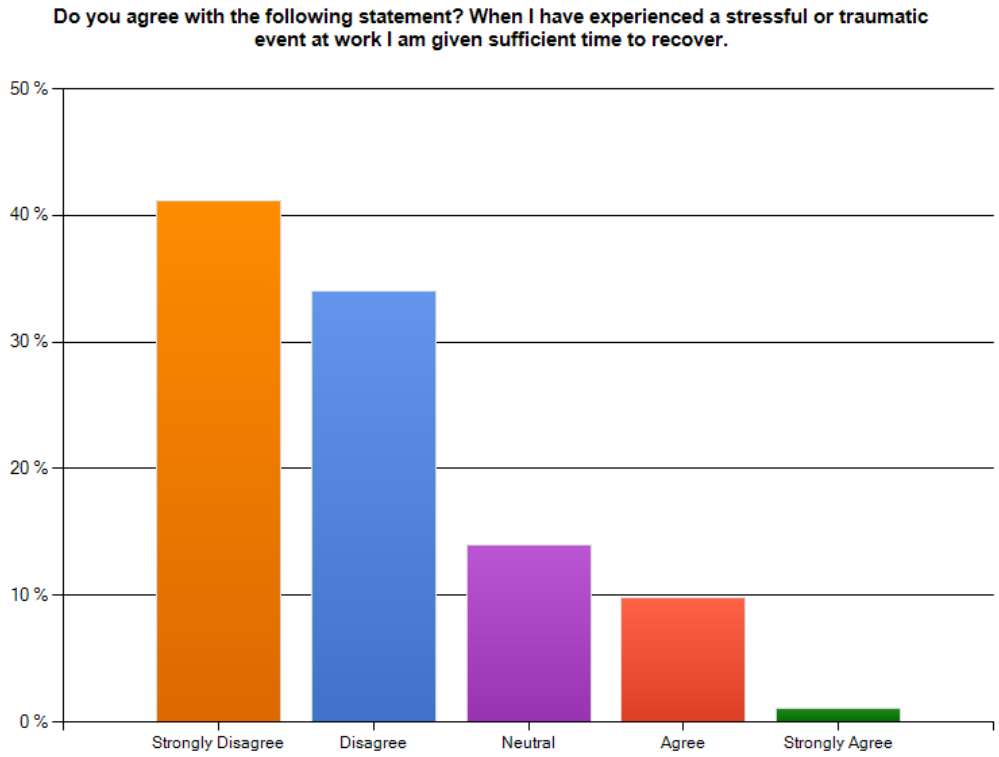
Trying to treat a patient in a moving vehicle under blue light conditions can be extremely harrowing as one paramedic that we interviewed for our submission explained:

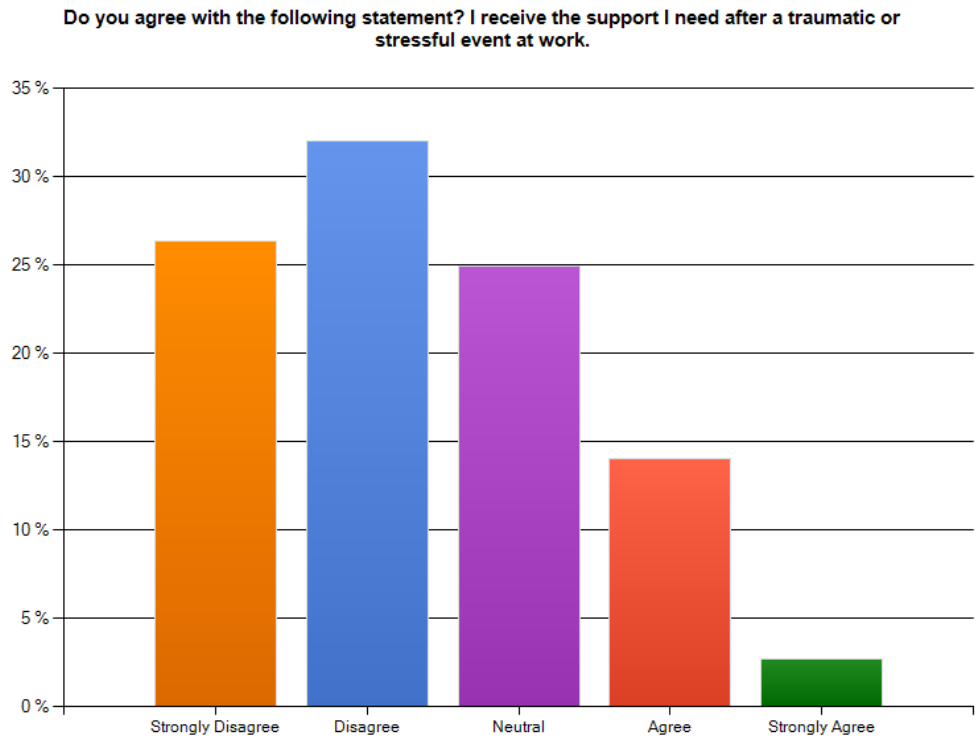
"My crew mate and I blued [drove under blue light conditions] someone who was having a massive MI [heart attack]. We blued him 28 miles, his blood pressure was 65 over 45 – really bad – and he was sweating buckets, he looked awful and I couldn't get the dots to stick on him to continue monitoring him en route to hospital – he was dying basically. We had to blue light him 28 miles to [the specialist heart hospital] to get him seen to.

I had his wife in the vehicle at the same time and the guy was bradycardic – his pulse was 46 as well as having awful blood pressure. You can give atropine to bump up the pulse but because this guy was having a heart attack and his blood pressure was in his boots I was concerned that if I gave him atropine I might actually kill him so I had to phone [the specialist hospital] for advice. I asked a consultant cardiologist should I give this man atropine or not and he said, 'If you want to, do it" and I said "I don't want to, I'm asking should I? I just want some advice."

Then the monitor went beserk and I thought he had died but then it went back to a normal rhythm and we got him to the hospital and he was ok."

In UNISON's survey of ambulance members we asked if respondents received time off and support after experiencing traumatic events. The graphs below show the responses.





The graphs provide a worrying picture of the emotional support ambulance workers, whether call handlers or ERS, receive after they have experienced a traumatic event.

In the case of call handlers, there is evidence to suggest they are exposed to job-related trauma that may make them more susceptible to developing post-traumatic stress disorder (PTSD)[39], though they may not be offered the same levels of support as staff working on ambulances.

It is well documented that the psychological strain on ambulance workers is more intense than most other occupations, the effects of which can be devastating to the individual and their family. The prevalence of anxiety and depression cases among ambulance staff are 22% and 10%, respectively [36].

The prevalence of post traumatic stress disorder (PTSD) in ambulance staff is much higher than in the general population. The NHS Information Centre has estimated the prevalence of PTSD in England at 3% of the general population [40]. By contrast, studies of emergency responders in the UK show that ambulance staff, and in particular paramedics and emergency medical technicians (EMTs), have a prevalence of PTSD of greater than 20% - an increase of around 700%. For example, in their 2004 study of emergency ambulance personnel in the UK, Bennett et al [41] found that 22% of the sample had scores indicative of a PTSD diagnosis after completing the Posttraumatic Diagnostic Scale[2].

This high prevalence of PTSD in ambulance staff is reflected in international research as well. In a study in Sweden, the authors found the prevalence of PTSD in ambulance workers (21.5%) to be much higher than among the general population (2.6%) [42,43]. Similarly, a study in an urban area in the USA revealed a 20% prevalence of PTSD symptoms among ambulance personnel, higher than the prevalence in the general population of 5% for men and 10% for women [44].

[2] The Post Diagnostic Scale is validated against psychiatric ratings and achieves an 82% concordance with psychiatric interview.

Even these high rates of PTSD in ambulance workers may not be representative of the actual situation however. Multiple studies theorised that the prevalence of PTSD in ambulance workers might be much higher than depicted, due jointly to a perceived 'macho' environment in the emergency response services [45], and the fact that these studies only investigate active workers, a group that excludes traumatised rescue workers on sick leave and those who have retired early due to ill-health [31].

Research has also shown that ambulance workers worldwide have a higher prevalence of PTSD than other rescue workers. In their review of 28 studies of PTSD in rescue workers, reporting on 40 samples with 20,424 rescue workers, Berger et al found that ambulance workers were the occupational group with the highest prevalence of PTSD [31]. In this analysis, the worldwide pooled prevalence of PTSD in ambulance workers was found to be 14.6%, which was significantly higher than that of either firefighters (7.3%) or police officers exposed to a major disaster (4.7%). This is also drastically higher than the prevalence of PTSD in UK veterans returning from the Iraq War (3-6%) [46]. Berger et al elaborates:

> "Our results support previous observations that ambulance personnel have the highest prevalence of PTSD among all occupational groups of rescue workers, and police officers the lowest. This difference in prevalence estimates may be explained by the fact that ambulance personnel are exposed to greater pressure and stress at work than other rescue teams. They respond to more emergency calls than police officers and firefighters combined and have closer contact with the victims, a fact that may foster the process of identification and potentially increase the feelings of guilt when they fail in their attempts to help them [31]."

This is reinforced by a paramedic we spoke to for this submission who often tried to follow up with patients she had treated where there was uncertainty about the outcome.

"It's stressful because you're worrying about people living and dying. As much as you probably don't want to admit that you're stressed or strung out, you do worry about your patients because otherwise you wouldn't do the job that you're doing."

Studies also found that the effects of PTSD are increased as exposure to traumatic events increases [47]. Given that responding to traumatic events is in the very nature of ambulance work, it can be assumed that ambulance staff suffer from the cumulative impact of traumatic events. For staff who work as an emergency responder for decades, the impact on their emotional health may be huge. Furthermore, research has demonstrated that the impact on an individual of cumulative traumatic events of less magnitude was similar to exposure to a major disaster [31]. In other words, the compounded daily routine of ambulance staff can be as psychologically damaging as experiencing a major disaster.

Options for redeployment

Due to the nature of ambulance trusts, options for the redeployment road-based ERS staff are limited. A UNISON branch secretary explained: "There is no automatic step down from frontline duties. Frontline staff could apply for alternative roles within the trust but these would have to be vacant roles and staff would have to follow the process. There would be no automatic right to the role. They could be redeployed due to ill health capability into an alternative role but there would have to be a vacant role. They would also have to take the pay this role is banded to, which could be far less that they were currently on. Overall the opportunities are very minimal and frustrating for staff who have worked frontline duties for many years."

Key points and recommendations

- UNISON believes that raising the retirement age will have a detrimental impact on the long term health of many staff within the NHS.

- UNISON is extremely concerned about the effect that working till 68 years old will have on the health of NHS staff and would press for continued monitoring of the situation to ensure that an increasing number of staff are not being made redundant for reasons of capability.

- UNISON believes that there are certain occupational groups within the NHS that will particularly struggle. Police and fire staff have retained a retirement age below the state pension age and UNISON believes the same should apply to ambulance 999 emergency responder staff due to the extreme conditions in which they must work.

- UNISON believes that in order to retain highly-trained and experienced staff there needs to be a real commitment to engaging the views of all NHS staff in any major structural change. Staff should not be used as a political football without regard for them as employees.

- NHS staff must feel supported if they are injured and employers should help staff to return to work as soon as they are able. However, staff must not feel as though they need to 'work through' injuries and illnesses through fear of losing their jobs.

- UNISON believes that further work needs to be done to look at the reasons behind the high mortality rate of manual workers and what can be done to address it.

- UNISON would like to see the promotion of healthier lifestyles in the NHS and a commitment from employers to provide opportunities for staff to undertake more healthy eating or more exercise should they choose to do so.

- Minimum staffing levels are now even more important with an ageing workforce in order to ensure that staff are able to take breaks and have adequate rest during their working day.

- UNISON would welcome more research into the effects of working on-call on health workers and its likely impact on workers' health as they age.

- UNISON would welcome a review of policies such as 'lie-in policies' or 'fatigue policies' in regards to shift working and on-call to consider how these should be enforced in order to ensure staff are not pressured into working when they are too tired to do so safely.

- UNISON believes that if the impact of shift work is greater for older workers there needs to be serious consideration given to how staff can adjust their working patterns as they get older without an unfair burden being placed on new or younger staff.

- UNISON urges the Working Longer Review to consider the impact on young people of raising the retirement age and to consider the implications for young people and what programmes, provisions and training must be put to place to ensure they are able to progress in their careers within the NHS. At a time when unemployment in those aged 16-24 is at a staggering 21.4% [48] and the workforce is shrinking as NHS organisations make staff redundant in order to cut costs, the impact on the future careers of young people could be devastating.

- UNISON recommends that, at a minimum, carer's leave and flexible working practices be strengthened and made available to all staff members.

- UNISON stresses the need for further consideration to be given to the ill-effects of shift working on older people and manual workers.

- Staff must have access to any necessary counselling or therapy services that may be required to prevent them from 'burning out'. Meanwhile, rapid access to services such as counselling or physiotherapy will help to reduce the numbers of staff who face redundancy following a capability procedure.

- More work is needed to address the limited redeployment opportunities within the NHS and to consider what training is necessary to help staff remain in work if they wish to.

- UNISON recommends that there needs to be more work done to ensure that staff take breaks from sitting at their desks and that health and safety measures regarding breaks from computer screens need to be more rigorously encouraged rather than left to individual members of staff to undertake.

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