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OTHER PEOPLE'S FAMILIES: TENSIONS AT WORK IN THE NHS

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ABSTRACT

This paper is draws on research conducted among nurses and in an acute NHS Trust. Interviews and a questionnaire survey with nursing and midwifery staff at all levels and across sites and disciplines covered policy usage, attitudes and experiences of balancing a career in the NHS with non-work life. In light of serious staffing problems, the promise of working hours and shift patterns to suit care responsibilities was used to attract new recruits and previously registered nurses and to retain existing staff over the lifecourse. However, the nature of nursing and midwifery work presented significant barriers to flexibility: low staff substitutability, resource constraints and time-critical tasks in a 24/7 service context. This paper focuses on two of the many tensions uncovered by the research. The first surrounded time off at short notice for family reasons. A cultural pressure not to take time off work and employee guilt about doing had arisen essentially because of low staffing levels and the constant pressure to minimise costs. The second tension was created by unequal access to flexible working between non-parents, who worked flexibly for the service and parents, who worked flexibly for family reason. Parents, particularly part-timers, worked fewer nights and weekends than non-parents suggesting an active avoidance of “shift-parenting” which non-parents had to compensate for by working more unsocial hours. The findings underline the potentially damaging effects on employee relations of simply appending a work-life balance agenda to existing working practices.

INTRODUCTION

The National Health Service's staff shortages are well publicised. In nursing, where recruitment drives have failed to keep pace with retirements and high attrition rates, the problems are particularly acute. In 2000, approximately 21,000 (7%) of nurses left the nursing register with a net result of 9,200 vacancies (full-time equivalent) (Watson *et al.* 2003). According to Shroud (1999) of the 140,000 trained nurses, midwives and health visitors not working in health care in England, nearly half were not doing so because of domestic or family commitments, many citing the lack of flexible working options as a reason not to return to practice.

Among the many policy initiatives to enhance the attractiveness of careers in the NHS are efforts to make nursing more 'family-friendly'. The NHS *Improving Working Lives* initiative (Department of Health 2000) follows the logic of the government's Work-life Balance campaign, that there is a 'business case' for helping employees to better manage their work and non-work time. By offering a range of working patterns and being supportive of employee's non-work responsibilities it is suggested that employers can improve their labour market competitiveness and staff morale with the result of increased productivity, retention rates and reduced absences (Bevan *et al.* 1999; DTI and Scotland Office 2001).

Health policy is a devolved matter for the Scottish Parliament (except for issues relating to pay). Unlike in England and Wales, NHS in Scotland (NHSiS) does not have specific targets for the introduction of work-life balance policies. However, they are referenced in a number of policy documents (Scottish Executive 2000; 2001) and benchmark policies have been developed in partnership with the unions although take up has been slow (PIN 2000).

Even if adopted, the type of work and level of resources which define NHS clinical work presents significant barriers to policy implementation. Employers perceive the main disadvantage of work-life policies to be the cost and disruption of dealing with the employee being absent from the workplace, especially if they have specialist skills or staffing levels are low (DTI 2000; Forth *et al.* 1997). If employees are doing similar jobs, the absent employee can be temporarily substituted with another. For example, in the

organisations studied by Yeandle *et al.* (2002), front-line employees' in retail, whose work was largely generic, were able to swap shifts informally without adversely impacting operations whereas council employees could not because their jobs were specialist. Even if employees are substitutable terms of skills, low staffing levels can create barriers to implementing leave and flexible working policies (Yeandle *et al.* 2002; Bond *et al.* 2002; Kodz *et al.* 2002). NHS nursing and midwifery characterised by low substitutability in terms of numbers *and* skills.

Control over tasks and time is another important element in facilitating work-life balance. Galinsky and Stein (1990) found that employees who have the power to solve work problems are likely to suffer lower stress and feel their job causes less interference with their life while Thomas and Ganster (1995) found that schedules which gave a group of nurses more control over their time reduced work-life conflict and symptoms of stress. In clinical jobs where tasks are time or space critical, it is more difficult to control work rate or where the work is carried out and therefore to operate policies like flexitime or home working.

In a low flexibility context created by resource and task constraints, tensions can arise between employees who have flexibility and those who do not. A 'backlash' from people not using work-life policies has attracted more media than academic attention but research has identified perception among full-time staff that their colleague's reduced hours can increase their workload (Kodz 2002, Epstein 1999) while the difficulties in accessing time off at short notice have also been noted (Crompton *et al.* 2003; Wise and Bond 2003).

The research uncovered many tensions both between and within individuals in the implementation and use of work-life policies; this paper focuses on two. Following a brief outline of the organisation, research methodology and the Trust's work-life policies, a cultural pressure not to take time off work at short notice for family reasons and employee guilt about doing is presented. Tensions created by unequal access to flexible working between non-parents, who worked flexibly for the service and parents, who worked flexibly for family reasons is then explored concluding with a discussion of the causes of these tensions and some implications for policy.

METHODOLOGY & RESEARCH OUTLINE

The Organisation

The research was conducted between April and November 2003 in a large, acute NHS Trust. Of the 11,000 people they employed, around 3,700 were trained nursing and midwifery staff¹. The organisation is referred to as “the Trust” although Trusts were recently abolished in Scotland and the organisation is now a “Division” of the Health Board.

The Trust comprised two large adult, a paediatric and two ‘medicine for the elderly’ hospitals. The managerial structure cut across these sites with four divisions: Medical, Surgical, Women and Children and Clinical Support Services. These divisions were split into “directorates” representing broad clinical fields and then into operational areas headed by a senior line manager. Each senior line manager had a number of line managers reporting to them who were responsible for a single ward or unit².

Running alongside the management structure was the clinical grading structure for nurses and midwives. There are currently six clinical grades each with between four and seven increment points. Broadly speaking, the system works as follows:

- **D grade:** Entry level trained staff nurse or enrolled nurse
- **E grade:** Entry level midwife or experienced staff nurse
- **F grade:** Experienced nurse or midwife with additional supervisory / managerial responsibilities (deputy line manager)
- **G grade:** Line manager, clinical specialist or community midwife
- **H and I grade:** Senior clinical specialist or senior line manager

¹ Trained staff includes registered nurses and midwives and enrolled nurses but excludes clinical support workers.

² Line managers were known in the organisation as Ward, Department or Team Managers although most used the old job titles of “Charge Nurse” or “Sister”.

Research Methods

There were two phases to the research: interviews and a staff survey.

Phase 1: Interviews

As discussed, the operation of work-life balance policies and practices is greatly affected by the working environment and the nature of the tasks performed therefore a good range of clinical areas were covered at the interview stage from outpatients to theatres, medicine for the elderly to midwifery. All but two of the eight geographical locations were covered by the interviews. In each of the twelve areas studied, the senior line manager provided the names of the line managers in their charge and two were selected at random for interview. The process was repeated with line managers for D to F grade staff. Table I shows the number of interviewees by clinical grade and division.

Table I Interviewees by Division and Clinical Grade

	D	E	F	G	H	I	Total
Medical Division	2	2	3	8	1	3	19
Surgical Division	4	3	4	11	4	1	27
Women and Children	1	2	3	9	-	3	18
Total	7	7	10	28	5	7	64

Interviews were deliberately clustered at the G grade level because of the crucial role played line managers in the operation of work-life policies (Yeandle *et al.* 2003). Efforts were made to interview more D and E grades but the shift work and greater patient contact their jobs entailed made contacting and interviewing this group more difficult.

Phase 2: Survey

A 14 page questionnaire was sent to the workplace of each of the 3679 nursing and midwifery staff on the human resource department's (HR) database. 1084 completed questionnaires were returned, an uncorrected response rate of 29%.

When compared to official workforce data provided by the Trust, the sample was broadly representative of the population. 8% of the sample and population were male³, the

³ Men account for 9% of nurses on the UK Nursing Register (Buchan and Seccombe 2003).

representation of clinical grades was good although part-timers were slightly underrepresented in the sample (33% compared to 38% in the workforce population).

More detailed demographic information collected by the survey showed that 36% (n=386) of respondents had dependent children⁴. 17% (n=183) had caring responsibilities for an adult, with just over a third stating they were the main carer (n=63).

THE TRUST AND WORK-LIFE POLICY

As a large, female-dominated, public-sector, unionised workplace with a highly-educated workforce we might expect to find reasonably well-developed work-life policies but at the time of the research this was not the case (see Dex and Smith 2002). Flexible working practices such as alternative shift patterns, part-time working, home working, term-time working and zero-hours contracts were available on an ad-hoc, localised basis. There were three different sets of leave policies (carers leave, compassionate leave and 'special' leave) because the Trust was the result of a merger of three "Hospital Trusts". Although unified policies had been developed their ratification had not been a priority for senior managers. Policies pre-dated the Employment Relations Act 1999 so statutory rights such as parental leave were theoretically available to staff but had not been formalised.

Despite incoherent policy provision, employees throughout the Trust were aware of the work-life balance agenda, particularly as a much needed tool for recruitment and retention. However, the ideals of promoting flexibility for staff to accommodate their non-work commitments appeared to conflict with the pressures of service provision giving rise to tensions within and between individuals.

TENSION 1: TAKING LEAVE AT SHORT NOTICE

Nurses and midwives experienced personal tension between family and work commitments in a number of ways not least because of the prevalence of long working hours and the requirements of shift work (discussed below). The focus here is the

⁴ Defined as children aged under 18 years and living in the household.

tension experienced by staff who took leave at short notice for family reasons: where family and professional commitments came into direct conflict.

As indicated above, there were different policies operating in the Trust. However, formal policy did not appear to substantially influence employee access to paid leave. Managers rarely consulted formal policy documents as senior line managers set the parameters of the leave. In the case of carers leave (time off at short notice for a dependant emergency), employees were generally entitled to three days paid leave but inconsistent definitions of “emergency” and “dependant” meant access was variable and largely reliant on manager attitudes.

Underlying the level of support felt by employees to take time off at short notice for family reason was a pressure not to use paid leave. It was more usual for employees to use annual leave than carers leave, even when the formal policies allowed it. Few were unaware of the statutory right to additional unpaid time off.

I can get three days carers leave but taking it is frowned upon by the Trust so I save up my annual leave and use that instead... The last time there was a problem with my Mum the response from my manager was “is your department covered” rather than “you just go”. When I came back no one asked how she was – it’s not a very caring environment to work in.

H grade midwife, line manager

There is definitely an expectation that you don’t take time off work... It is the culture of the NHS that no one cares for the carers. We care for everyone else but no one cares for us.

G grade midwife

Awareness of leave policies was variable and with many areas experiencing high sickness absence, some managers had become suspicious of staff who knew their entitlements and used this to limit access to paid leave.

There are some people who push the system and others who are genuine and honest who will offer to take annual leave but will end up with carers leave. A lot depends on the relationship between managers and staff.

H grade nurse, senior line manager

I used to always take annual leave and they will let you do it if you offer but a colleague warned me against it. Now I get paid leave...

D grade nurse

It was fairly easy for me to get carers leave, mainly because of my position. I knew what I could get. The senior people are my friends and I didn't find it difficult to ask but I can see in this unit that other staff could find it more difficult because of the staffing problems. Staffing is so very thin, even if you are off sick you feel guilty about being off.

F grade nurse, deputy line manager

Guilt about not being at work added to awareness issues and a sense that taking paid leave was 'frowned upon'.

I feel I've given an awful lot to the health service and that I should be supported so I don't feel guilty about taking [carers leave] but I do feel guilty about leaving the nurses on the ward.

G grade nurse, line manager

I had a day's carers leave and although my management were supportive, I still felt bad about doing it.

G grade nurse, line manager

When you take time off you are aware that you are leaving your colleagues stuck and that's at the back of your mind ... in general you can't give much notice and you feel guilty.

F grade nurse, deputy line manager

These feelings of guilt centred around the impact that their absence would have on colleagues. There was so little 'slack' in the system that one absence made a huge difference to service delivery. Efforts would normally be made to replace absent employee by juggling staff in other wards or using bank or agency staff. A replacement could not always be found and even it could, if the replacement was unfamiliar with the ward and its work it could create more problems for permanent staff than it solved.

There were staff who actively resisted the guilt surrounding taking time off work citing serious trauma in their personal life as giving them a change in perspective. Similar reasoning was used by those who resisted feeling guilty about leaving work on time which was also evident.

When I was nursing my grandmother at home that was my priority, then I didn't feel guilty even although I knew I wouldn't be replaced, the ward will still run because it always does. I think I have more of that attitude now.

F grade nurse, deputy line manager

With everything that's happened, I've got to an age where my highest priority is my family, not work. I don't feel guilty about taking time off but I don't know if that's what the management want here ...

G grade nurse, line manager

For individuals taking leave at short notice to deal with family problems there was a tension between their professional loyalty to job and colleagues and to their non-work responsibilities. The knowledge of that their absence for family reasons would add to colleagues' workload was added to by a sense that the organisation did not give paid leave easily and an expectation to use annual leave instead or not take time off at all.

TENSION 2: CONTROL OVER WORKING HOURS

Service provision in the NHS is incredibly labour intensive and it is nurses and midwives who provide the bulk of round the clock care for patients. In 24/7 in-patient services, 12½ hour shifts were the norm while areas such as theatres and outpatient clinics had different shift patterns to suit operational needs. The 12½ hour shift pattern usually entailed working days and nights (known as *internal rotation*) and at weekends. This section focuses on the 60% of respondents (n=641) who worked 12½ hour shifts, mainly D to F grades (E to G grade for midwives).

This shift pattern appeared to be popular with many staff. Just over half of respondents thought that doing 12½ hour shifts had made balancing work and home life easier (n=331). The main perceived benefit was an increased number of rest days compared to the previous 'core shift' system (where shorter shifts were worked more frequently). For those with care responsibilities this meant that fewer days of formal or informal care had to be found. However, because the shift was so long care providers could not cover the whole shift (including workplace crèche). Perhaps as a result, more than twice the proportion of people with current care responsibilities (children and adults) found that the

12½ hour shifts had made balancing work and home life more difficult (30% compared to 13%⁵).

The research also underlined the difficulties that parents face in dovetailing work with the education and childcare. 37% of respondents whose youngest child was of primary and high school age (5-11 years and 12-17 years) found the 12½ hour shifts had made work-life balance more difficult compared to 21% of those whose youngest child was under five⁶.

The problems associated with the length of shifts were compounded by the variability and unpredictability of the shift patterns found in the “off duty” or staff roster. The possible combination of shifts were endless and there was no common approach or minimum standards, other than adherence to the limits of the Working Time Directive, on how many shifts could be worked in a row, rest days between night and day shifts or how much notice staff had of their shifts. 48% of respondents had four or more weeks notice of their shifts while 13% (n=80) had a ‘rolling rota’ (a shift pattern repeated, for example, every 6 or 8 weeks). For a large minority working hours were highly unpredictable: 35% (n=217) had three weeks or less advance notice of their “off duty”.

In my ward we have little advance notice of our off duty, only one or two weeks so it's difficult to plan things in advance....

D grade nurse

There is little consistency between departments as to how off duties are made up and how far in advance staff know what they are working...

E grade nurse

As Skinner (2003) highlights, children have to be picked up and dropped off for education and/or care at fixed times during the day so being able to know working hours in advance is crucial. Unpredictable working hours therefore presented those with care responsibilities with particular problems.

⁵ CHI-SQUARE SIGNIFICANCE = 0.000 (99% confidence level)

⁶ CHI-SQUARE SIGNIFICANCE = 0.039 (95% confidence level)

Occasionally the question of me being more flexible is raised. However, childcare is not flexible at my young daughter's school. Days have to be booked for the year in advance and they're not willing to swap days about.

E Grade Nurse

The option of working set days and nights is not available in the department where I work so I cannot get childcare. As a result I stay up all day, work all night and stay up all the next day.

E Grade Nurse

With such variable and unpredictable working hours employees attempted to exert some control over working hours, the two most common being informal shift swapping and the “request book”. Generally, the request book was used to integrate ad hoc requests for rest days and annual leave into the off duty. While it created more work for them, line managers recognised the importance of trying to accommodate such requests for staff morale. They were particularly sympathetic of the needs of parents to have greater control and predictability over their working hours and viewed this as necessary to retain staff over the lifecourse.

Managers reported that many of the requests in the request book came from parents. The survey revealed that parents were more likely than non-parents to feel they had some control or input into their working hours other. Table II shows that respondents with dependent children were more likely think formal or informal *self rostering*⁷ available to them and where such control over shifts was available, it was equally popular with parents and non-parents.

Table II Respondents stating *self rostering* available and of those used in the last year

	<i>Available*</i>	<i>Used in last year</i> (of those who said available)
Dependent Children	48% (99)	89% (86)
No Dependent Children	33% (138)	89% (123)
ALL	38% (237)	89% (209)

BASE: RESPONDENTS WORKING 12½ HOUR SHIFTS (n = 617)

* CHI-SQUARE SIGNIFICANCE = 0.000 (99% confidence level)

⁷ Defined in the survey as having control or input into working hours not including the use of request books.

With so many operational hours and minimal staff to cover them, the practice of allowing parents greater control over their working hours was perceived to be having a negative impact on other staff who worked whatever the off duty dictated. Many felt that the off duty was created for parents and everyone else had to 'fit around' their needs.

For those of us who don't have children it can feel like we are being penalised by having to make up the shortfall created by tailoring the off duty for those with dependants. This creates additional stress and low morale, and ultimately retention problems in the staff group.

E grade nurse

We had a phase when we had a lot of part-timers on the ward who seemed to have a set pattern and the rest of us had to fit around it. You don't mind but sometimes you feel "Why should I?", they knew the hours when they came into the job – it should be the hours to suit the ward, not the individual.

D grade nurse

Everything nowadays is centred around people who have children... staff who usually work full-time end up doing all the shifts that these people want to do. It seems we are rewarding one group of people and punishing our loyal workforce.

G grade nurse

Accusations of 'inflexibility' tended to be directed towards part-timers with children rather than parents in general and the survey confirmed that parents who work part-time were significantly more likely to have used formal or informal *self rostering* than parents who worked full-time (48% compared to 31%)⁸. The reason for this are unclear as on the measures used in the questionnaire part-time and full-time parents faced similar challenges in the practicalities of childcare. There were no significant differences in the type of childcare they used and working hours of their partner (e.g. shift work or office hours). However, parents who worked part-time were more likely to describe themselves as the "main carer" (63%) compared to full-timers (24%)⁹.

A lot of the resentment about parents' control over their hours centred around the type of requests that were being made. Many felt that parents were not 'taking their turn' working unsocial hours, especially weekends.

⁸ CHI SQUARE SIGNIFICANCE = 0.017 (95% confidence level)

⁹ CHI SQUARE SIGNIFICANCE = 0.000 (99% confidence level)

Understandably, provision has to be made for staff with children but this should not be to the detriment of those who choose not to have families. I am sick of having to work 6 or 7 weekends in a row because staff with children don't have childcare.

G grade midwife

I would say that I work a lot more weekends than some people because they have childcare needs.... That's the way the NHS is going – they want to attract people by telling them they can dictate their hours and they can to a degree but you can't change the NHS that much. I just hope that when I have kids I get weekends off...

D grade nurse

Older nurses and midwives commented that when their children were young working nights and weekends was the only 'flexible working practice' available. Working unsocial hours reduced the reliance on formal childcare as their partner could look after the children, a strategy known as 'shift parenting'. However, as well as being more likely to work in areas with more regular hours (e.g. clinics, outpatients and other support services); the survey also found that parents working areas where shift work was required worked fewer nights and weekends than non-parents¹⁰. Although childcare was cited as a reason not to work unsocial hours, parents who work no weekends or only one in four were no more likely to have a partner who worked shifts than those who worked three or four weekends in four. Research has shown that shift parenting is not an ideal childcare solution (La Valle *et al.* 2002) and these findings suggest that some parents were seeking to avoid the negative impact it can have on group family time.

Whatever the reasons for parents working fewer night and weekend shifts, many childless employees felt that in prioritising these needs, the organisation failed to recognise that they too had lives outside work.

We are discriminated against us singletons... It's not just people with kids who have issues and problems outside work. I think that gets forgotten a bit sometimes.

D grade nurse

I find it very annoying that if you have no children you are expected to be more flexible with your hours as "you don't have children to go home to"... Just because I don't have children doesn't mean I don't have a life outside work.

G grade nurse

¹⁰ Comparing those work 12½ hour shifts only. Of the small number of respondents worked nights and/or weekends only, the majority were parents.

There is a lot of emphasis on parents and childcare. What about those of us who don't have children but still have lives? We don't get paternity or maternity leave or the opportunity to change our hours. How about some sabbatical time for the loyal members of society who slog away providing for parents...

G grade nurse

This was a significant employee relations issue for the organisation. While the above quote was at the extreme end of the views, many of interviewees mentioned the tension which had arisen between parents and non-parents over working hours. Line managers reported that they found it very difficult to balance the needs of the ward with the competing needs of individuals. They felt pressurised into saying yes to requests for greater control over working hours because of the dire need to retain staff but this ad hoc approach clearly had negative knock-on effects.

THE CAUSES OF TENSIONS

The tensions outlined above were different in nature. In taking leave at short notice for family reasons, the tension was a personal conflict between family responsibilities and a sense of duty to colleagues. The greater control over working hours experienced by parents (particularly part-timers) created tension between those who worked flexibly for the service and those who worked flexibly for family reasons.

Scarce resources were a major factor in both of these tensions. Low staff substitutability meant that just one employee needing time off at short notice placed considerable pressure on the rest of the staff while pressures on costs contributed to the expectation not to take time off making accessing paid leave particularly difficult.

Scarce resources also impacted on the control over working hours. Creating the off duty was one of the biggest challenges for line managers who had to account for individual's working time needs, the needs of the service and try to fit in annual leave, mandatory training and at the same time minimise costs. It has already been stated that requests for working hours were dealt with an ad hoc basis and so was the creation of the off duty. There was no training or minimum guidelines for managers to follow and it was clear that some were fairer than others in distributing hours between staff. Off duties being produced only a week or two in advance and unfair shifts were a symptom of the

G grade line managers workload. The clinical and administrative pressures were huge and there was rarely enough time to devote to tasks such as the off duty, in fact it was often done at home, in their own time.

With thinly spread staff and intensified workloads there was no 'slack' in the system so a request made by one staff member had a potentially big impact on the others. Part of costs minimisation was reducing the numbers of employees working at night and at weekends because rates of pay were higher. This should mean that everyone should have worked fewer unsocial hours but it seems that the distribution was unequal.

The nature of the work clearly influenced access to both leave and control over working hours. Those in clinical roles clearly had to perform the task at work and because these tasks are time critical, if they were absent someone else had to perform them. This should have meant that those with non-clinical jobs should have found it easier to take time off work but the high workloads and long working hours associated with these roles meant they too felt guilty about taking time off. For control over working hours the nature of the work was critical. Parents had 'voted with their feet' and were more likely than non-parents to work in areas that had hours more conducive to family life but for those working in 24/7 in-patient areas to avoid such hours when they were intrinsic to the job caused problems.

Shift length also created problems. In the past there were more staff on each day working shorter hours so if cover had to be found, it had to be found for a shorter time. Despite the fact that employees liked the increased rest days it meant that when they were working those days were given entirely over to work and were so exhausting perhaps increasing resentment around weekend working.

CONCLUSIONS & IMPLICATIONS

The NHS Trust studied had grasped the notion of work-life balance and were actively using it as a recruitment and retention tool although at the time of the research it had not been prioritised at the strategic level. Despite this, at all levels of the organisation there was awareness that in order to recruit and retain employees over the lifecourse, accommodation had to be made for those with care responsibilities in terms of leave and

working hours. However, implementation was ad hoc creating tangible tensions both within and between staff.

Many felt guilty about taking time off work for family reasons because of the negative impact their absence would have on colleagues. There was evidence of pressures not to use paid leave policies because of the additional costs this entailed often leaving employees unsupported by the organisation.

The 12½ hour shift pattern was overall welcomed by staff as making work-life balance easier but those with care responsibilities, school age children, had found it made life more difficult. The length and unpredictability of shifts made finding permanent childcare a challenge leading parents (particularly those who work part-time) to try to exert control over the shifts they worked, creating tensions between staff who worked flexibly for the service and staff who worked flexibly for their families. The main tension arose because parents worked fewer weekends.

The work-life balance agenda was supposed to be inclusive and move beyond the “family friendly” arena but where resources are scarce and prioritisation is made between employees’ needs for working hours a conflict situation was created. If the accommodations made for employees with families had no or only a negligible effect on others it is unlikely such tensions would ever arise.

Time is spent developing national level policy documents on the NHS’s commitment to work-life balance but in front-line NHS work there is no time available for managers to think strategically about around working hours. Improved predictability and control over working hours for everyone, more realistic staffing levels and alternatives to the 12½ hour shift pattern were needed. Some clinical areas had demonstrated that this could be done but for many the knee-jerk approach to working hours and retention was the norm. Can the aim of improving working lives for all NHS employees be achieved by allowing parents to avoid doing night shifts and weekend work where such hours are intrinsic to the job?

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