'You're a human being not the robot' - supporting the community-based Healthcare Assistants

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Healthcare Assistant role

In United Kingdom HCAs are nursing support workers who:

‘*work within the team under the supervision of a registered nurse, delivering delegated task orientated care consisting of routine, high-volume activities with little variance*’.

(The Royal College of Nursing 2025)

But everyday reality looks very different for many healthcare assistants…

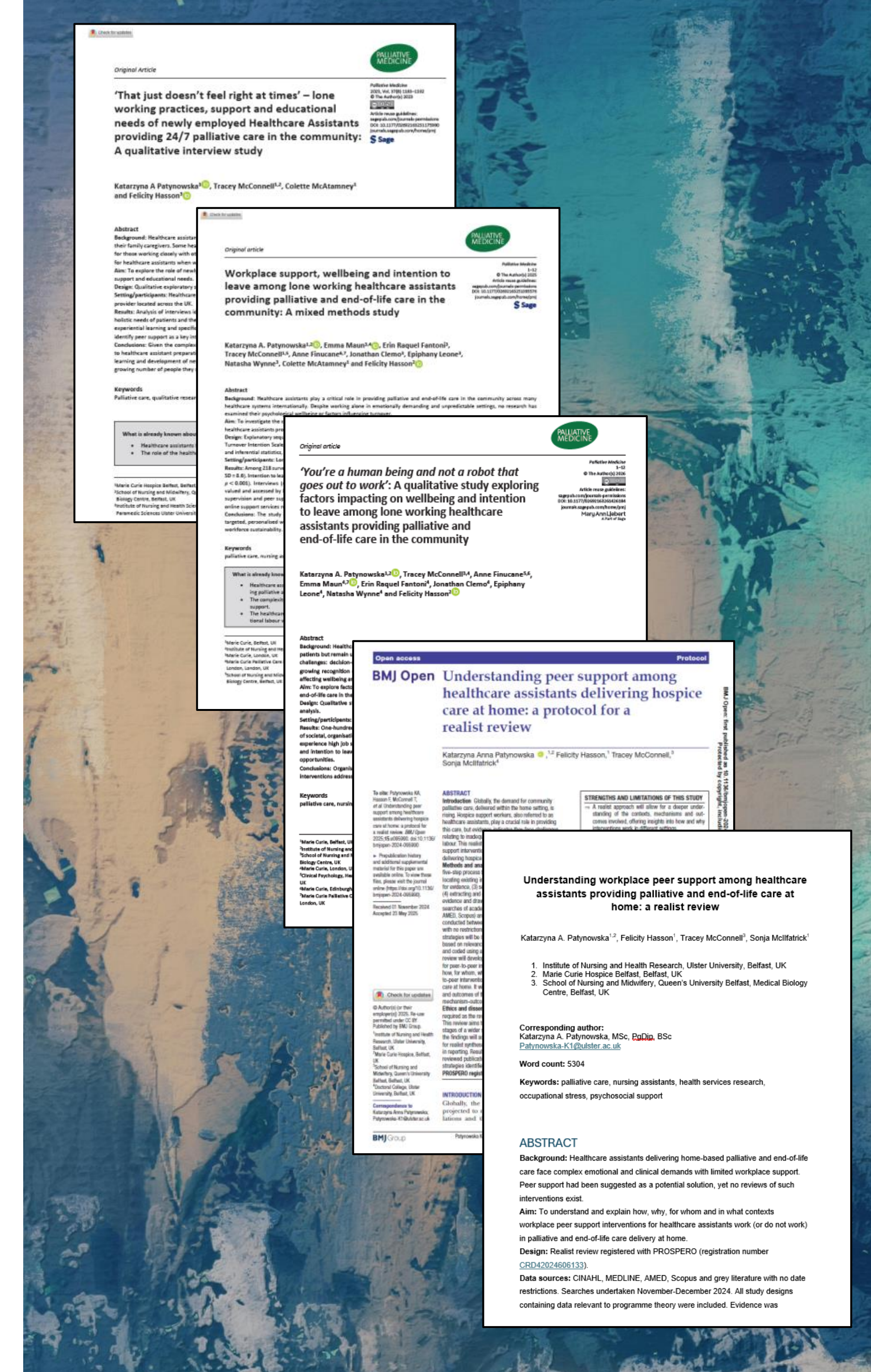
Why is it important?

- Providing majority of direct care
- Multifaceted role
- Limited training and preparation for the role
- Increasingly challenging context

2020-2026

1. Qualitative study: lone working practices, support and training needs
2. Mixed-methods: wellbeing, support needs and intention to leave
3. Realist review and evaluation: Workplace peer support intervention

Thank you to all who made this work possible!


Original Article

'That just doesn't feel right at times' – lone working practices, support and educational needs of newly employed Healthcare Assistants providing 24/7 palliative care in the community: A qualitative interview study

Katarzyna A Patynowska, Tracey McConnell, Colette McAtamney and Felicity Hasson

Original article

Workplace support, wellbeing and intention to leave among lone working healthcare assistants providing palliative and end-of-life care in the community: A mixed methods study

Original article

'You're a human being and not a robot that goes out to work': A qualitative study exploring factors impacting on wellbeing and intention to leave among lone working healthcare assistants providing palliative and end-of-life care in the community

Open access Protocol

BMJ Open Understanding peer support among healthcare assistants delivering hospice care at home: a protocol for a realist review

Understanding workplace peer support among healthcare assistants providing palliative and end-of-life care at home: a realist review

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Word count: 5304

Keywords: palliative care, nursing assistants, health services research, occupational stress, psychosocial support

ABSTRACT

Background: Healthcare assistants delivering home-based palliative and end-of-life care face complex emotional and clinical demands with limited workplace support. Peer support had been suggested as a potential solution, yet no reviews of such interventions exist.

Aim: To understand and explain how, why, for whom and in what contexts workplace peer support interventions for healthcare assistants work (or do not work) in palliative and end-of-life care delivery at home.

Design: Realist review registered with PROSPERO (registration number CRD42024606133).

Data sources: CINAHL, MEDLINE, AMED, Scopus and grey literature with no date restrictions. Searches undertaken November-December 2024. All study designs containing data relevant to programme theory were included. Evidence was

Factors impacting wellbeing and intention to leave

Societal Factors

- Public perceptions of HCA role
- Public image of the employing organisation
- Value and recognition of caring roles

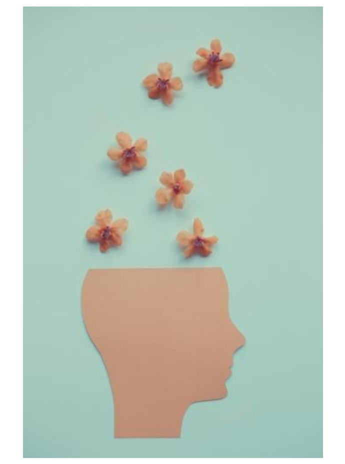
Organisational Factors

- Valued and recognised
- Lone working practices
- Workplace culture and support
- Training and career progression
- Organisational and system changes

Individual Factors

- Job satisfaction
- Personal qualities, skills and previous experience
- Physical and emotional impact of work
- Work-life balance

HCA workplace wellbeing



HCA intention to leave

High wellbeing and job satisfaction

- High job satisfaction
- **77%** reported average to high mental wellbeing
- **Higher wellbeing correlated with lower intention to leave** (r (216) = -0.25, p <.001)
- But work practices are evolving

'My passion is end of life care and I want to provide the best care I can with professionalism and dignity.'

(Healthcare assistant)

Doing essential job, feeling invisible

- **78%** feels that salary is inadequate for the job given the current job market conditions
- Understanding of the HCA role - not ‘sitters’
- Limited career progression

‘We all put in so many extra hours without pay and you will never hear anyone complain about that.’

(Healthcare assistant)

Evolving work practices

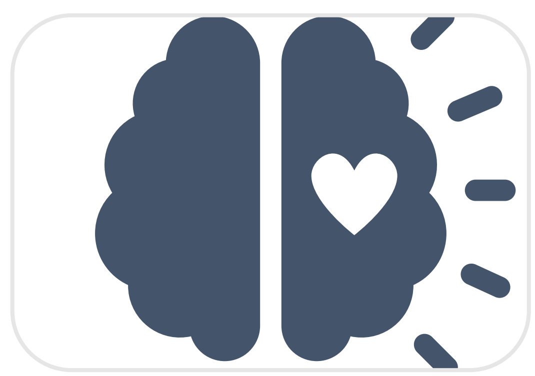
- Increased digitalisation of communication
- Increased loneliness and isolation
- Risks and opportunities

> *‘My tablet is my boss.’*
>
> (Healthcare assistant)

Support needs

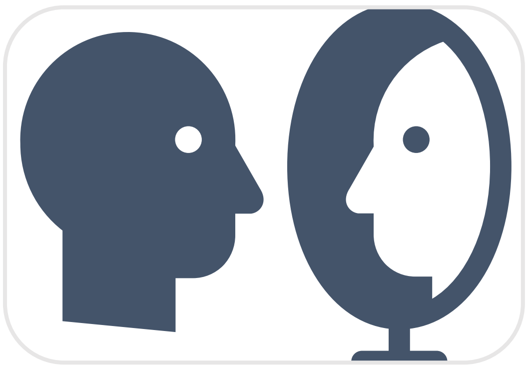
Form of Support	Accessed Support N (%)	Helpfulness of support accessed (range 1-4)
Line manager	**190 (87.2)**	**3.7**
Clinical supervision	166 (76.2)	3.5
Other healthcare assistants	**157 (72.0)**	**3.8**
Other healthcare workers	149 (68.3)	3.6
Family and friends	121 (55.5)	3.6
Employee Assistance Program	21 (9.6)	3.6
Health and Wellbeing Hub	19 (8.7)	3.7
Unmind app	7 (3.2)	3.5
Schwartz rounds	4 (1.8)	3.5

Outcomes of peer support



Enhanced mental wellbeing

Reduced workplace isolation



Strengthened role identity and value

Development of community of practice

Improved care quality and workforce sustainability

What works?

Regular Peer Facilitated Group Meetings

24/7 Peer Support Access

Peer Mentorship

HCA Workplace Peer Support

‘I had burnout. I literally had taken everyone’s emotions on. I couldn’t then offload it to anyone else (…)
There’s times when we all struggle. Even though the knowledge we have, and a lot of our knowledge comes from experiences through our jobs or personal experiences… we realise, we’ve all been through it and we know what’s coming, how it can affect us.’

(Healthcare assistant, lone worker)

‘’And to me it looks like support after a visit and we’re chatting away about it. And how do you feel that that went for you? And just being able to just say, decompress and having that conversation with each other, knowing that you both have trust in each other and it’s not going to go anywhere else.

(Senior Nurse)

Key Messages

HCAs are an essential workforce providing complex care in people's homes - committed, motivated, but increasingly isolated and systemically undervalued.

Workplace peer support is one of the most valued and impactful forms of support - delivering benefits for wellbeing, isolation, role identity and building the community of practice - all of which feed into better care quality and staff retention.

Pee support needs the right conditions: trained peer facilitators, integration with existing supervisory and educational structures, and visible organisational endorsement

Thank You

Link to peer support project website

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MAIN: Supporting Wellbeing at Work: Experiences of Staff Caring for People with Advanced Illness
June 2026

“We are running on the fumes of goodwill” Professional’s experiences of delivering 24/7 end-of-life care to children and their families

L.Barrett, L.Fraser, S.Jarvis, L.Ziegler, S.Picton,J.Hackett

Background

- Families with a child reaching the end of life are living in a state of precarity
- Changing symptoms, pain or distress do not wait for 'opening hours'
- High quality 24/7 end-of-life care is core to supporting choice in place of care
- Postcode lottery of access to 24/7 services
- Important to understand the impact on parent and professionals
- So that services are developed based on evidence and local context

Research aim

To develop the components of an intervention to help the delivery of, and access to, 24/7 paediatric end-of-life care in the North-East and Yorkshire region, by assessing parent and professional experiences and needs, and patterns of care at end-of-life and outcomes in other regions where interventions have been developed

Study design

YEAR 1

YEAR 2

YEAR 3

WS1: Focus groups with health care professionals

WS2: Interviews with parents

WS3: Quantitative assessment of regional disparities, and evaluate changes in emergency healthcare use, place of death; and cost estimations

Intervention development and
Recommendations for parents and professionals

What we did

- **Setting:** 4 ICBs in North-East and Yorkshire
- **Participants:** Professionals supporting families with a child at the end of life
- **Recruitment:** Through 3 NHS sites, 7 hospices, and snowball sampling
- **Data collection**: Focus groups
- **Data analysis**: Thematic analysis

11 focus groups with 53 professionals:

- NHS specialist palliative care teams
- Hospice teams
- Paediatric oncology teams
- Hospital based paediatricians and nurses
- Community based paediatricians, community nurses, GPs, allied professionals

Themes

- Working in a fragmented landscape
- Constraints on choice – default not preferred place of care?
- The personal cost of making it work

Working within a fragmented landscape

- Stark regional variation. Some areas have **existing mechanism** to provide seamless 24/7 end-of-life care
- Others 'patch together with an **ad-hoc** team/**bespoke** solution
- **Uncertainty** makes planning hard
- Difficulties of **co-ordinating** services without infrastructure
- Integrating to provide **sustainable** solutions

It's about building that relationship...and they know they can phone and run it past somebody, even if it is 3:00am in the morning, and then move forward. (Hospice SPPC Consultant)

We're kind of having to mishmash things together to try and make it work for the family and give them the experience that they should deserve. (Community Children's Nurse)

There's not going to be hundreds of specialist palliative care consultants.... So, they're not going to be enough of those kinds of people, so you need to be able to skill up other more generic paediatricians to be able to help deliver with other personnel, nurses and so on. (Consultant Paediatrician)

Constraints on choice – default not preferred place of care?

- Striving to provide care **where** the family wants to be. **Moral distress** when unable to do so.
- Availability **of community nurses** was the building block to providing care a home
- HCPs recognised and **valued specialist palliative care input**
- Professionals worked with families to **avoid hospital** admissions

The only thing that's guaranteed is if you stay in hospital, you will get a nurse. If you go to a hospice, you will have people around. We can't guarantee any more than that. It does feel like home isn't an option because we don't have 24-hour carers (Palliative Care Service Nurse)

Most CCN's cannot extend their hours or put ad hoc rotas up but more importantly because they haven't been doing that, they don't have the skills or the confidence (SPPC Service Consultant)

I need that phone a friend to go to 'you know what, I'm really worried about this patient and this has happened and that's happened, and have you got any ideas?' (Palliative Care Service Nurse)

The personal cost of making it work

- Lack of experience and confidence
- Personal toll as current system **relies on staff goodwill**
- Most professionals described the **privilege** they felt caring for a child at the EoL
- Staff ‘stepping up’ does not help the **case for change**

It’s very difficult, we do, do a 24-hour on call service for children who are at end of life, but there’s two of us, so it ends up being me basically on call for two to three weeks....It can be really draining, it can be really tiring, but obviously we do what we have to do for the patients. (Community Children’s Nurse)

I don’t even think we’re running on goodwill anymore. I think we’re running on the fumes of goodwill because everybody’s so knackered and with the recruitment and retention issues, we don’t have that pool. (Specialist Palliative Care Nurse)

You sometimes need to create a crisis to get the recognition,” and I said, “It’s very difficult for you if you are the person dealing with the patient to create a crisis because you don’t want the patient to suffer because you’re trying to make a national crisis.” (Consultant)

Impacts on staff wellbeing

Staff 'stepping up', working extra hours, skeleton rotas, giving out personal numbers		HCPs are exhausted, blurring boundaries. Lone working
Lack of commissioned services, means reduced opportunity to provide EoL care		HCPs not gaining experience or maintaining vital skills; feeling out of depth
Bespoke solutions with no supporting IT or admin infrastructure		Increased mental workload of coordinating services:
Shortage of specialist paediatric palliative care		No back up to seek advice from about medications etc: worry and stress
Inability to provide equitable services		HCPs carry burden of moral distress

To all the parents and professionals’ who shared their experiences

Thank you

Supporting mental wellbeing of staff caring for people with life-limiting illness

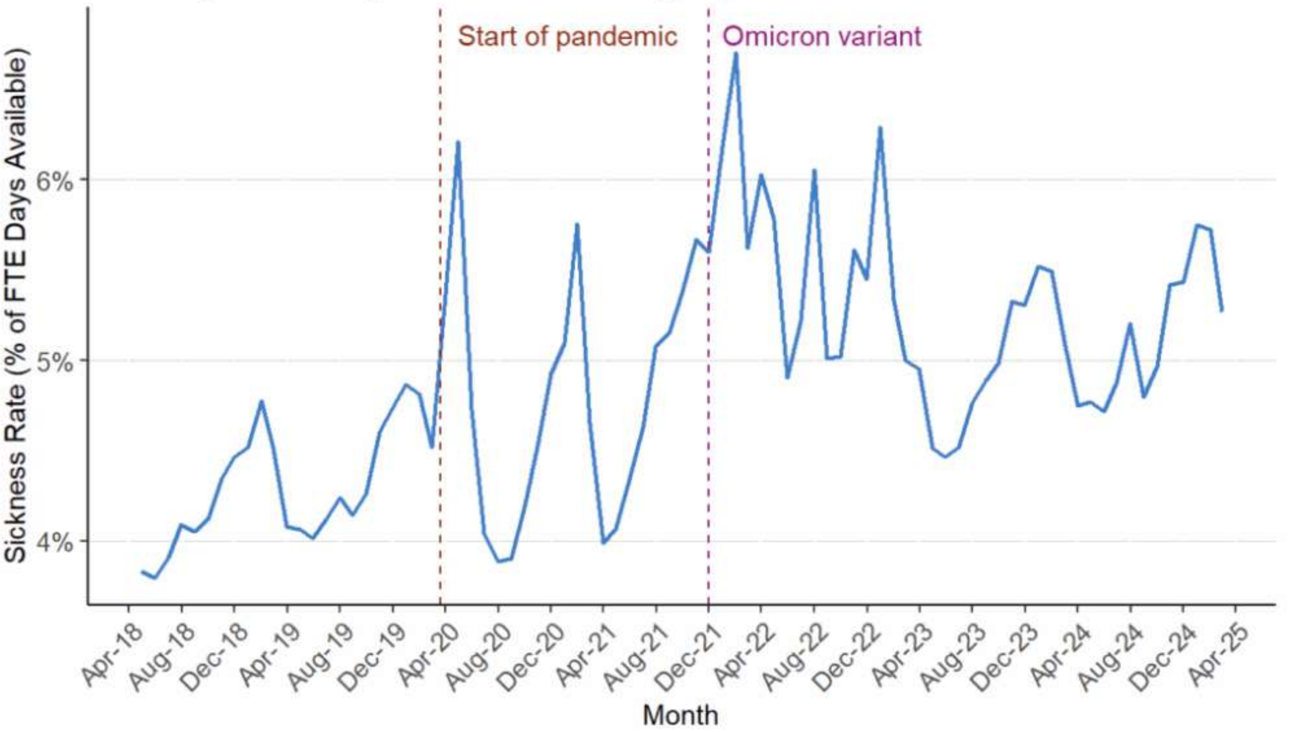
Dr Anne Finucane

Marie Curie Senior Research Fellow,

University of Edinburgh

Some statistics

Sickness absence rates remain significantly higher after the pandemic



Sickness absence rates

- NHS England **5.3%**

Marie Curie

Some statistics

The Herald

News | Politics | Sport | Opinion | Education | Business | Arts & Culture | Lifestyle | USA Today | Notices | Events

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NHS staff sickness absence rate rises to highest level in 10 years

20TH AUGUST 2025 | NHS SCOTLAND | SCOTTISH GOVERNMENT | HEALTH | JOBS AND CAREERS | SCOTLAND

By Katrine Bussey

STV News

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News / Scotland

NHS staff sickness absence rate rises to highest level in ten years

New workforce statistics for the NHS in Scotland were published on Tuesday.

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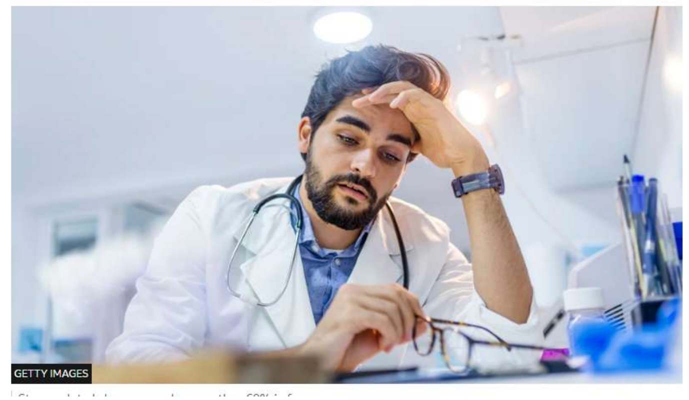
NHS Wales: Up to a third of staff absence stress-related

30 December 2023

Coronavirus

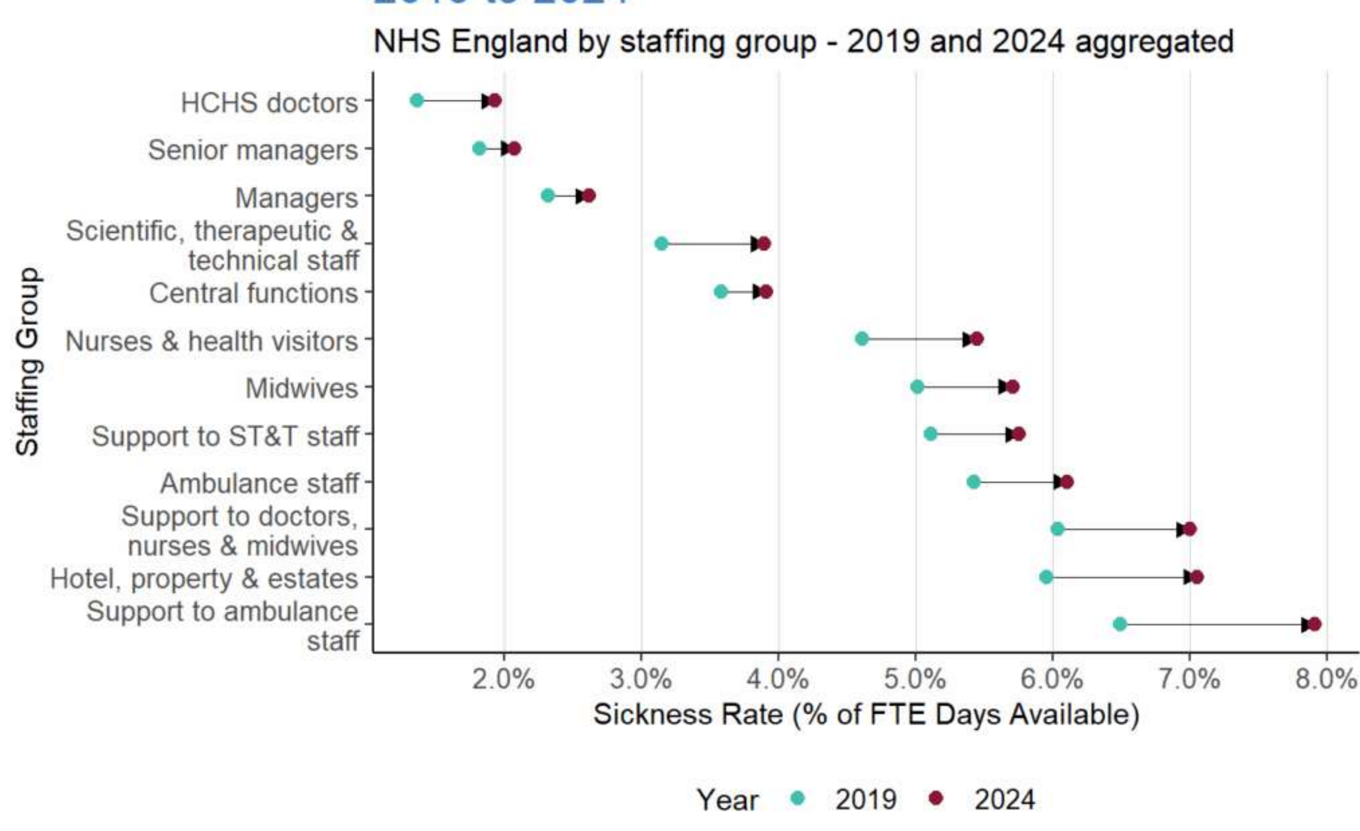


GETTY IMAGES

Sickness absence rates

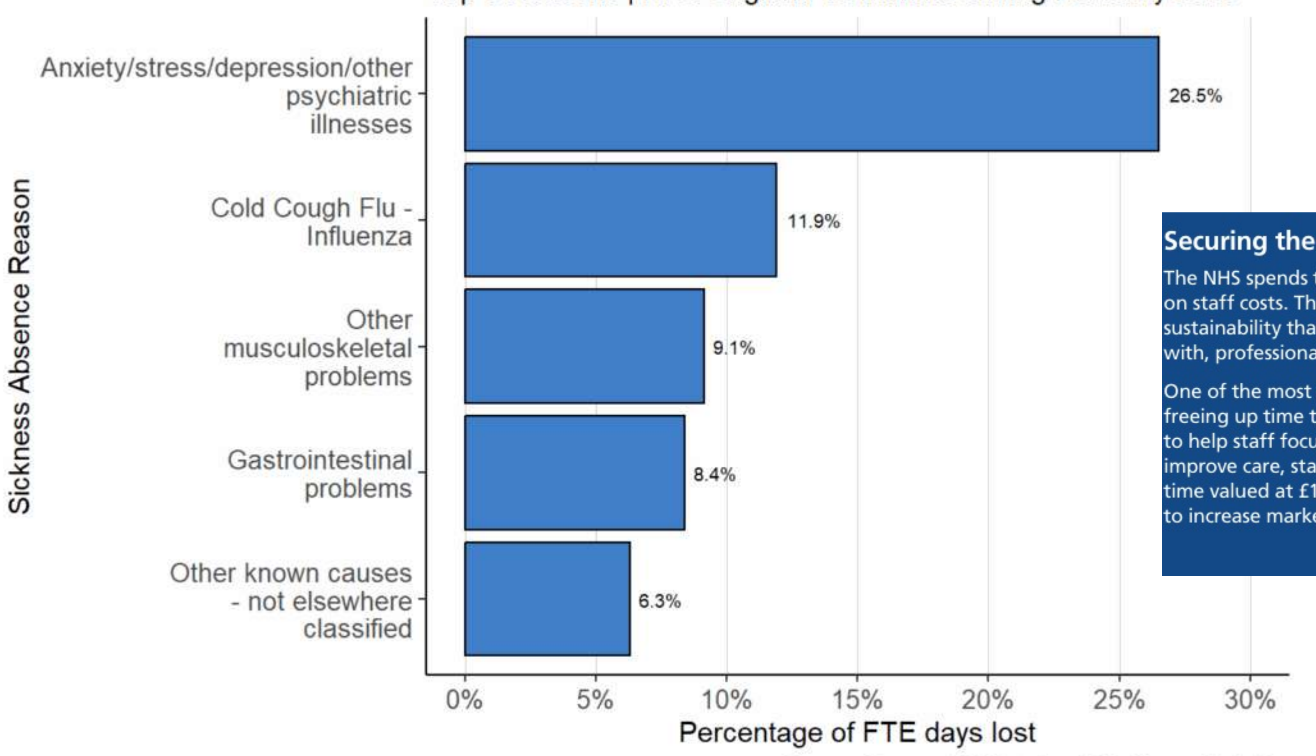
- NHS England **5.3%**
- NHS Scotland **6.4%**
- NHS Wales **6.2%**

Some Statistics



Marie Curie

Some statistics



Securing the financial sustainability of the NHS

The NHS spends the majority of its budget on staff costs. There is no path to financial sustainability that does not include, and work with, professionals.

One of the most effective tools we have is freeing up time to care. By using technology to help staff focus on patients, we can improve care, staff experience and release time valued at £13 billion[217]. This figure is likely to increase markedly as technology develops.

Across the whole economy, it is clear that happier, healthier staff deliver higher-quality work. Beyond lower sickness absence, an evidence review by the International Public Policy Observatory, the University of East Anglia and Rand Europe[218] estimated the cost of poor mental health and wellbeing among NHS staff at over £12 billion per year. We will prioritise staff wellbeing both because it is the right thing to do, and also because it is common sense for public finances.

Workplace wellbeing

The overall quality of an employees experience and functioning at work shaped by physical health, psychological and social wellbeing.

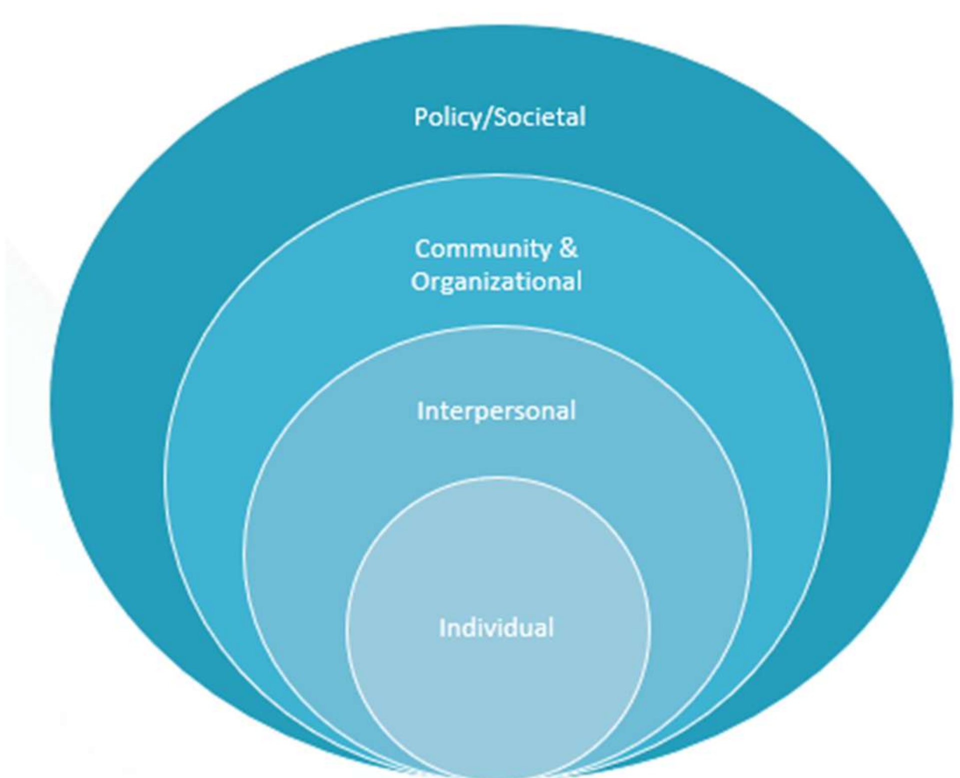
Dana & Griffin (1999)

"How we feel about our work" encompassing

- job satisfaction
- the emotional experience of work
- how meaningful and purposeful work activities are

De Neve and Ward (2023)

Factors influencing workplace wellbeing



The socio-ecological model of health (adapted from Bronfenbrenner)

Factors influencing workplace wellbeing

Policy/Societal

Community & Organizational

Interpersonal

Individual

The socio-ecological model of health (adapted from Bronfenbrenner)

POLICY: Public sector pay-scales, employment rights.
SOCIETY: economic conditions & cost of living

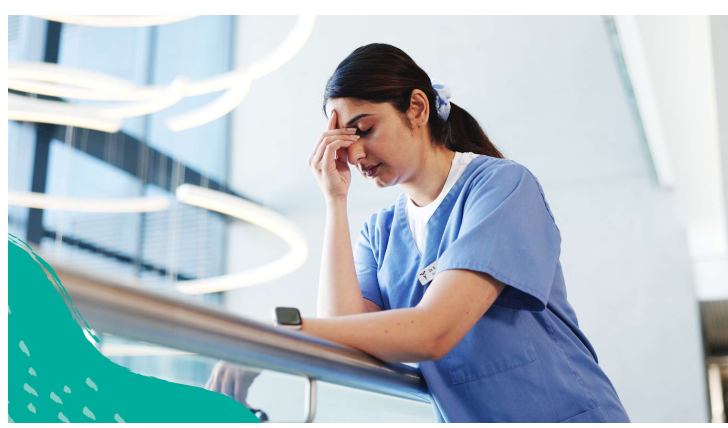
COMMUNITY: poor care coordination, inequalities in access
ORG: High workload, organizational culture/support/stress, training, compensation, opportunities,

INTERPERSONAL: Working relationships, peer support, relationships with patients and families, exposure to death and suffering.

INDIVIDUAL: Experience, confidence, personality, personal values, coping, self-care, personal circumstances, physical health, meaning & purpose

Papworth et al. (2023)

Moral distress & moral injury



Moral distress may arise when staff experience a discrepancy between what they believe should happen and what is possible considering organisational, interpersonal, legal, or resource constraints

(Sanderson et al., 2019).

Moral injury is a strong cognitive and emotional response that can occur following events that violate a person's moral or ethical code

(Litz et al. 2009)

Marie Curie

Psychological interventions

Review Article

Improving the wellbeing of staff who work in palliative care settings: A systematic review of psychosocial interventions

Palliative Medicine
2016, Vol. 30(9) 825–833
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DOI: 10.1177/0269216316637237
pmj.sagepub.com
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Rebecca C Hill[1], Martin Dempster[1], Michael Donnelly[1] and Noleen K McCorry[1,2]

Abstract

Background: Staff in palliative care settings perform emotionally demanding roles which may lead to psychological distress including stress and burnout. Therefore, interventions have been designed to address these occupational risks.

Aim: To investigate quantitative studies exploring the effectiveness of psychosocial interventions that attempt to improve psychological wellbeing of palliative care staff.

Design: A systematic review was conducted according to methodological guidance from UK Centre for Reviews and Dissemination.

Data sources: A search strategy was developed based on the initial scans of palliative care studies. Potentially eligible research articles were identified by searching the following databases: CINAHL, MEDLINE (Ovid), PsycINFO and Web of Science. Two reviewers independently screened studies against pre-set eligibility criteria. To assess quality, both researchers separately assessed the remaining studies using the Quality Assessment Tool for Quantitative Studies.

Results: A total of 1786 potentially eligible articles were identified – nine remained following screening and quality assessment. Study types included two randomised controlled trials, two non-randomised controlled trial designs, four one-group pre–post evaluations and one process evaluation. Studies took place in the United States and Canada (5), Europe (3) and Hong Kong (1). Interventions comprised a mixture of relaxation, education, support and cognitive training and targeted stress, fatigue, burnout, depression and satisfaction. The randomised controlled trial evaluations did not improve psychological wellbeing of palliative care staff. Only two of the quasi-experimental studies appeared to show improved staff wellbeing although these studies were methodologically weak.

Conclusion: There is an urgent need to address the lack of intervention development work and high-quality research in this area.

MENTAL HEALTH AND WELLBEING IN ADVANCED ILLNESS: A MIXED METHODS STUDY TO IDENTIFY AND PRIORITISE KEY RESEARCH QUESTIONS

Anne Finucane[1], Nik Willi[1], Charlotte Simpson-Greene[2], David Gillanders[1], Liz Forbat[3], Emily Harrop[4], Lisa Graham-Wisener[5], Phillippa Ashcroft[2], Briony Hudson[2].

[1]University of Edinburgh, UK; [2]Marie Curie, UK; [3]University of Stirling, UK; [4]Cardiff University, UK; [5]Queens University Belfast, UK.

Introduction

Optimising wellbeing through psychological, social and spiritual support is an essential component of palliative care.

However evidence on mental health and wellbeing for people with a life-limiting illness is fragmented and lacks visibility. Priority areas for future research need to be identified to inform research efforts.

Aim

We sought to identify priority areas for research focused on mental health and wellbeing for people impacted by advanced life-limiting illness.

Methods

- A mixed-methods study consisting of a secondary data analysis and four focus groups.
- We analysed data from the 2024 James Lind Alliance Palliative and End-of-life Care Research Priorities Project survey (1,032 respondents).
- Focus groups were conducted with people with experience of life-limiting illness (n=6), health care professionals (n=7), advocates and third sector representatives (n=7) and researchers (n=9).
- Data from both the James Lind Alliance dataset and focus groups were imported into NVivo 14 and analysed thematically.

Results

We identified ten **key** priority areas for future research.

LIVING WELL: What are the best ways to support people to live well with a serious life-limiting illness?

COMMUNICATION: What are the best ways to enable open, timely and sensitive conversations about living with serious life-limiting illness?

ANXIETY & PSYCHOLOGICAL DISTRESS MANAGEMENT: What are the best ways to prevent and treat anxiety and psychological distress for people with a serious life-limiting illness?

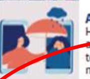
SOCIAL CONNECTION: What are the best ways to support people with a serious life-limiting illness to remain connected to others?

SPIRITUAL CARE: What are the best ways to provide spiritual support to people with a life-limiting illness?

CAREGIVERS: What are the best ways to support caregivers experiencing stress, distress and exhaustion?

BEREAVEMENT: What are the best ways to provide culturally sensitive and timely bereavement support?

INTERVENTION DELIVERY: What are the best ways to deliver and implement mental wellbeing support?



ACCESS: How can it be ensured that everyone with a serious life-limiting illness has access to mental wellbeing support should they need it?

WORKFORCE: What approaches are best to upskill a broader range of professionals to provide mental wellbeing support for people impacted by serious life-liming illness, and what are the best ways to sustain workforce wellbeing?

Conclusion

People affected by life-limiting illness and health and social care professionals identified several areas where evidence is needed to support mental wellbeing towards end-of-life. Our findings will help guide researchers and funders when making decisions regarding future research activities and resource allocation.

Contact: Anne Finucane, Clinical Psychology, University of Edinburgh: a.finucane@ed.ac.uk

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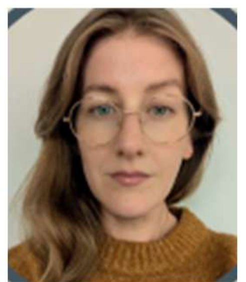

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Frances Waite
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A cluster randomised controlled trial of online Acceptance and Commitment Training (ACT) to improve mental wellbeing in staff caring for terminally ill people and their caregivers.

RESTORE

- Randomised controlled trial
- Online ACT versus usual wellbeing support
- Target: 30 hospices (28 open for recruitment)
- Target: 300 participants (379 recruited to date)

Original Article

PALLIATIVE MEDICINE

Palliative Medicine
2023, Vol. 37(2) 244–256
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Feasibility of RESTORE: An online Acceptance and Commitment Therapy intervention to improve palliative care staff wellbeing

Anne M Finucane[1,2], Nicholas J Hulbert-Williams[3], Brooke Swash[4], Juliet A Spiller[5], Brigid Wright[5], Libby Milton[5] and David Gillanders[1]

Abstract

Background: Acceptance and Commitment Therapy is a form of Cognitive Behavioural Therapy which uses behavioural psychology, values, acceptance and mindfulness techniques to improve mental health and wellbeing. Acceptance and Commitment Therapy is efficacious in treating stress, anxiety and depression in a broad range of settings including occupational contexts where emotional labour is high. This approach could help palliative care staff to manage work-related stress and promote wellbeing.

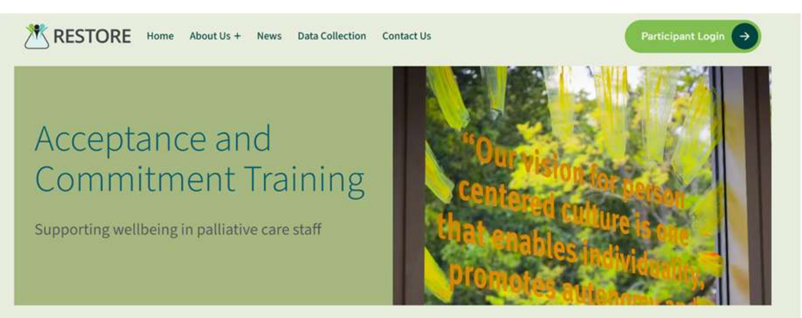
Aim: To develop, and feasibility test, an online Acceptance and Commitment Therapy intervention to improve wellbeing of palliative care staff.

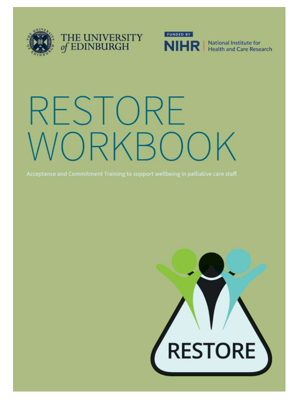
Design: A single-arm feasibility trial of an 8-week Acceptance and Commitment Therapy based intervention for staff, consisting of three online facilitated group workshops and five online individual self-directed learning modules. Data was collected via online questionnaire at four time-points and online focus groups at follow-up.

Setting/participants: Participants were recruited from Marie Curie hospice and nursing services in Scotland.

Results: Twenty five staff commenced and 23 completed the intervention (93%). Fifteen participated in focus groups. Twelve (48%) completed questionnaires at follow-up. Participants found the intervention enjoyable, informative and beneficial. There was preliminary evidence for improvements in psychological flexibility (Cohen's $d = 0.7$) and mental wellbeing (Cohen's $d = 0.49$) between baseline and follow-up, but minimal change in perceived stress, burnout or compassion satisfaction.

Conclusion: Online Acceptance and Commitment Therapy for wellbeing is acceptable to palliative care staff and feasible to implement using Microsoft Teams in a palliative care setting. Incorporating ways to promote long-term maintenance of behaviour changes, and strategies to optimise data collection at follow-up are key considerations for future intervention refinement and evaluation.





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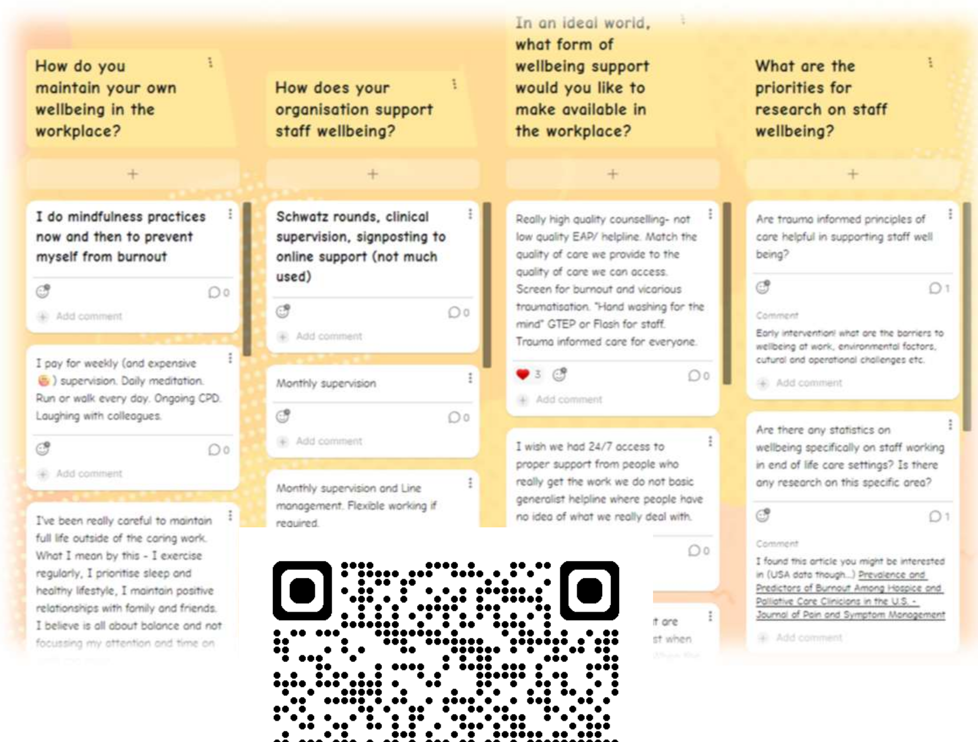

- Clinical supervision and professional support
- Peer support and psychological awareness
- Team & social connection
- Boundaries (.e.g. leaving work on time)
- Self-care (e.g. exercise, nature, lifestyle)
- Organisational & systematic issues

Thank you

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