Is the NHS ready for a four-day week?

Article

Accepted Version

Analysis

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Word count: 2021 + 2 Figures + 1 Box
References: 30

KEY MESSAGES

- Studies from other sectors demonstrate the potential of a four-day week to improve service quality and efficiency and generate savings. However, benefits may not offset costs in a healthcare setting.
- Absenteeism, high staff turnover, and burnout that reduce service quality and increase healthcare costs are all likely to improve under a four-day week.
- Improved scheduling and team-based productivity could enhance efficiency, helping to maintain or improve delivery. If absenteeism, turnover and errors are reduced, savings may accrue.
- The NHS will need rigorous sector-specific evidence of the potential impact of a four-day week on workforce, service quality and productivity, as well as on its costs, risks and challenges, before considering implementation.

Contributors and sources

This article was prepared by a multidisciplinary team of experts in economics, sociology, strategic human resource management and medicine, bringing together diverse perspectives on the feasibility of a four-day week in healthcare. Pedro Gomes (Birkbeck, University of London) and Rita Fontinha (Henley Business School, University of Reading) coordinated a private sector trial of a four-day week in Portugal, while Brendan Burchell (University of Cambridge) contributed to research on a UK private sector trial and an ongoing pilot in the South Cambridgeshire District Council. Jolene Skordis (University College London), Pedro Pita Barros (Nova School of Business and Economics), and Sotiris Vandoros (University College London & Harvard T.H. Chan School of Public Health) are Professors of Economics specialising in health, with expertise in the challenges facing healthcare systems in the UK, Portugal, and the US among other contexts. Amélie Morin (PhD), as a Consultant Obstetrician and Gynaecologist, has frontline experience in the NHS. All were involved in early discussions. Pedro Gomes drafted the initial manuscript based on these discussions, with all authors contributing to subsequent revisions. The article draws on findings from international trials, academic research, and policy reports. Pedro Gomes is the guarantor and corresponding author.

Acknowledgements

We would like to thank João Medeiros and Ron Smith for comments on the draft, and Victoria Fernandez Garcia De Las Heras, a Consultant Child and Adolescent Psychiatrist and Leon Clark, a General Practitioner for discussing their views on the feasibility of the four-day week in the NHS. During the review process, Andrew Copas, Professor of Trials in Global Health (University College London), advised on the evaluation design and Johnas Aronsson, Nurse Anaesthetist and Unit Manager in the Department of Anaesthesia and Intensive Care at Vrinnevi Hospital, explained us how the Swedish pilot featured in Box 1 was organized. We are also like to thank Dr. Rachel Hinton, the BMJ Editorial Team and four referees for their comments.

Patient involvement

No patients were involved.

Conflicts of Interest

We have read and understood BMJ policy on declaration of interests and have no interests to declare.

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Standfirst

Pedro Gomes and colleagues call for the NHS to evaluate whether a four-day week could lead to improvements in staff retention and reduced absenteeism, without compromising productivity or care quality.

Background

The four-day week is a form of working time reduction in which average weekly hours are significantly reduced, typically by providing regular additional days off. It can be structured flexibly without implying a reduction of opening or service delivery hours. It is implemented at the institutional level for all workers, coordinated across teams and accompanied by an internal reorganization of work.[1,2.] While employees value working fewer hours, the symbiotic synthesis of rest and work reorganisation may drive productivity gains, needed to ensure that neither service provision nor wages are compromised.

The NHS is experiencing multiple staffing challenges including difficulties recruiting, high staff turnover, absenteeism and low morale. Wage increases and new technologies are being considered as strategies to improve staffing and productivity. Could the four-day week be an additional cost-effective tool?

Evaluations of the four-day week have been conducted across several countries and sectors, reporting benefits for workers and employers.[3,4] These results should be interpreted with caution. First, they were conducted in self-selecting organizations and often carried out without a control group.[3] Second, studies published in peer-reviewed journals are largely from sectors that may not share the unique characteristics of healthcare, and the complexity and heterogeneity of a lifesaving organization.[5,6,7] Third, peer-reviewed studies conducted in healthcare settings[8,9,10] or pilots in hospitals in Sweden and South Korea[11,12] were either small-scale, tested smaller reductions in hours or weren't rigorously evaluated. To understand whether this practice could benefit the NHS, both in terms of staffing and care outcomes, new evidence is needed.

This article discusses why the NHS should consider testing a four-day week, to assess its potential to address current challenges on staffing and productivity. Based on previous studies, we describe the mechanisms by which it might be effective in healthcare. We argue that there is sufficient evidence to suggest it may benefit the NHS, and enough equipoise to justify

rigorous further evaluation. We propose a realist evaluation approach, focussing on understanding not just whether it works, but how, for whom, and under what conditions. This approach is well-suited to complex organisational changes, such as reshaping work schedules, where impacts may vary across departments, roles, and staff groups.[13]

Would staff value a four-day week?

The NHS struggles to attract and retain health professionals. A 2022 BMA survey of 4,500 resident doctors in England found that 79% often thought about leaving the NHS. The most cited reasons were low pay and its erosion since 2008, deteriorating working conditions, and increased workload—each mentioned by over 75% of respondents.[14] These findings are confirmed by subsequent surveys[15] and are common across Europe.[16]

In real terms, NHS staff wages remain lower than in 2010 (9-11% for doctors and 8% for nurses).[17] This is a serious issue for staff, as demonstrated by the ongoing pay dispute and industrial action. Raising wages enhances retention through better morale and financial security. However, it carries a substantial financial cost and, on its own, won't alleviate overwork and burnout among professionals. Even its efficacy as a tool to improve retention has been questioned. A 2024 study analysing NHS data from the past decade, found that a 10% increase in wages only increased staff's willingness to work as full-time equivalent by 0.8%, concluding that pay is a necessary but not sufficient solution to its crisis.[18]

The four-day week might be an acceptable, complementary solution to wage increases or other interventions. If implemented without salary cuts, it raises hourly pay. Additionally, poor work-life balance is now the most common reason for leaving the NHS beside retirement.[19] In the last decade, voluntary resignations due to health rose by 189% and due to work-life balance by 163%. Resignations attributed to poor reward package increased by 94%, still substantive but smaller by comparison.[20]

Shortening the working week and the consequent work reorganization is complex to operate, particularly in tertiary care, but there is evidence that workers would value it. More so for two reasons. First, reducing hours doesn't prevent staff who prioritize increased income from monetizing their free time with extra shifts. Second, women are more likely to seek part-time or flexible roles—often with lower wages and slower promotions. Given that women make up nearly 90% of nurses and midwives and the majority of doctors registered to practise in the UK[21], healthcare workers may be particularly receptive to this model.

While a four-day week is likely to be valued by staff on average, its impact across different NHS staff groups and teams remains untested—an important evidence gap. We next consider the potential value and risks to the service as a whole.

Could the NHS benefit financially?

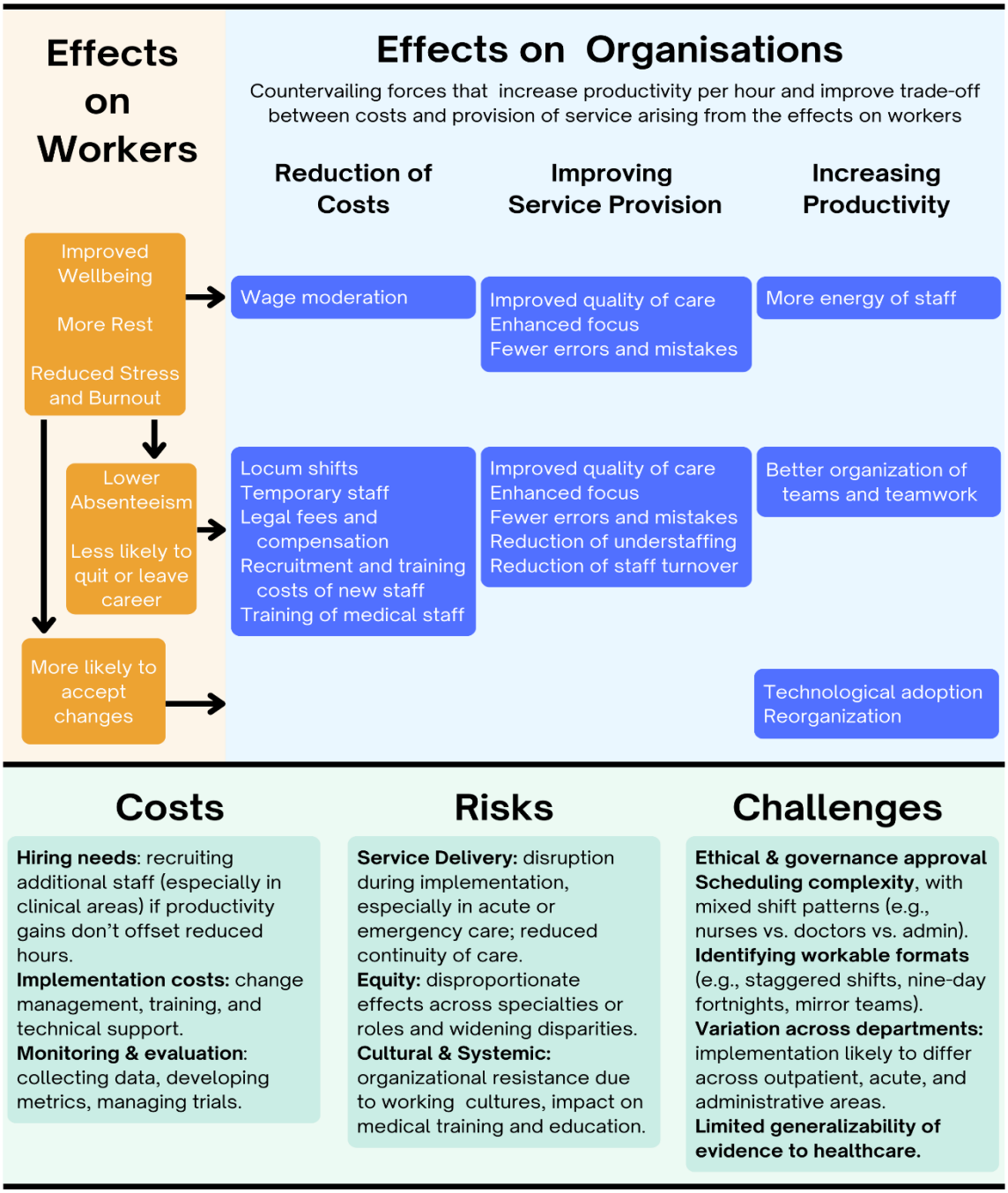
Figure 1 outlines the mechanisms through which a four-day week may positively affect NHS staff and the organization, as well as its potential costs, risks and challenges, noting that there is equipoise and a need for formal evaluation.

Stress from intense workloads contributes to absenteeism and staff turnover[14,15], which undermine service quality and impose a financial burden through reliance on agency and bank staff (costing NHS England 10.4 billion in 2022/23[22]). It also increases the cost of training doctors and nurses in service.[23] In 2011, 71% of F2 doctors progressed into specialty training posts, but by 2019 that number had halved to 35%,[24] effectively doubling the training cost per new specialist in post. The link between fatigue and errors or accidents is also well-documented.[25] Errors in the NHS can have serious implications for patient safety, cause secondary problems that further increase workload, and entail a financial burden through legal costs and compensation of clinical negligence claims (estimated £6.6 billion in 2022/23[26]).

In previous four-day week studies, workers reported improved well-being, more rest, and reduced stress and burnout.[5,6] Participating companies reported increased productivity, lower absenteeism and turnover rates, and enhanced personal efficacy, with employees making fewer errors.[3,4] This evidence is merely suggestive. We need robust evidence on whether it could reduce absenteeism, staff turnover and attrition, and medical errors in the NHS context, and generate savings. We note that an increase in staffing may be needed in areas facing shortages, to avoid gaps in complex staffing rotas adding pressure on remaining staff, or if productivity per hour doesn't increase sufficiently, potentially offsetting those savings.

Figure 1: Summary of Potential Mechanisms in Healthcare

Own elaboration of the potential multiple impacts of the four-day week on savings, provision of services and productivity, based on effects documented in peer-reviewed publications in healthcare[8,9,10] and other sectors[5,6] non-peer reviewed reports on international pilots[3,4], monographs[1,2], a peer-reviewed systematic review[7] and two international case studies in hospitals described in the press[11,12], as well as its potential costs, risks and challenges. The quantification of these mechanisms for the NHS have not been established.



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Could the NHS be more productive with a four-day week?

Prior studies indicate three key pathways through which productivity might increase, including onboarding efficiency, task reorganisation and technology adoption.[2,3,4]

Employees are rarely at peak efficiency when starting a new role. Onboarding requires familiarization with institutional procedures, IT systems, patient needs and team dynamics. High staff turnover or reliance on agency workers means many employees never reach optimal performance. Frequent onboarding also entails workload associated with recruitment and mandatory training. These constitute a productivity loss to patient-facing activities that may be reduced by a four-day week, if it improves staff retention.

Productivity extends beyond individual efficiency. It is a team concept, influenced by how work is organized, coordination and communication among workers, the allocation of time and resources in work processes, and the effective use of technology. Changes in NHS processes can be difficult to implement. Often perceived as cost-cutting, many workers view change with scepticism, fearing negative effects on their professional and personal lives.[27] Prior four-day week studies suggest that it might incentivize workers to contribute to reorganizing workflows, streamlining processes, identifying waste, improving task allocation and adopting new technologies or AI.[2,3,4] While these interventions can be pursued independently, the four-day week might complement them, acting as a catalyst—helping to secure employee buy-in and facilitating broader changes.

However, these benefits depend on the identification of opportunities to create efficiencies through work reorganisation or technological adoption. Similarly, the benefits of onboarding efficiencies can only be realised if staff are retained. While both are possible, only formal testing can establish their size, and compare the effects with other interventions.

Evidence required to evaluate a four-day week in the NHS

Rigorous evaluation is essential for any major organisational change—especially in healthcare, where lives are at stake. Existing evidence suggests that a four-day week is worth testing in the NHS to assess whether it is acceptable, feasible, and cost-effective.[28] Given the complexity of healthcare delivery, a realist evaluation allows for an in-depth exploration of how specific mechanisms (such as a reduction in weekly hours) lead to particular outcomes (such as improved retention, reduced stress or lower absenteeism), and how these effects vary by

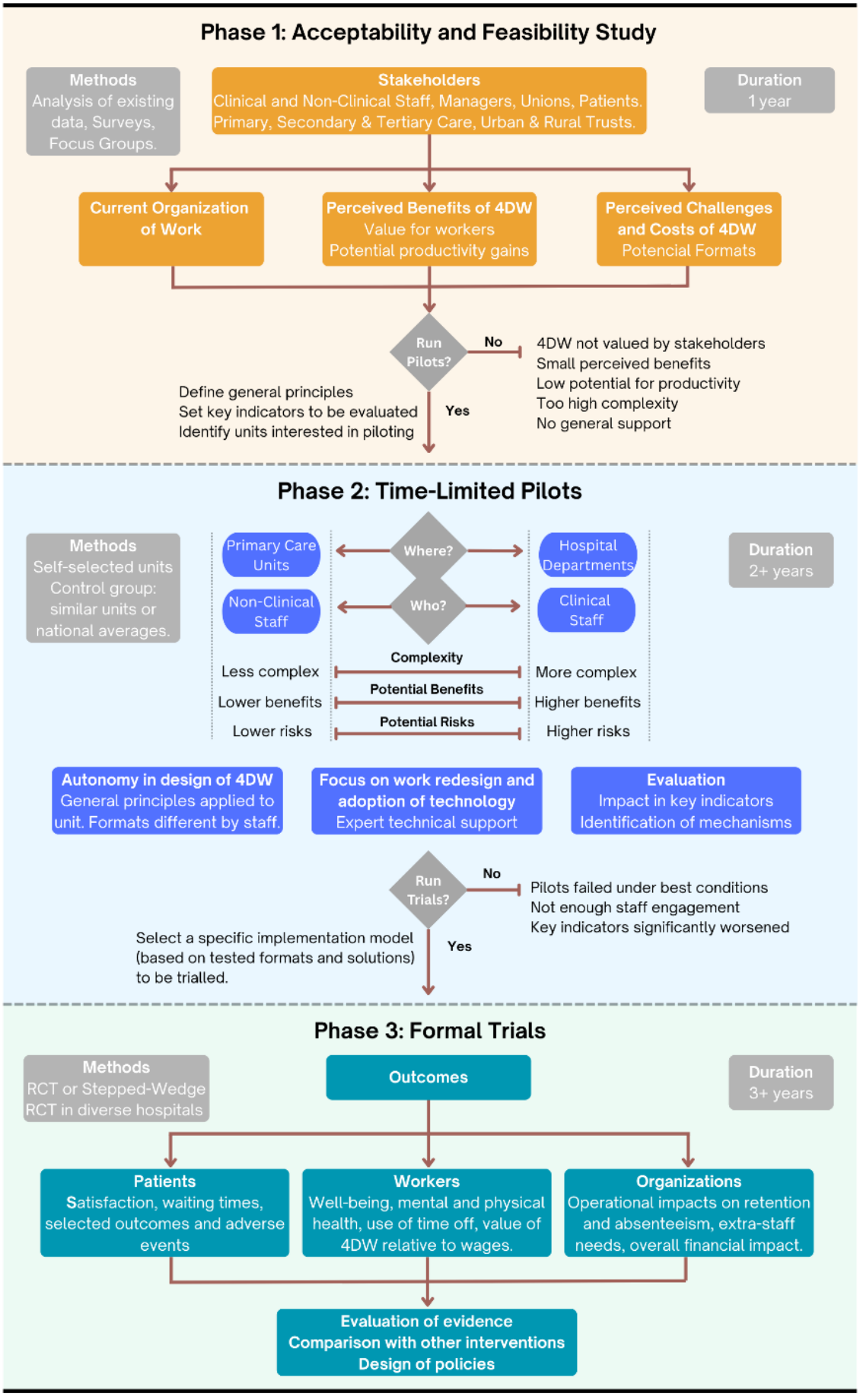
local context—such as staff group or care setting.[13] Figure 2 outlines our three-stage approach.

Establishing feasibility is a critical first step.[29] An acceptability and feasibility study should gather insights into the expectations and preferences of key stakeholders. Mixed-methods data collection among staff would explore perceptions of a four-day week in relation to pay, its practicality and desirability, and anticipated barriers. A survey of managers could assess their willingness to test the model. The study should identify key indicators to be evaluated and viable implementation models—such as staggered shifts, annualised hours, or nine-day fortnights—and consider how they might interact with existing rota systems.

Depending on the results, the evaluation could progress to time-limited pilots. Insights from the initial phase should inform which settings and staff groups are best suited for testing. While it may be easier to trial in primary care, the potential gains are lower—nearly 80% of GPs already work less than full-time.[30] For many, this work pattern has been adopted to reduce the risk of burnout and still involves substantive unpaid hours. However, in this context a four-day week would resemble more a pay increase or shift reorganisation. In contrast, secondary and tertiary care settings, though more complex, allow for evaluation across a broader range of staff—including nurses, doctors, and allied health professionals—and across functions such as elective and acute care.

Early engagement with interested hospitals could help identify appropriate departments and staff groups to pilot the approach, and encourage conversations on how teams might adapt tasks, shifts, and responsibilities to maintain continuity of care. Rather than a one-size-fits-all approach, we propose treating the four-day week as a service redesign applied to most staff within selected teams, while allowing for role-specific flexibility. We recognise that in both primary and tertiary care many staff—particularly nurses and other shift-based roles—already work part-time, compressed hours or flexible patterns, and any pilot would need to account for these existing arrangements. Box 1 outlines a relevant example with nurses in surgical wards in two Swedish hospitals. Temporary financial support may be necessary during the pilot to safeguard service delivery.

Figure 2: Staggered Realist Evaluation of the Four-Day Week in the NHS



These pilots offer a low-risk, cost-effective way to demonstrate any negative effects. If it fails with willing leadership and expert guidance, broader implementation is unlikely to succeed. They also help to understand the influence of HR policies—such as overtime, extra shifts, annual leave, and student training programs—as well as technological tools on pilot outcomes.

The findings should be evaluated by a multidisciplinary team of researchers, policymakers, and senior personnel, with patient representation. If outcomes are positive, the final stage would involve formal trials. The intervention could be tailored to specific staff groups or departments and adapted to local contexts, as expected in any national rollout. Randomising a diverse range of hospitals to the intervention or routine practice, or to the timing of the intervention's start, would offer the highest methodological standard.

A four-day week poses potential risks, including benefits failing to materialise, inflated costs from additional hiring, and social norms obstructing successful implementation. Pending approval by an Ethics Board, these alone aren't arguments against testing a strategy that may offer significant benefits. A trial that demonstrates it is too complex or prohibitively costly will shift the evidence base. Similarly, positive results won't necessarily justify immediate system-wide adoption. The risk of a trial lies mainly in potential disruptions to care at participating sites. These risks—even in time-limited pilots—can be mitigated through careful design, expert technical support, access to supplementary funding for additional staff if needed, and a Trial Safety Monitoring Board to intervene promptly if service quality or safety declines.

One of the NHS's greatest strengths is its reliance on evidence-based medicine to make cost-effective decisions. The same rigorous approach should be applied to the organization of work.

Box 1: Example of a Hospital-Based Shorter Working Week Pilot in Sweden[14]

In 2022, two 24/7 surgical wards at Vrinnevisjukhuset and Linköping University Hospital in Region Östergötland launched a two-year pilot to test a reduced working week, involving around 300 nurses. One ward had nine operating theatres and the other about 20, covering orthopaedics, general surgery, urology, gynaecology, and thoracic procedures. Day, night, and weekend teams consisted of operating theatre nurses, anaesthetic nurses, and healthcare assistants in various proportions. One hospital relied on agency staff during weekends; the other operated entirely with employed staff, occasionally supported by retired workers. In the Thoracic and Vascular Surgery unit, both elective and emergency procedures were supported by teams including perfusionists, with 24/7 on-call coverage.

The pilot aimed to address staffing pressures, including high sickness absence, difficulties retaining staff in full-time roles, and concerns about long-term career sustainability. Weekly hours were reduced by 12% – from 38.25 (or 37 for healthcare assistants) to 34 hours – without pay cuts. The remaining hours were classified as "scheduled rest." Participation required full-time work and involvement in rotating shifts (day, evening, and night). Around 20–30% of staff were part-time before the pilot; many increased their hours to qualify, partially offsetting the hour reductions of existing full-time staff.

The initiative was voluntary and approached as a team-based transformation rather than an individual benefit. The reorganisation required advance planning of rotas and shift coverage, to maintain continuity of service. In the Swedish system, rotas are scheduled through *Individual Schedule Planning*. Rather than having a centralized rota management, staff collaboratively build their schedules – supported by software – before central validation ensures adequate coverage.

During the pilot, the structure and length of shifts remained unchanged. Staff would schedule clinical hours (34 hours × number of weeks in the scheduling period – usually 8 to 10 weeks ahead), as well as the recovery time (total contracted time – clinical hours over the scheduling period). The software had to be updated to allow for this new category. Recovery time had to be scheduled regularly (weekly or biweekly) and couldn't be accumulated or used during annual leave or major holiday periods. Employees weren't required to be available during recovery time and could use it freely. They couldn't be called into work, but they could voluntarily choose to work extra shifts during recovery time if they wished.

No new staff were hired for the pilot. Costs rose modestly as part-time workers increased their hours. A local collective agreement was reached with unions to support the trial. Importantly, framing the reduction as "scheduled recovery time" – rather than time off – was key to gaining governance acceptance, by presenting the pilot as a workforce sustainability strategy, rather than reduced service.

An internal evaluation compared indicators to the final scheduling period of 2021. Despite fewer hours per worker, total surgical hours increased, due to improved retention, reduced sick leave, and less reliance on agency staff. Staff reported better well-being and work–life balance; managers reported fewer rota gaps, lower overtime costs, and improved continuity of care. The reduced overtime costs helped offset higher wage costs linked to increased full-time employment.

The pilot has since been extended for another year. Further external evaluation is underway, and results aren't yet available in technical reports or peer-reviewed publications. A similar pilot is now being considered in the region of Stockholm.

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