

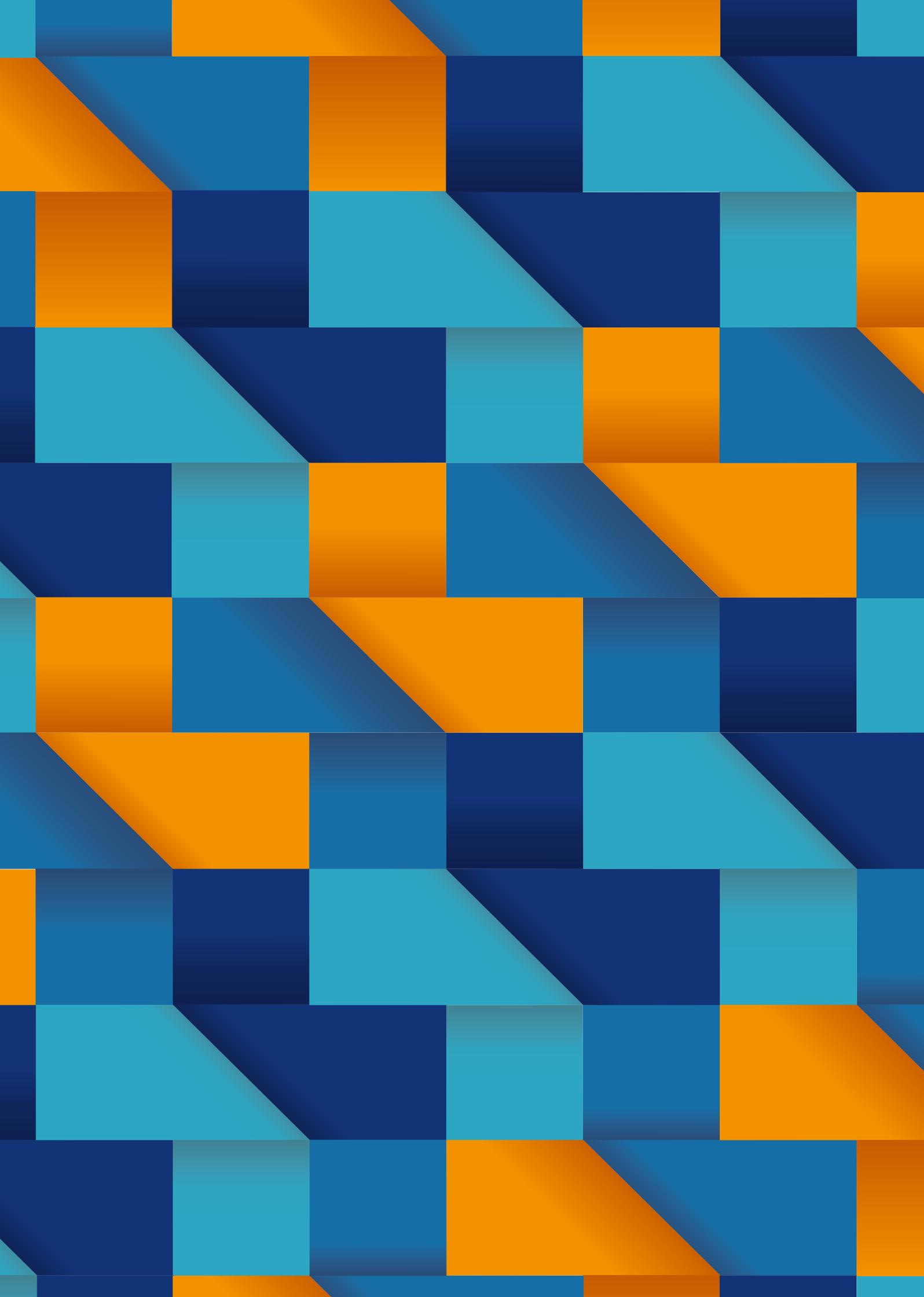
# The state of medical education and practice in the UK

2019



Working with doctors Working for patients

General  
Medical  
Council



# The state of medical education and practice in the UK

2019

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# Contents

<b>Foreword</b>	<b>09</b>
<b>An information resource</b>	<b>10</b>
<b>Executive summary</b>	<b>12</b>
<b>The evidence</b>	<b>12</b>
<b>Key challenges and areas for action</b>	<b>13</b>
<b>Key contributions</b>	<b>13</b>
<b>Chapter 1: Supporting a profession under pressure</b>	<b>15</b>
<b>A focus on wellbeing in the workplace and flexibility in training</b>	<b>16</b>
The urgent need for workplace and training arrangements to improve	
Evidence in this report underlines the need for change	
Implications for future action	
<b>Chapter 2: Wellbeing and retention of doctors</b>	<b>21</b>
<b>Doctors continue to work under sustained pressure in 2019</b>	<b>22</b>
Pressure is not felt in the same way by all doctors	
<b>Causes of pressure</b>	<b>24</b>
High workload and demand on the health service mean many doctors regularly work beyond their rostered hours	
Satisfied and dissatisfied doctors alike struggle with long hours and high workloads	
Support is important for doctors but often they are feeling unsupported by both their colleagues and senior medical staff	

<b>Symptoms of pressure</b>	<b>29</b>
<ul style="list-style-type: none"> <li>The high workloads reported by doctors are leading some to feel unable to cope</li> <li>Many doctors feel burnt out and emotionally exhausted</li> <li>Dissatisfied doctors are more likely to have a high risk of burnout than their satisfied colleagues</li> </ul>	
<b>Consequences of pressure</b>	<b>33</b>
<ul style="list-style-type: none"> <li>We are temporarily losing doctors from the workforce when they have to take time out due to stress</li> <li>Doctors have refused to take on additional workload to cope with pressure</li> <li>Reduced hours</li> <li>Many doctors find it difficult to participate in a range of professional activities, which help both to maintain their skills and to contribute to the system as a whole</li> </ul>	
<b>Doctors' intentions as a result of pressure</b>	<b>36</b>
<ul style="list-style-type: none"> <li>Most doctors are considering making a career change in the next year</li> <li>Almost two-fifths of doctors said they were most likely to make a career change that would see them spending less time in clinical practice or leaving the UK profession permanently</li> <li>Doctors have taken a range of soft and hard steps towards leaving the profession, and those who have taken hard steps are most likely to be dissatisfied and/or burnt out</li> <li>Doctors gave a wide range of reasons for their planned career changes</li> </ul>	
<b>Pressure and its implications</b>	<b>41</b>
<b>Protective factors for doctors' wellbeing</b>	<b>42</b>
<ul style="list-style-type: none"> <li>Workplace culture – team working</li> <li>Workplace culture – support systems</li> <li>Leadership – supportive management and shaping positive cultures through effective leadership</li> </ul>	

---

<b>Chapter 3: The state of medical education</b>	<b>45</b>
<b>Introduction</b>	<b>46</b>
In this challenging climate, what choices are trainees making?	
The UK medical training pathway	
National training survey key findings	
<b>Training environments and experiences</b>	<b>49</b>
Satisfaction with teaching and supervision remains high, but doctors in training and trainers experience challenges around workload and rota design	
Heavy workloads and poor rota design in training environments are longstanding challenges, but there are some welcome signs of sustained improvement	
Where working environments are fully supportive, trainers and trainees are more positive about their experiences, and more confident their concerns will be addressed	
Lack of a supportive environment is linked to frustration and higher risk of burnout	
Summary	
<b>Making sure training is safe and effective</b>	<b>57</b>
Enhanced monitoring	
<b>More doctors are pausing their training as they progress through a system under pressure</b>	<b>60</b>
Doctors pausing their training after their F2 year is now the norm	
Most doctors who take a pause after F2 return to training within three years	
It's rare for doctors who paused after F2 to return to training after pauses of longer than three years	
A pause in training after F2 does not necessarily – or usually – mean a break from working in medicine	
There are several factors influencing doctors' decisions to pause training	
Doctors' preferred specialty can influence their decision to pause their training	
Doctors who paused training after F2 had a lower risk of burnout at core or specialist training, compared with those who didn't pause their training	
Trainees' experiences vary throughout the pathway, but a higher proportion of foundation trainees report feeling burnt out, short of sleep at work, and forced to cope with work beyond their clinical competence	

More doctors are choosing to train on a less-than-full-time basis, with potential benefits for their wellbeing and work-life balance

Summary

**Preparing medical students for foundation training is a key aspect of undergraduate education** **72**

Most new graduates feel prepared for their first postgraduate training role, but this is declining gradually

Student assistantships and shadowing periods help prepare trainees, but their perceived effectiveness is decreasing

Preparedness at F1 may signal long-term trends in doctors' perceptions of training

Preparedness at F1 relates to a longer-term risk of burnout

Trainees in foundation and acute specialty posts were least positive about inductions

Summary

**An introduction to our work with UKMED** **77**

Research opportunities

**Chapter summary** **79**

Good training is being delivered in challenging environments

Preparing doctors for future challenges is crucial

Pausing the training pathway and having greater flexibility may protect trainees from feeling burnt out

<b>Chapter 4: Primary care</b>	<b>81</b>
<b>System pressures affecting primary care</b>	<b>82</b>
Pressures persist in primary care	
<b>The GP workforce</b>	<b>83</b>
LTFT working is currently more common among female GPs and those in the middle of their careers	
<b>While GP training continues to be popular, with a particular growth in trainees aged 40 years and over, patient demand appears to be outstripping supply</b>	<b>84</b>
Negative perceptions of working in general practice remain, but can be overcome by engaged and motivated trainers	
Innovative models of medical education and training are being used to encourage more doctors in training into general practice	
<b>GPs' experiences of pressures and their responses</b>	<b>86</b>
Growing patient demand and more complex cases are increasing pressure on GPs	
Workload pressures are affecting GPs' wellbeing, with many feeling dissatisfied	
Most GPs struggle to cope with workloads, and some have taken a leave of absence due to stress	
Some pressures are specific to working in certain areas, with some GPs working in deprived communities finding their work particularly emotionally draining	
Working under pressure has consequences for patient care, with some GPs feeling they can't always give patients the level of care they need	
As pressures on the medical workforce persist, doctors may reduce their hours or leave the profession	
<b>Protective factors for GPs</b>	<b>91</b>
Around half of GPs are satisfied in their work, largely driven by a sense of fulfilment	
A sense of belonging is important to doctors – the sense that they are part of an effective and supportive team appears to help mitigate stress and avoid burnout	
There appears to be an association between how well supported a GP feels and their risk of burnout	
There are indications that working less than full time may be a protective factor against the impacts of pressure	
<b>Establishing a sustainable GP workforce, while building on innovations in primary care</b>	<b>94</b>

<b>Chapter 5: Impact on patient care</b>	<b>95</b>
<b>System pressures are affecting patient care</b>	<b>96</b>
<b>Most doctors experience times when it is difficult to provide patients with the level of care they need</b>	<b>97</b>
<b>Doctors are witnessing patient safety or care being compromised</b>	<b>98</b>
Workload pressures and communication problems contribute to patient safety or care being compromised	
Workloads or resourcing issues	
Inadequate communication between healthcare professionals or between doctors and patients	
<b>Workload pressures lead doctors to make more patient referrals</b>	<b>101</b>
Four out of five doctors have received a patient referral when it may not have been strictly necessary	
Referrals can be a source of tension between healthcare professionals	
<b>Unnecessary referrals are a patient safety concern</b>	<b>104</b>
Having more patients in the system is detrimental to patient care	
Unnecessary referrals can delay patients receiving the treatment or advice they need and result in undue harm	
<b>How patients experience the referral journey</b>	<b>104</b>
Most patients were satisfied with their referral experience but one out of 10 felt their referral was unnecessary	
Patients see referrals as reassuring and are happy to be referred	
The logistics and practicalities of the referral	
Patient records and admin issues	
Quality of the interaction	
<b>Improvements that patients would like to see</b>	<b>112</b>

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<b>Chapter 6: Clinical leadership</b>	<b>113</b>
<b>Leadership and workplace cultures</b>	<b>114</b>
Clinical leadership is complex and multifaceted	
<b>The benefits of good leadership in shaping healthy workplace cultures</b>	<b>115</b>
Doctors are more likely to recognise their formal roles as leadership, but these are often the aspects of their work they feel less prepared for	
Though time consuming, formal leadership roles seem to have personal and professional benefits for doctors	
Inclusive and compassionate workplace cultures have a positive impact on doctors' wellbeing and, crucially, on the quality of patient care	
Everyday leadership can be difficult to define and often goes unrecognised by doctors, but it's crucial for shaping positive workplace cultures	
There are differences in leadership between primary and secondary care	
We must take a multi-professional view of leadership to make sure organisations have inclusive cultures and productivity is maximised	
<b>Current challenges to effective clinical leadership</b>	<b>120</b>
Progression into formal leadership roles can be haphazard, and doctors rarely undertake specific leadership training	
Negative cultures enable unprofessional behaviour, such as bullying, harassment and discrimination, with consequences for doctors' wellbeing	
<b>Systemic opportunities to improve leadership</b>	<b>122</b>
Organisations can support doctors in leadership roles by improving the culture of leadership at all levels	
We're committed to taking forward the wealth of recommendations from the research and reviews we've commissioned, ultimately to support doctors	

<b>Chapter 7: What needs to be done</b>	<b>123</b>
<b>Introduction</b>	<b>124</b>
<b>Action is needed in five key areas</b>	<b>124</b>
Workforce supply	
Medical education and training	
Workplace and wellbeing	
Regulation	
Multi-professional working	
<b>Our path from 2020</b>	<b>128</b>
<b>Glossary</b>	<b>129</b>
<b>A note on research and data</b>	<b>130</b>
<b>References</b>	<b>134</b>
<b>Acknowledgements</b>	<b>139</b>

# Foreword

In the 2019 election campaign, all parties put the UK health service front and centre of their spending plans. There is broad agreement that more must be done to ensure the healthcare system can deliver, and we're committed to playing our part.

Long-term success relies on decision-making rooted in evidence.

Without a comprehensive understanding of today's landscape, joint efforts to create health and social care systems fit for the future will be hampered, and patient care will suffer.

Our ninth *The state of medical education and practice in the UK* report points to some stark trends, which will change healthcare delivery in the years ahead. It shows that young doctors are pursuing different career paths from their older colleagues. Be it taking years out of UK practice, reducing hours or leaving clinical work in the NHS earlier, these shifts are having a direct impact on the capacity of the UK's health service to plan for patient needs.

We must respond to these trends now. If we don't, patient care and safety will be compromised. There are solutions to be found: more flexible training and career options, clinical leadership that supports the wellbeing of doctors and a joined-up approach to regulation can all make a difference.

This work will be a key focus for the GMC in 2020.

Given the emphasis the incoming Government has placed on the NHS, it must hear and take to heart the lessons from this report. It is vital that we all play our part by listening to the concerns of employers, patients and doctors and take action to grow and retain a sustainable workforce.

Above all, future plans must take account of the new reality. That means looking at the data and insight at our disposal, and making decisions based on evidence, not expediency.



**Dame Clare Marx**  
Chair



**Charlie Massey**  
Chief Executive & Registrar

# An information resource

Alongside this report, we publish a range of data and information resources, which underpin many of the analyses and findings that follow. These include a set of reference tables, GMC Data Explorer, GMC education data reporting tool.

## Reference tables

The reference tables are published on our website\*

The five areas these data cover are:

- 1 Who is on the register of medical practitioners?
- 2 How does the make-up of the register differ by country and region?
- 3 Who are doctors in training and what are their training programmes?
- 4 Who are medical students?
- 5 Fitness to practise data

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## GMC Data Explorer

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## Accessing our data through GMC Data Explorer

GMC Data Explorer is an interactive data sharing tool, which allows external users to access our registration, revalidation, fitness to practise and education data directly.

It provides access to data on:

- the makeup of the medical registers, including ethnicity, specialty over time and doctor country location
- revalidation activity
- education
- doctors' training and fitness to practise, including:
  - the number of UK graduate doctors, which can be broken down by the body that awarded their primary medical qualification or by the doctor's register type, eg specialist register, GP register

\* See [www.gmc-uk.org/about/what-we-do-and-why/data-and-research/the-state-of-medical-education-and-practice-in-the-uk/workforce-report-2019#Data%20tables](http://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/the-state-of-medical-education-and-practice-in-the-uk/workforce-report-2019#Data%20tables)

- the current location of registered doctors, where they graduated from and their deanery/local education providers
- the number of doctors with open cases and active sanctions at each designated body
- the allegations made about doctors over time.

## How can users access GMC Data Explorer?

GMC Data Explorer can be accessed through:  
<https://data.gmc-uk.org/gmcdata/home/#/>

## The GMC education data reporting tool

Our education data reporting tool allows users to access a wide range of information regarding medical education in the UK. The tool is commonly used by deaneries, royal colleges, trusts, and local education providers to quality assure medical education.

The tool contains:

- our national training survey results, viewable at different organisation and specialty levels, including:
  - results from the trainee and trainer surveys
  - reports specific to different training programmes
- comparisons between full time and less than full-time trainees
- results to our burnout questions
- an enhanced monitoring dashboard, displaying the number of current cases in each UK country or region
- progression reports on key stages in doctors' training, such as:
  - specialty examinations
  - annual review of competence progression
  - application and entry into specialty training
  - foundation doctors' preparedness for postgraduate training
- a summary dashboard showing a snapshot of data for any geographic location.

## How can users access the GMC education data reporting tool?

The tool can be accessed through:  
[www.gmc-uk.org/about/what-we-do-and-why/data-and-research/national-training-surveys-reports](http://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/national-training-surveys-reports)

# Executive summary

Our ninth annual *The state of medical education and practice in the UK* report sets out some of the challenges and opportunities in sustaining the successes of the medical profession.

## The evidence

The UK is increasingly reliant on the world market for doctors at a time when peoples' aspirations for work-life balance are changing. If the UK is to attract and retain a high-quality medical workforce, we must have more flexible working and training arrangements in place (chapter 1).

We now have two years of evidence that shows that doctors are still working in pressurised environments (chapter 2). GPs are at particular risk of burnout due to these pressures and two thirds (65%) of GPs reported working beyond their rostered hours every day (chapter 4). Over a quarter (28%) of doctors reported feeling unable to cope with their workload at least once a week. There's also evidence of how these pressures have had an impact on patient care and safety (chapter 5).

Workforce strategies across the UK set out the priority actions for securing and sustaining good staffing levels in the health services. Workplaces that support wellbeing are central to this. The evidence presented here demonstrates how effective communication, knowledge sharing, and support from colleagues are protective factors for doctors' wellbeing (chapter 2). Despite high workloads and long working hours, doctors report feeling the value of support from their colleagues.

There is growing evidence of the role of effective leadership and positive workplace cultures on staff wellbeing and patient outcomes. Leadership that is compassionate and inclusive sees all doctors practising in just workplaces. These cultures promote learning rather than blame, are intolerant of unprofessional behaviours, and make sure that all doctors are supported to provide the best patient care possible (chapter 6).

The evidence presented here of persistent pressures impacting on wellbeing, work life balance, and career intentions points to the need for greater flexibility in the system. More flexible working patterns and training pathways would not only enable better lifelong learning, but new data in this year's report show it can also protect against burnout. Being unprepared for postgraduate training early in a doctor's career is associated with a higher risk of burnout for at least the subsequent six years (chapter 3).

## Key challenges and areas for action

Doctors are practising in a changing context. Ongoing pressures are set against a backdrop of rising demand and a need to recruit and retain a sustainable medical workforce.

Action must be taken in five key areas.

- 1 Establishing a sustainable workforce by increasing supply. It is especially important to grow the number of expert generalists to ease the particularly high workloads in primary care.
- 2 Building greater flexibility in medical training and practice. We must ensure that all doctors are enabled to make the most beneficial contribution to the health service whilst also supporting their own health and wellbeing.
- 3 Better resourcing and planning of clinical leadership. Effective clinical leadership can shape just workplace cultures that support the competence and wellbeing of all doctors and healthcare workers (chapter 6).
- 4 Ensure that joined-up regulation across the UK's health services protects patient safety while being proportionate.
- 5 Enabling new models of care, new medical associate professions, and greater multi-professional working to flourish. This will be achieved by ensuring that training and working environments are safe, supportive and inclusive for all healthcare workers.

## Key contributions

There are some contributions that we can make alone through our statutory responsibilities, and others that we can make with our partners across the UK (chapter 7). As we look into 2020, some of our key priorities include:

- Ensuring a smooth route on to the UK medical register for international medical graduates. We have already doubled the capacity of our PLAB centre and are working with partners to achieve legislative reform of Certificate of Eligibility for the Specialist/GP register routes to registration for non-UK doctors. This would make these routes less complex and more flexible.
- Maximising flexibility in training pathways. We are considering with partners how we can ensure that doctors who wish to change specialty during their training don't undergo unnecessary repetition.
- Working closely with others across the UK to encourage effective clinical leadership. In England we are working closely with the Faculty of Medical Leadership and

Management, and with the CQC to develop the well-led domain. We are working closely with the Scottish Government's Short Life Working Group on Culture in the NHS and the leadership development programme, Project Lift, to consider how we align our work in Scotland.

- Introducing regulation of two new medical associate professions - physician associates (PA) and anaesthesia associates (AA). Their vital contribution to the health services can be enhanced through formal regulation and professional development.

- As a regulator, we will use all our influence and powers to support doctors and medical students in ensuring that they are receiving appropriate and consistent support in their workplaces.



# Supporting a profession under pressure



## A focus on wellbeing in the workplace and flexibility in training

2019's report shows that while many doctors are thriving, medicine operates in a rapidly changing context and pressures remain acute. There are opportunities that offer both efficiency gains and new possibilities for treating patients. To take full advantage of these, we need to recognise and tackle the pressures the health system is under.

The UK is increasingly reliant on the world market for doctors. By 2030, it's predicted there'll be a global shortage of 20% in healthcare workers.<sup>1,2</sup> People's aspirations for work-life balance are changing. A more mobile profession will demand greater flexibility and require better support and induction into new organisations and roles.

The context in which medicine is practised is evolving, with medical and technological advances, rising patient expectations, an older population, and consequently, new models of care. Education, training and practice all need to adapt, in some cases radically, over the next few years to meet current and future challenges. Medical regulation needs to be a constructive partner in both stimulating and enabling changes.

The growing gap is not only between demand for and supply of the medical workforce, but also between the right mix of skills, care arrangements, and training and employment opportunities.

Our *State of medical education and practice workforce report*<sup>3</sup> published in 2019 reported both the trends increasing these gaps and the resulting issues for workforce supply. The uptake of new

doctors training in general practice and some short supply specialties is already increasing. Reductions in working hours and retention issues remain key, as does the flexibility of training and enabling life-long learning.

### The urgent need for workplace and training arrangements to improve

This report provides new evidence on doctor wellbeing, as well as data showing the connection between better support in the workplace with reduced burnout, doctor satisfaction, retention and, critically, patient care and safety. We also demonstrate the need for greater flexibility in medical education and continuing professional development.

Workplace arrangements are contributing to doctors struggling with their wellbeing. Too little resource and planning is being put into medical leadership and this is leaving many doctors feeling unsupported. Many doctors are choosing to work less than full-time or as a locum. However, this is often being done as a reaction to workplace pressure, rather than as an active and positive change in role. The health systems

need to increase the supply of medical associate professions and increase multi-professional working. This will maximise doctors' productivity, protect their wellbeing, and guarantee quality of patient care.

Training arrangements also need to change. Despite the pressures, our national training surveys show training is of high quality, but it needs to produce more doctors with the skill mixes needed. The health systems are not producing enough expert generalists, such as GPs, who can address the multi-morbidity that is becoming ever more common. Nor are we producing enough specialists that the national workforce plans suggest are required; for example psychiatrists to meet mental health needs or radiologists to take maximum advantage of medical and technological advance. The existing training pathways are too inflexible to meet doctors' aspirations for their work-life balance, or the system's need for flexibility and time for CPD.

We said in 2018 that we were at a critical juncture in addressing these issues. And we called for a coordinated approach from the four UK governments, employers and other relevant bodies, including ourselves. The emergence and further development of national workforce strategies during 2019 is therefore a very positive step.

## Evidence in this report underlines the need for change

It is too early for the impact of the workforce strategies to be discernible in national level data. Over time, we anticipate that our commissioned annual barometer survey of the profession will help to show how successful the four healthcare services are at addressing the challenges. In the meantime, findings from this year's barometer survey, showed doctors are still experiencing the issues we reported in 2018 from *What it means to be a Doctor* and *Adapting, Coping and Compromising*.<sup>4</sup>

Further insights on these issues from this year's report include:

### Workplace wellbeing

- There are potential protective factors to workplace wellbeing that should be encouraged. For example: effective communications and communication skills, knowledge sharing, and day-to-day support from colleagues and senior clinical staff. But workload remains an important factor (chapter 2).
- Doctors experience pressure and the consequences of pressure in different ways (chapters 2, 3 and 4). For example:
  - two-thirds of GPs work beyond rostered hours, double the proportion overall

- a fifth of SAS & LE doctors undertook tasks that would usually be completed by more senior doctors at least once a week -double that of other doctors
- a fifth of doctors have reduced clinical practice and over past year, over one in ten reported having to take time off due to stress
- challenges around workload and rota design leave over a fifth of trainers and trainees short of sleep at work at least once a week or more.

### Education and training

- There are signs that more flexible training pathways are required; for example, the number of doctors having training pauses after Foundation Year 2 is higher than ever before and the trend is continuing (chapter 3).
- Doctors feeling prepared and supported at career transitions is key. Doctors who reported feeling not adequately prepared for postgraduate training reported higher risk of burnout, which continues for at least 6 years (chapter 3).

### GPs and patient care

- GPs report more severe pressures and consequences to their wellbeing compared with other doctors. There is some direct evidence of how this is affecting patient care (chapters 4 and 5).
- There are potential costs to both patients and the health system, where patient referrals are numerous. Although patients

are understanding and sympathetic to the pressure doctors are under, they feel their experience of the referral system could be improved. Patients often don't know what to expect when referred and are often not given the information they feel they need. They expect their GP to offer more advice and reassurance, to do more to explain the referral process. And they expect far better joined up administration. A particular theme was raised around notes going missing and/or being inaccurate when patients attend their referral appointment (chapter 5).

- There's the broader impact of pressures on patient safety: one out of eight doctors who witnessed a patient safety concern said problems around resourcing was the sole contributing factor to the most recent patient safety incident (chapter 5).

### Leadership and culture

- Research on leadership commissioned for this report and the findings of *Caring for doctors Caring for patients*<sup>5</sup> show the degree to which leadership is unplanned and under-resourced. There is a strong link between leadership and compassionate care cultures that generate substantially better outcomes for both doctors and patients (chapter 6).
- Supportive cultures are directly related to burnout. Half of doctors with a low burnout risk say they never feel unsupported by immediate colleagues, compared with only a quarter of those with a very high burnout risk (chapters 2 and 6).

- Where staff treat each other with respect and focus on teamwork and building confidence, trainers and trainees are more positive and feel their concerns will be addressed (chapter 3).

## Implications for future action

There is no single solution to alleviating current pressures. However, this report suggests that key to success for the new Government in Westminster and the devolved governments is action in five areas.

- 1 Workforce:** Workforce supply and patient demand need to be brought more into line. This includes: retaining the current workforce, building on recent increases in the supply of non-UK doctors, continuing to increase the capacity of UK medical education and training – particularly for GP and certain specialties prioritised in workforce strategies – and raising productivity with new models of care, new professional roles and multi-professional working. Equally important is the need to manage demand, so focussing on illness prevention through public health activity, and systemic issues, such as the volume of referrals (chapter 5).

Work we are doing to address workforce issues includes advocating for more flexibility in generalist areas of medicine, such as letting trainees from specialist postgraduate programmes work in a GP practice. We have supported the increase in UK medical school places and doubled our Professional and Linguistic Assessment Board (PLAB) test capacity to allow more international medical graduates to join the UK register. We have also introduced more guidance to help doctors

returning to medical practice in the UK after an absence.

- 2 Flexibility:** Increased flexibility in both training and working patterns is required, as is increasing the overall supply of new doctors and medical associate professionals. Good inductions to new roles, teams and employers, more time for training and more flexible opportunities for CPD will all be vital in achieving high standards within a more flexible international workforce operating in a wide variety of care models.

We have developed a process for GMC-regulated credentials and will be bringing several early adopters through the process. This will have the potential to address areas of patient safety risk while allowing for greater career flexibility for doctors. We have also encouraged a greater focus on generic capabilities and transferable skills in the training process. As we assist with these changes in medical training and practice, we will also focus on supporting the wellbeing of doctors at all stages of their careers.

- 3 Workplace:** We present evidence that workplace pressures are associated with risks to patient care, doctor wellbeing and reduced supply. Many doctors are witnessing patient safety issues due to these pressures. Wellbeing, reflected in risk of burnout, is reduced for many doctors and creates further risks for patient care, as well as negatively affecting retention. Workplace culture issues are also a concern. Although the national training surveys have shown a decline in the reporting of bullying and undermining in recent years, we still consider any instances of this taking place to be unacceptable.

Three independent GMC-commissioned reports and reviews published in 2019 show the importance of workplace culture.<sup>5,6,7</sup> All three present strong themes in relation to good culture and support the need for consistency of:

- compassionate and collective leadership
- accessible and effective clinical supervision
- workplace environments that are inclusive and fair
- induction and ongoing support for doctors
- a learning culture in which systemic issues are addressed and considered when things go wrong
- proportionate local investigations with fair decision making.

We are coordinating our work so we can implement the recommendations from these three reviews as a priority.

Key to enabling effective workplace cultures is clinical leadership that is better planned and resourced. This is particularly emphasised by our research on doctors' day-to-day experience of leadership (chapter 6).

**4 Regulatory alignment:** Enabling legislative reforms that make regulation more efficient and fit for purpose as new models of care develop. These must be supported by new professional roles and increased multi-professional team working. The data, research and findings of the independent reviews feeding into 2019's report confirm the importance of recent efforts. These

have involved professional and systems regulators working together to go beyond their traditional roles of reacting when things go wrong, and put more resource into collaborative preventative approaches. Legislation and policy reform is necessary to help us accelerate these.

**5 Multi-professional working:** Many doctors have reported frustrations about taking on tasks that are outside of their professional role and not having the right support to deliver the care they would like to (chapter 2). Part of the solution to both these issues is more multi-professional teams made up of medical associate professions. We are taking on the regulation of two of these professions: physicians associates and anaesthesia associates (chapter 7).

We hope that the evidence presented throughout this report and the implications for action outlined in the last chapter will help with the further development of the national workforce strategies. Some progress is being made already and we hope to report on this in 2020.



## Wellbeing and retention of doctors

**63%**

of doctors are satisfied with their day-to-day work but many are feeling the strain of persistent system pressure



High workloads remain a challenge for doctors: 32% have worked beyond their rostered hours every day in the past year and 28% have struggled to cope with their workload at least once a week



Workplace support appears to be related to a lower risk of burnout for doctors: 53% of those with a very low burnout risk reported that they've never felt unsupported by immediate colleagues. Only 6% of those with a low risk of burnout took a leave of absence due to stress in the past year

**23%**

of doctors with a high risk of burnout have taken a leave of absence due to stress in the past year

## Doctors continue to work under sustained pressure in 2019

In the past three editions of this report, we've highlighted the pressures facing all UK health systems. In 2018, we reported on two vicious cycles that are affecting the capacity and sustainability of the medical profession.<sup>8,9</sup>

In the *Adapting, Coping, Compromising*<sup>8</sup> research in 2018, doctors reported how rising pressure caused by workforce shortages are leading some doctors to become stressed and unwell. This results in sickness absences, reduced hours, or doctors leaving the profession. Ultimately, this compounds the existing issue (figure 1).

Doctors also discussed how they sometimes adapt to a lack of time by prioritising short-term patient needs over long-term outcomes. This may

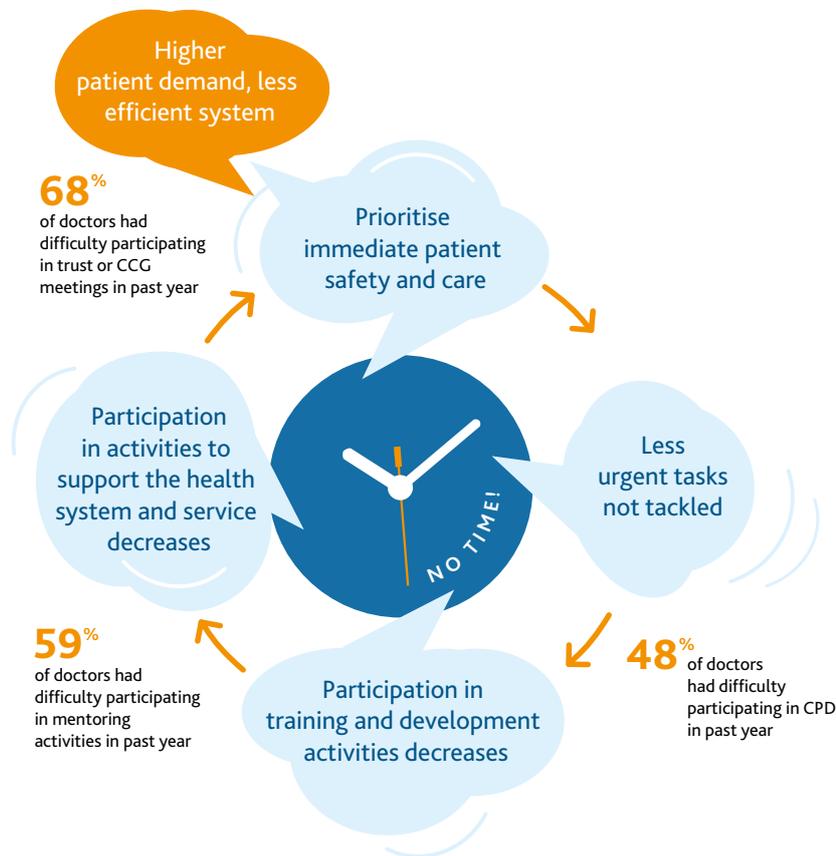
benefit patients with immediate health needs, but can mean patients with long-term health issues are overlooked. This also leaves less time for personal and team development, which potentially has an impact on the quality of the overall health workforce.<sup>8</sup>

Those in the health systems across the UK must work together to break these cycles, so doctors can provide quality care to all patients.

Figure 1: Vicious cycle of workforce shortages



Figure 2: Vicious cycle of pressure-induced short-termism



*Adapting, Coping, Compromising (2018)*  
*The 2019 barometer survey (2019)*

*n = 2,617 – 3,791 (varied by activity – all those who said the activity was relevant to them),*  
*The 2019 barometer survey QC8\_3/7/18, values do not add up to 100% as multiple questions presented.*

In 2019, these pressures remain sharp in all four countries of the UK. They're particularly having an impact on doctors' wellbeing, staffing levels, quality of care, and patient safety. The recently published *Workforce report*<sup>3</sup> underlined why protecting doctors' wellbeing is vital to retain the UK's medical workforce.

Chapter 5 explores patients' experience in a system under pressure.

The barometer survey painted a picture of:

- a workforce where the majority of doctors are satisfied in their day-to-day work, but where a significant minority (30%) are not
- sustained pressure manifesting as widespread long working hours, high workloads and prevalent symptoms of burnout
- pressures and wellbeing concerns having an impact on both patients and doctors.

\* See research and data note on page 130 for more information.

## Pressure is not felt in the same way by all doctors

Doctors' experiences of pressure will vary on an individual basis, but the barometer survey illustrated patterns across groups of doctors.

- 65% of GPs reported working beyond rostered hours every day, compared with 32% of doctors overall. In chapter 4, we explore GPs' experiences of working in primary care.
- 21% of SAS and LE doctors said they have carried out tasks usually completed by a doctor who has a more senior role, weekly or more often, compared with 11% of doctors overall.
- 18% of doctors in training reported having to take a leave of absence due to stress during the past year, compared with 12% of doctors overall.

- 43% of specialists said they have refused to carry out additional work as a result of pressure on their workload and capacity, compared with 33% of doctors overall.

Three-fifths (63%) of doctors reported feeling satisfied in their day-to-day work, but many said they were feeling the strain of persistent system pressure. This pressure can be mitigated by the protection of workplace cultures and leadership. This was expressed in the survey as positive relationships with, and support received from, colleagues.

This chapter will first look at the causes of pressure, before considering some of the symptoms and consequences for doctors, and for the system more widely.

## Causes of pressure

### High workload and demand on the health service mean many doctors regularly work beyond their rostered hours

Almost seven out of 10 (69%) doctors worked beyond their rostered hours at least once a week, and around half of these doctors – a third (32%) of doctors overall – did so daily.

This issue is most prevalent among GPs and specialists. Two-thirds (65%) of GPs reported working beyond their rostered hours every day. Nine out of 10 (90%) GPs and three-quarters (75%) of specialists did so every week. In comparison, doctors in training worked beyond their rostered hours less frequently – around 56% did so on a weekly basis.

## Satisfied and dissatisfied doctors alike struggle with long hours and high workloads

Although most pronounced among GPs, a proportion of every group of doctors reported dissatisfaction in their day-to-day work:

- 45% of GPs
- 27% of specialists
- 26% of doctors in training
- 22% of SAS and LE doctors.

Working long hours is a key driver of dissatisfaction for many doctors. In the open responses,\* two-fifths (42%) of dissatisfied doctors gave increasingly high workloads and long hours as their reasons for dissatisfaction. And around one out of eight (12%) satisfied doctors suggested that long hours and high workload were a challenge for them.

Dissatisfied doctors gave a range of reasons for dissatisfaction in their role, many of which are causes and/or consequences of system pressures. They included:

- care being compromised despite best efforts/working under unsafe conditions – 22%
- working under pressure/time constraints – 19%
- finding it increasingly difficult to deal with patient expectations and dissatisfaction – 19%
- diminishing/overstretched resources and services – 15%.

GPs were more likely to report finding it increasingly difficult to deal with patient expectations and dissatisfaction than other doctors. A third (36%) of GPs felt this way compared with one out of 10 specialists (11%), 12% of SAS and LE doctors and only 5% of doctors in training.

Over a quarter (29%) of dissatisfied doctors in training said being disillusioned with the profession or not feeling respected was a driver for dissatisfaction, compared with 16% of dissatisfied doctors overall. This is a worrying sign for the future workforce supply, with doctors feeling disillusioned early in their careers.

Similarly, 11% of dissatisfied SAS and LE doctors gave their reason for dissatisfaction as a lack or loss of autonomy, compared with 8% of dissatisfied doctors overall.

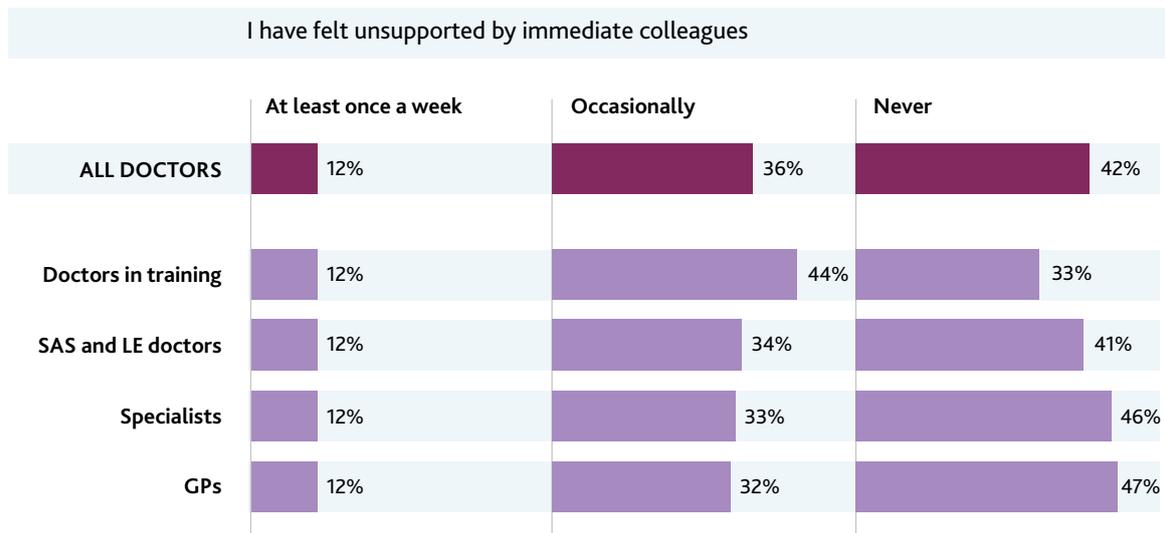
## Support is important for doctors but often they are feeling unsupported by both their colleagues and senior medical staff

In the *Adapting, Coping, Compromising*<sup>8</sup> and *What it means to be a doctor*<sup>9</sup> research, doctors raised a lack of support as being both a cause and a consequence of pressure. In the barometer survey, doctors were asked how frequently they felt unsupported by a range of colleagues (figure 3).

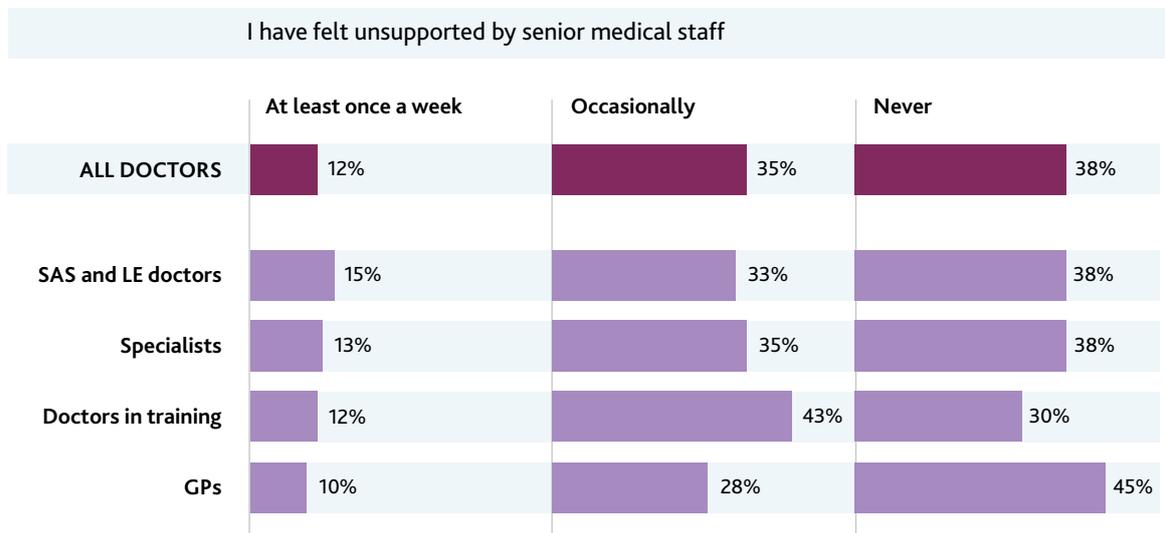
\* For more information on the use of open responses in the barometer survey, please see research and data note on page 130.

**Figure 3: Proportions of doctors who regularly, occasionally, or never feel unsupported by their immediate colleagues or senior medical staff**

*How frequently, if at all, over the last year have you experienced the following?*



*n = 3,876 (all doctors), the 2019 barometer survey QC1\_5, values do not add up to 100% as not all response options are included.*



*n = 3,876 (all doctors), the 2019 barometer survey QC1\_6, values do not add up to 100% as not all response options are included.*

A frequent (at least once a week) feeling of a lack of support is relatively uncommon among all types of doctors. 12% of doctors felt unsupported by immediate colleagues or senior medical staff at least once a week. Considerably more GPs said they never felt unsupported by senior medical staff (45%), compared with other register types.

Two-fifths of doctors in training reported occasionally feeling unsupported by their immediate colleagues (44%) which is much higher than other register types, or by senior medical staff (43%). Doctors in training are the least likely to say they never felt unsupported by their immediate colleagues (33%) or by senior medical staff (30%).

Of the one out of 10 (12%) doctors in training who said they felt unsupported by senior medical staff at least once a week, almost a third (30%) fall into the high risk of burnout category, compared with only 11% with a very low burnout risk. For doctors in training, a lack of support from senior medical colleagues may be a driver of burnout.

SAS and LE doctors reported feeling unsupported by senior medical staff at least once a week – a slightly higher rate than other register types. They were also slightly less likely than GPs and specialists to have said they never felt unsupported by immediate colleagues – two-fifths of SAS and LE doctors (41%), compared with almost half of GPs (47%) and specialists (46%).

Almost half (46%) of specialists reported never feeling unsupported by their immediate colleagues. This is broadly similar to the experience of GPs. Over a third of specialists said they occasionally (35%) or never (38%) felt unsupported by senior medical staff.

Of all groups of doctors, specialists were the most likely to report feeling unsupported by non-clinical management. Nearly nine out of 10 (88%) specialists reported feeling this way in the past year, compared with around three-quarters of SAS and LE (72%) doctors and doctors in training (77%), and around seven out of 10 (68%) GPs.

### Box 1: Indicators of burnout in the 2019 barometer survey

The barometer survey included questions from the Copenhagen Burnout Inventory<sup>11</sup> – an internationally-recognised and validated tool for assessing the physical and psychological fatigue associated with burnout.

Burnout is a state of emotional, mental and often physical exhaustion caused by prolonged or repeated work-related stress. Feeling depressed and lacking motivation are characteristics of burnout.

Participants were asked seven questions:

#### To what degree do you feel the following about your work?

- 1 Is your work emotionally exhausting?
- 2 Do you feel burnt out because of your work?
- 3 Does your work frustrate you?

#### How often, if at all, do you feel the following about your work?

- 4 Do you feel worn out at the end of the day?
- 5 Are you exhausted in the morning at the thought of another day at work?
- 6 Do you feel that every working hour is tiring for you?
- 7 Do you have enough energy for family and friends during leisure time?

When analysing the barometer survey, differing risk levels for burnout were suggested by the number of indicators to which participants gave a 'negative' score. A negative score was typically answering a question with:

- experienced to a 'high' or 'very high' degree
- experienced 'often' or 'always'
- 'seldom or never' were considered the negative responses to the question around having 'energy for family and friends'.

In this report, responses have been grouped into four categories.

<b>Very low burnout risk</b>	Participants who gave a negative burnout response on 0–1 of the seven indicators
<b>Low burnout risk</b>	Participants who gave a negative burnout response on 2–3 of the seven indicators
<b>Moderate burnout risk</b>	Participants who gave a negative burnout response on 4–5 of the seven indicators
<b>High burnout risk</b>	Participants who gave a negative burnout response on 6–7 of the seven indicators

These categorisations are indicative only, acknowledging the subjective nature of burnout.

# Symptoms of pressure

## The high workloads reported by doctors are leading some to feel unable to cope

More than three-quarters (79%) of doctors reported they've been unable to cope with their workload at least occasionally in the past year. While this might be expected to some degree, over a quarter (28%) of doctors felt this way every week.

GPs in particular are struggling to cope with their workloads, with a sixth (17%) reporting feeling this way every day. This is more than twice the

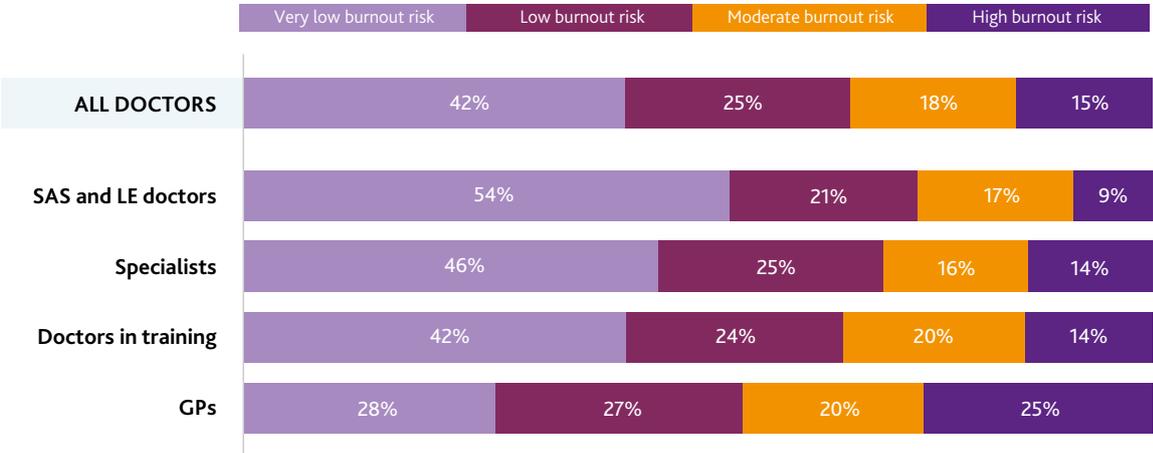
proportion of specialists (7%), more than four times SAS and LE doctors (4%), and more than five times doctors in training (3%).

## Many doctors feel burnt out and emotionally exhausted

Burnout is a state of emotional, mental and often physical exhaustion caused by prolonged or repeated work-related stress. Feeling depressed and lacking motivation are characteristics of burnout. Figure 4 shows the overall indications of burnout risk for each registration type.

Figure 4: Risk of burnout by registration type

Summary of number of burnout indicators to which a negative burnout answer given



n = 3,876 (all doctors), the 2019 barometer survey QD1/D2, information on categorisations of burnout can be found in box 1 on page 28.

A sixth (15%) of doctors overall fall into the category of a high risk of burnout.\*

Over half (54%) of SAS and LE doctors can be categorised as very low risk of burnout, more than all other register types. In turn, these doctors also indicated a high risk of burnout the least, at 9%.

GPs indicated the highest risk of burnout compared with other register types, with a quarter (25%) of GPs indicating high burnout risk.

The burnout indicators most frequently experienced by all doctors were:

- feeling worn out at the end of the day – over three-fifths (63%) of doctors felt this way often or always
- finding work emotionally exhausting – nearly half (49%) felt this to a high or very high degree.

As these indicators are experienced by a high proportion of doctors, including satisfied doctors, it seems likely that these factors are accepted by many as part of the reality of life as a doctor.

GPs are particularly likely to find their work emotionally exhausting – two-thirds (65%) of GPs felt their work was emotionally exhausting to a high degree, compared with 49% of doctors overall. This is explored further in chapter 4, including in relation to the specific challenges faced by some GPs working in deprived communities.

Around a third (34%) of doctors found their work frustrating and over a quarter (29%) felt burnt out to a high or very high degree because of their work. A third (33%) of doctors felt exhausted at the thought of another day at work on a regular basis. This is particularly high among doctors in training – two-fifths (42%) always or often felt exhausted in the morning at the thought of another day at work.

A quarter (26%) of doctors found every working hour tiring often or always. And, similarly, a quarter (26%) of doctors said they never or seldom have enough energy for family and friends.

### **Dissatisfied doctors are more likely to have a high risk of burnout than their satisfied colleagues**

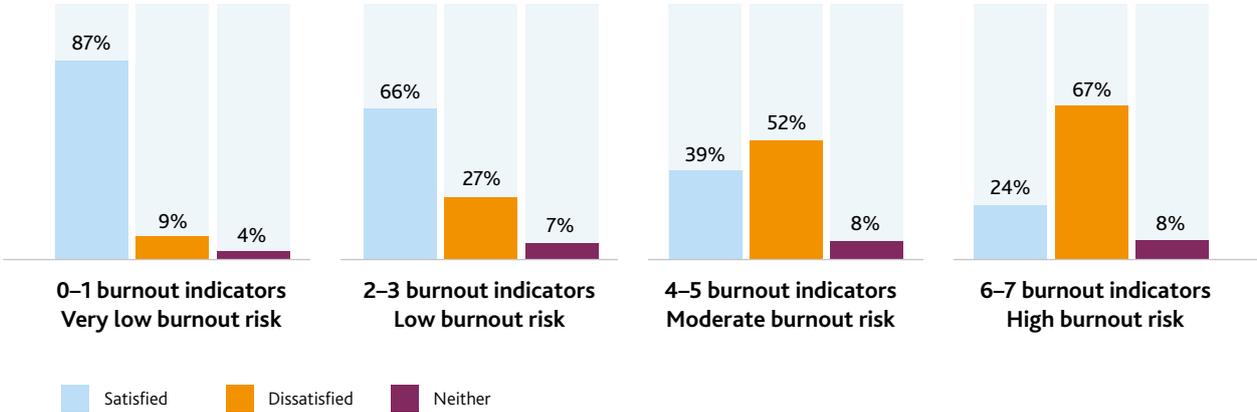
Risk of burnout is closely related to dissatisfaction. Two thirds (67%) of doctors in the highest risk of burnout group were also dissatisfied in their day-to-day work, compared with only one out of 10 (9%) of the doctors with very low burnout risk.

There's no individual measure of burnout that appears to be a particularly strong indicator of dissatisfaction, rather it's the compounding effect of multiple experiences that lead to dissatisfaction.

\* Further information on categorisations of burnout can be found in box 1 on page 28.

**Figure 5: Proportion of satisfied and dissatisfied doctors across the range of burnout measures**

Summary of risk of burnout compared with doctors' reported level of satisfaction in their day-to-day work



n = 3,876 (all doctors), the 2019 barometer survey, QD1/D2 & QA1, information on categorisations of burnout can be found in box 1 on page 28.

In the *What it means to be a doctor* survey,<sup>9</sup> 95% of doctors said their mental health and wellbeing was important to them, with over half (57%) saying it was extremely important. This suggests

that significant proportions of doctors would take action to reduce the pressures of their work if their personal wellbeing were at risk.

**Box 2:**  
**NTS data on burnout and facilities for rest and study**

In the 2019 national training surveys, over 50,000 doctors chose to answer seven voluntary questions based on the Copenhagen Burnout Inventory.<sup>11</sup> The findings were almost identical to the 2018 results when we first added the questions to the survey.

- Over a fifth of doctors in training and trainers reported feeling burnt out to a high or very high degree.\*

- Two-fifths of doctors in training and trainers found their work emotionally exhausting to a high or very high degree.
- Over half of doctors in training and trainers told us they always or often felt worn out at the end of the working day.

In 2019, following discussions with representatives of doctors in training, education bodies and our survey advisory

\* This is in response to a specific question asking participants 'Do you feel burnt out because of your work?', rather than by grouping burnout indicators.

group, we asked doctors in training and trainers new questions on resources and facilities for rest and study. The responses to these new questions highlighted several issues and different experiences:

- One out of 10 doctors in training told us there was no common room or mess available to them in their post.
- Two out of 10 doctors in training described their common room or mess facilities as poor or very poor.
- A third of trainers (excluding GP trainers) told us a mess or common room wasn't available to them. 12.9% had access to these facilities but rated them as poor or very poor. This means around half of non-GP trainers only have access to a poor common room/mess or no access at all.

The results also identified that many doctors were concerned about the out-of-hours resources and facilities available to them:

- A quarter of doctors in training and a fifth of non-GP trainers disagreed that there was a mechanism for them to travel safely to and from work when working out-of-hours or after long shifts.
- A quarter of doctors in training and around a third of non-GP trainers told us that free of charge rest facilities were not available

to them when they were working on call, out of hours.

- Around one out of 10 doctors in training and non-GP trainers also told us that, while rest facilities were available, they had to pay to use them.

One important factor in recognising, managing and responding to health and wellbeing issues is being confident about who to talk to in your professional environment. In 2019, for the first time, we asked a question to that effect. It is encouraging that around two-thirds of doctors in training and four out of five trainers know who to contact in their trust/board (or equivalent) to discuss matters relating to occupational health and wellbeing. However, a third of doctors in training – over 18,000 doctors – either didn't know or weren't sure they knew who they should talk to.

We know that employers in all four countries of the UK are already looking at these issues. We'll continue to work with them to help address the causes of poor wellbeing for doctors across all career stages. And we hope that data from these new questions will help us further our work in this area, and bring about improvements to doctors' training and working environments.

## Consequences of pressure

Doctors understand that their roles come with considerable responsibility, potentially antisocial working hours, and moments of high emotional stress.<sup>8,9</sup> Given the risk of burnout and not coping with workload already reported in this chapter, there is a notable impact on doctors' wellbeing. This is affecting how doctors are practising and the quality of care they're able to offer to patients.

This chapter explores the impacts of pressure on doctors' wellbeing and their careers. Chapter 5 explores how patients are affected.

### **We are temporarily losing doctors from the workforce when they have to take time out due to stress**

More than one out of 10 (12%) doctors said they've had to take a leave of absence due to stress in the past year. Of these doctors, 10% have taken such a leave of absence occasionally and the remaining 2% have taken one once a month or more frequently.

Satisfied doctors are much less likely to have taken a leave of absence than their dissatisfied colleagues – less than one out of 10 (9%), compared with almost a fifth (19%).

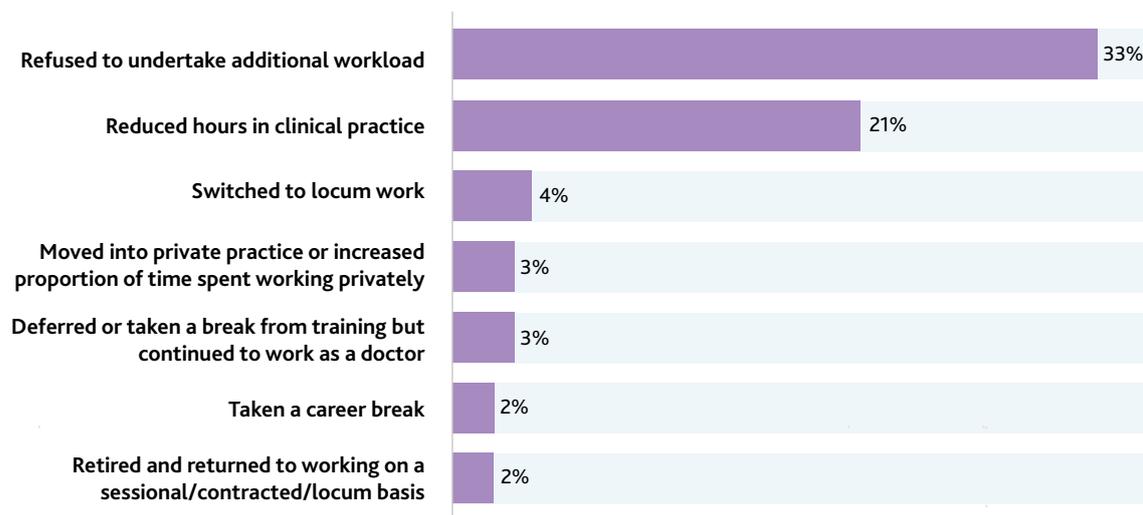
The higher the risk of burnout indicated, the greater the proportion of doctors who have had to take a leave of absence due to stress in the past year. For doctors with very low risk of burnout, 6% have had to take a leave of absence in the past year. This figure rose to 23% for doctors with high risk of burnout.

### **Doctors have refused to take on additional workload to cope with pressure**

Half of doctors (52%) reported taking some action to adjust their work as a result of workload and capacity pressure. Most commonly, doctors have refused to carry out additional work – a third of doctors (33%) said they have done so. 43% of specialists said they have refused to carry out additional work, the highest proportion of the different registration types.

**Figure 6: Adjustments doctors report making to working patterns as a result of workload pressures**

*In the last year, have you done any of the following to adjust your work as a result of pressure on workload and capacity?*



*n = 3,876 (all doctors), the 2019 barometer survey QC2, values do not add up to 100% as it was possible to select multiple responses and not all response options are included.*

## Reduced hours

In the short-term, supply of doctors could be affected as a fifth of doctors (21%) have reduced their hours in clinical practice in the past year (figure 6). At 36%, the proportion of GPs who said they have reduced their clinical hours in the past year was markedly higher than other registration types.

Reducing hours in clinical practice could mean a number of different things for individual doctors. For some, it could mean reducing hours spent in patient care to take on an additional leadership or management role – more information on doctors' experiences of these roles can be found in chapter 6 – and for others it could mean an overall reduction in working hours.

## Reducing hours to less than full-time working can be beneficial for doctors

The barometer survey indicated wellbeing benefits for doctors working less than full-time, compared with those who work full-time.

- Specialists working less than full-time were more likely to be satisfied in their day-to-day work than those working full-time.
- SAS and LE doctors working less than full-time were less likely to be experiencing moderate to high burnout risk than their full-time colleagues.
- Doctors in training working less than full-time were less likely to feel they were unable to cope with their workload on a weekly basis, compared with their full-time colleagues.

For many doctors, working less than full-time is a positive choice that signals other life commitments and/or a desire for good work-life balance. It’s important that the system can accommodate those who wish to work in this way, while maintaining a supply of doctors that is able to match patient demand.

**Many doctors find it difficult to participate in a range of professional activities, which help both to maintain their skills and to contribute to the system as a whole**

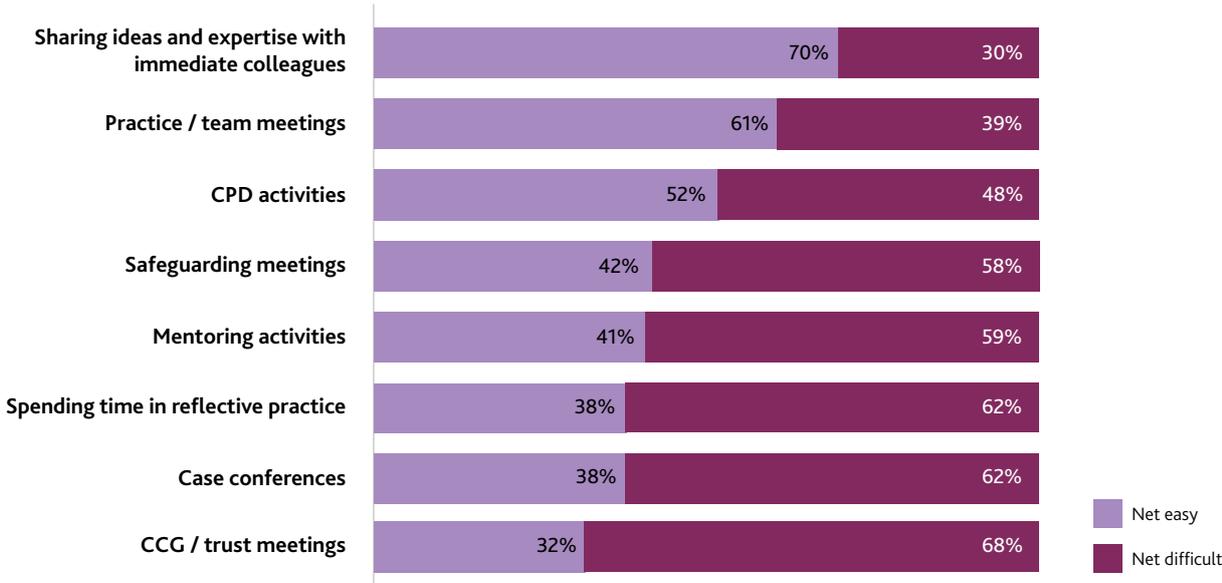
Some doctors respond to system pressures by prioritising immediate patient care over a range

of professional activities,<sup>8</sup> such as continuing professional development, attending meetings at a range of levels, and mentoring other doctors. All of these activities help to maintain doctors’ own skills and the skills of others, as well as contributing to the health system as a whole.

In 2019, the barometer survey included questions about doctors’ ability to participate in a range of such professional activities over the past year. Figure 7 shows the proportions of doctors overall who found it easy or difficult to take part in these activities.

**Figure 7: Proportions of doctors who found it easy or difficult to participate in non-patient facing professional activities**

*Over the past year, how easy or difficult has it been to participate in each of the following activities to the level needed to undertake your role effectively?*



*n = 2,989 – 3,856 (varied by activity – all doctors who reported that activities were relevant to them), the 2019 barometer survey Qc8, values do not add up to 100% as not all response options included.*

## Almost half of doctors find it hard to participate in continuing professional development

Continuing professional development (CPD) is any formal or informal learning outside of undergraduate education or postgraduate training that helps doctors maintain and improve their performance. It includes knowledge, skills, attitudes and behaviour. As well as being part of a doctor's duty to keep up to date, it's also important for a doctor's wellbeing and the quality of patient care.

We set the standards for CPD, although we do not stipulate how many hours a doctor should spend on it. Employers are expected to enable doctors to complete CPD in work time.

While half of doctors (52%) said they've found it easy to participate in CPD activities, almost as many (48%) said it was fairly or very difficult to do so.

## Doctors who are burnt out or struggling to cope with workloads are more likely to find it difficult to participate in professional activities

Almost three-quarters (73%) of doctors with a high risk of burnout found it difficult to undertake CPD activities. This is compared with only a third (32%) of those with a very low risk of burnout.

Almost three-fifths (80%) of doctors who felt unable to cope with their workloads at least once a week have found it difficult to find the time to participate in trust or clinical commissioning group meetings. This fell to only two-fifths (63%) for those who struggled to cope with workload less than once a week.

## Doctors' intentions as a result of pressure

Sustained pressures, risks to wellbeing, and the frustration of compromised patient care may be causing some doctors to want to reduce the time they spend in direct patient care. Doctors may move away from this highly pressurised environment to practise elsewhere in the world or consider leaving the medical profession entirely.

### Most doctors are considering making a career change in the next year

We recently published *The workforce report*<sup>3</sup> highlighting that seven out of 10 doctors (71%) said in the barometer survey that they were likely to make a career change in the next year.

In response to being asked how likely they were to make a range of career changes within the next year, around half (52%) of doctors said they were likely to make a change that would see them spending less time in clinical practice.

This was most common among GPs (66%) and specialists (59%). Only around two-fifths of SAS and LE (37%) doctors and doctors in training (39%) were considering reducing their hours in clinical practice.

Almost a fifth (19%) of doctors said they were considering leaving the UK medical profession entirely. Excluding those of retirement age who said they were considering retiring, 17% of doctors under retirement age were considering making a career change that would take them permanently out of the UK's medical workforce.

### Almost two-fifths of doctors said they were most likely to make a career change that would see them spending less time in clinical practice or leaving the UK profession permanently

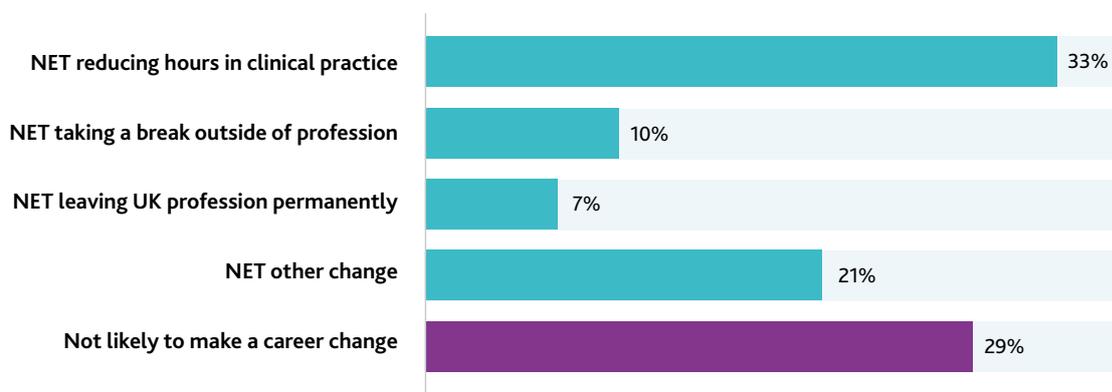
Figure 8 shows the career changes doctors were most likely to make.

A third (33%) of doctors said they were most likely to make a career change that would see them reduce their hours in clinical practice. This was most common among GPs – over two-fifths (45%) gave this as their most likely career change.

Alongside GPs, specialists were more likely than other register types to be considering reducing their hours in clinical practice, with two-fifths (40%) saying this was the change they were most likely to make within the next year. Unlike GPs, this does not appear to be linked to dissatisfaction or burnout; instead it's more likely related to concerns about pensions. Specialists were much more likely to mention pensions in a negative light in their open survey responses – a fifth (21%), compared with less than one out of 10 (8%) of doctors overall.

**Figure 8: Career changes that doctors said they were most likely to make within the next year**

Please select which career change you are most likely to make



*n = 3,876 (all doctors), the 2019 barometer survey QB1a, information on the net values can be found in the data note on page 130.*

A small proportion (7%) of doctors said they were most likely to leave the UK profession entirely. This includes those who reported that they were most likely to leave the profession permanently, to move to practise abroad on a permanent basis, or to retire. This overall 7% can be split into two groups:

- those considering leaving and approaching normal retirement age
- those who are under the standard retirement age but are considering leaving the UK profession permanently.

While the first of these groups may be considered standard retirees, just over one out of 20 (6%) doctors were under retirement age and considering leaving the UK profession permanently. This is linked to dissatisfaction: the proportion considering leaving permanently and before retirement age rises to one out of 10 among those doctors who were dissatisfied and who reported a high risk of burnout.

Doctors aged between 50 and 59 years were more likely to be in this second group of potential leavers (9%). This possibly reflects the early retirement option that is open to this group.

When doctors who said they were planning early retirement are considered as a group, there are indicators that their plans are associated with dissatisfaction, capacity pressures and other systemic issues. Doctors considering retiring

early are less likely than average to be satisfied and more likely to be GPs. They're also more likely than other register types to be working on a less than full-time basis, which suggests they have already taken partial steps towards retirement, and/or such steps have failed to alleviate the issues causing their dissatisfaction.

### **Doctors have taken a range of soft and hard steps towards leaving the profession, and those who have taken hard steps are most likely to be dissatisfied and/or burnt out**

Doctors who reported that they were likely to leave the medical profession were asked what steps they have already taken (figure 9). It was common for those leaving for reasons other than retirement to have taken initial steps, such as discussing their thoughts with others or doing research.

However, a small proportion – 3% of the profession overall, but two-fifths of those who said they were most likely to leave for a reason other than retirement – said they have taken hard steps towards leaving the profession, such as contacting a recruiter or applying for a role outside medicine.

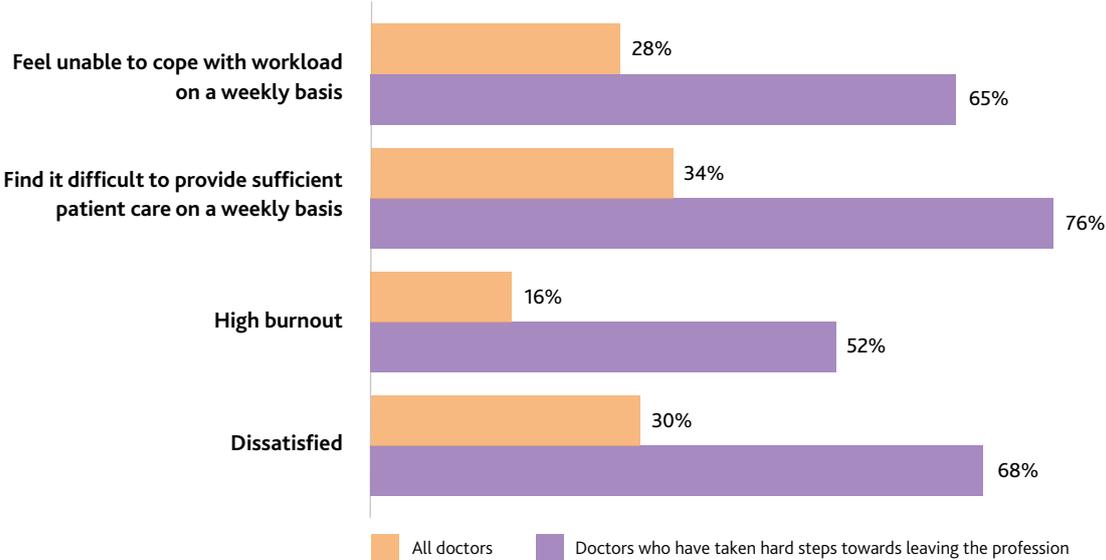
Figure 9: Proportions of doctors taking steps towards leaving the medical profession



*n = 313 (those fairly or very likely to leave the medical profession, excluding retirees), the 2019 barometer survey QB3, values do not add up to 100% as it was possible to select multiple responses.*

Taking hard steps towards leaving the profession is strongly associated with dissatisfaction and burnout, as well as finding it difficult to provide a sufficient level of patient care and being unable to cope with workload on a weekly basis (figure 10).

Figure 10: Characteristics of doctors who have taken hard steps towards leaving the profession compared with doctors overall



*n = 119 (those fairly or very likely to leave the medical profession, and who say they have taken hard steps towards leaving), the 2019 barometer survey QB3, information on categorisations of burnout can be found in box 1 on page 28.*

## Doctors gave a wide range of reasons for their planned career changes

Doctors who said they were likely to make a career change were asked about their reasons for doing so.

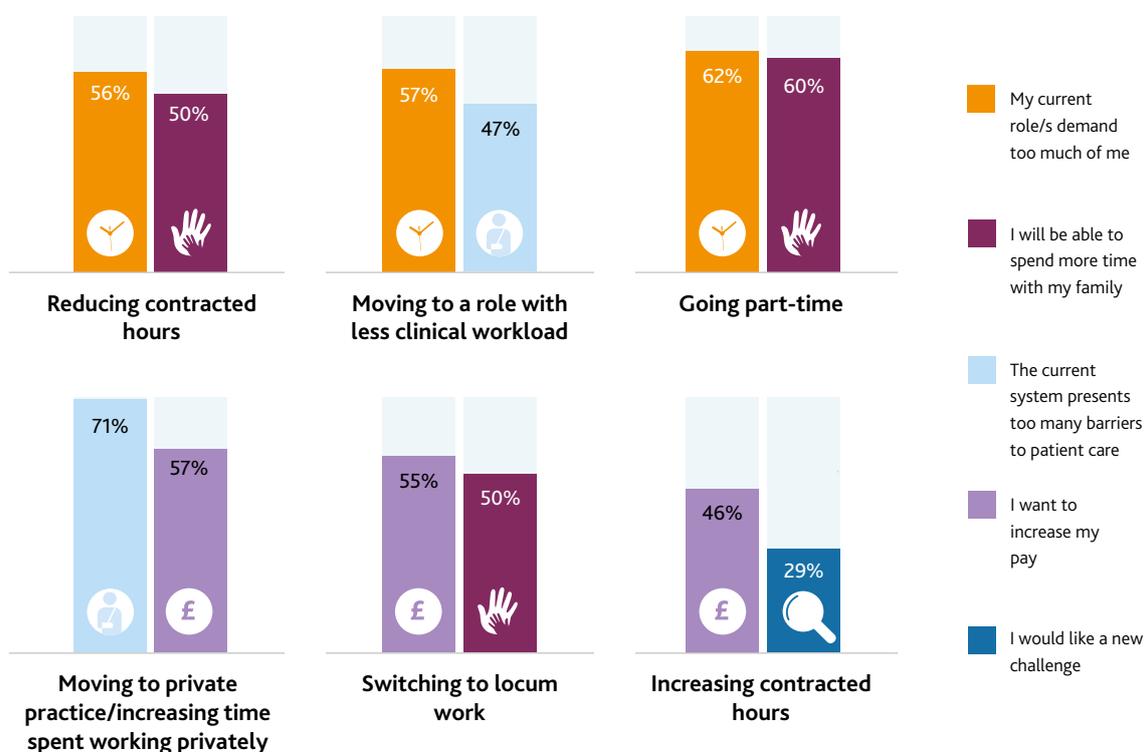
- Three-fifths (62%) of these doctors mentioned the excessive demands of their current role; or the current system was presenting too many barriers to patient care.
- Over half (54%) mentioned their desire to have more leisure time or time with their family.

- Two out of five (40%) mentioned both leisure/family time and demands/barriers.

Excessive demands of their current role emerged as a common reason for a range of potential career changes, including as the most prominent reason among doctors planning to reduce their contracted hours (56%), to move to a role with less clinical workload (57%), and to go part-time (62%).

Figure 11 shows the top two reasons given by doctors for making their most likely career change, across a range of different career changes.

Figure 11: Top two reasons selected by doctors for making their most likely career change



*n = 124 – 925 (varied depending on number that selected each career change as the most likely), the 2019 barometer survey QB2, values do not add up to 100% as multiple option combinations presented.*

# Pressure and its implications

Workloads remain high for most doctors, with working extra hours an established part of medical practice for many.

Analysis of the relationship between working hours and ability to cope identified four distinct groups of doctors. Regularly working beyond rostered hours is defined as working beyond rostered hours weekly or more. Regularly coping with workload refers to those unable to cope with their workload less than weekly (figure 12).

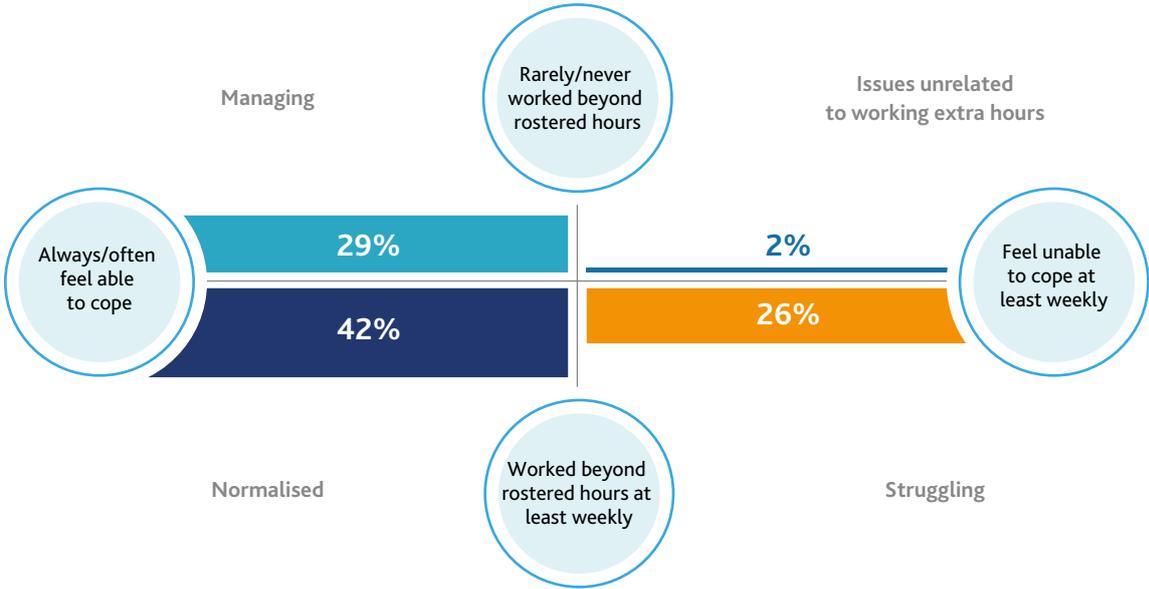
- **Managing** – not regularly working beyond rostered hours and coping with workload. Three out of 10 of the overall population of doctors fall into this category.
- **Normalised** – regularly working beyond rostered hours and coping with workload less often than this. This is the largest group,

with two out of five doctors falling into this category. This suggests that working beyond rostered hours is a normal part of a doctor’s life that many can cope with.

- **Issues unrelated to working extra hours** – not regularly working beyond rostered hours but not coping with workload. Only a very small minority of doctors fall into this group. It seems likely there are other factors outside of workload causing these doctors to feel unable to cope.
- **Struggling** – regularly working beyond rostered hours and not coping with workload. A quarter of doctors fit into this group, showing that a sizeable proportion of the profession have ongoing issues with high workload.

Figure 12: Quadrant analysis of doctors working beyond rostered hours on a weekly basis and doctors feeling unable to cope on a weekly basis

How frequently, if at all, over the year have you experienced the following?  
Worked beyond rostered hours/felt unable to cope with workload



n = 3,876 (all doctors), the 2019 barometer survey QC1.

## Protective factors for doctors' wellbeing

While persistent pressures pose risks both to doctors' wellbeing and to patient care, there are important protective factors that can mitigate them. *Caring for doctors Caring for patients*<sup>5</sup> highlighted the importance of good workplace culture, shaped by compassionate leadership, for the wellbeing of doctors' and for patient safety.\* Good team working, effective communication, and an appropriate level of support are fundamental to creating these cultures, in which all healthcare staff are satisfied in their work and are productive.

### Workplace culture – team working

The *What it means to be a doctor*<sup>9</sup> research showed that doctors value spending time sharing skills and expertise with colleagues (figure 13). This develops personal and team skills, as well as creating an open sharing culture. Liking and respecting colleagues and team members is an important element of day-to-day satisfaction.<sup>9</sup> In response to the 2019 barometer survey, over two-thirds (70%) of doctors said they found it easy to share expertise and ideas with immediate colleagues.

Over half of doctors (58%) said it was easy to take part in practice or team meetings.

When looking at the professional activities that doctors felt they couldn't find the time to participate in, sharing ideas and expertise with immediate colleagues appeared to be less affected by wellbeing issues. Over half (54%) of doctors who felt unable to cope at least once a week still found it easy to share expertise and ideas with immediate colleagues.

Having support from colleagues is associated with a lower risk of burnout. Doctors who reported liking and respecting their colleagues as a reason for feeling satisfied were slightly less likely to indicate burnout. Almost a quarter (23%) of satisfied doctors with very low burnout risk said that liking and respecting their colleagues was a reason for job satisfaction, compared with a fifth (19%) of doctors overall.

A doctor's immediate colleagues have an influence on levels of burnout. And positive relationships can act as protection, for example by easing the pressure experienced by individuals and/or making them feel more able to cope with this pressure.

### Workplace culture – support systems

Findings from our national training surveys also suggest that, where working environments are supportive, doctors in training and trainers are most positive about their experiences. This is discussed in detail in chapter 3.

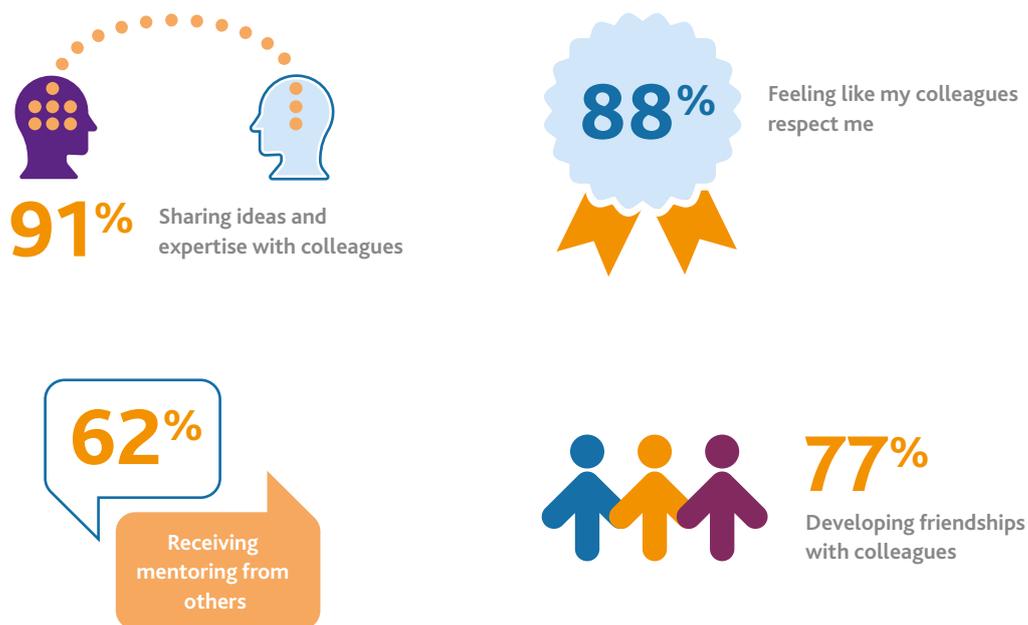
There are certain points in doctors' careers where they feel the least supported. Beginning a new rotation during training, starting a role in the NHS as a doctor trained outside of the UK, or moving to a consultant role for the first time are all transition points at which some doctors lack the necessary support. Making sure that quality induction is available to all doctors is a key priority for the health service.

We have recently published a guide for doctors returning to UK practice after time away as we know this is one of the stages of their career at

\* Professor Michael West and Dame Denise Coia co-chaired this review until May 2019, when Dame Denise Coia stepped down from her role prior to the production of the report because of health problems. Professor West led on the review until its conclusion, but Dame Denise Coia's views up to that point are fully represented in the report.

**Figure 13: Proportion of doctors who reported that elements of team working were related to their job satisfaction**

*How do each of the following activities relate to how much satisfaction you feel in your role when working with colleagues?*



*n = 2,249 (all practising doctors), what it means to be a doctor survey Q14, net values used, information on net values can be found in the data note on page 130.*

which some doctors feel they would benefit from additional support (chapter 7).

The *What it means to be a doctor*<sup>9</sup> research found that the most optimistic and satisfied doctors highly valued having access to additional support systems inside and outside work. Half of doctors overall (54%) reported that having additional support systems available through employers was important to them. And a large majority (90%) of doctors said that having good support outside of work was important to them.

It's important that workplaces foster a culture that allows doctors to maintain a good work-life balance. For nearly nine out of 10 (87%) doctors maintaining a clear boundary between home and work life was important to their satisfaction.

Maximising flexibility in training programmes and practice arrangements could help to manage the workloads of doctors at all stages of their careers, help create the necessary capacity for doctors to engage with important professional activities, and support work-life balance (chapter 7).

**Figure 14: Proportion of doctors who reported that elements of leadership were related to their job satisfaction**

*How do each of the following activities relate to how much satisfaction you feel in your role when working with colleagues?*



*n = 2,249 (all practising doctors) what it means to be a doctor survey Q14, net values used, information on net values can be found in the data note on page 130.*

## Leadership – supportive management and shaping positive cultures through effective leadership

Leadership shapes culture at every level of healthcare and it's important that all doctors feel enabled to be both effective leaders and empowered followers.

The *What it means to be a doctor*<sup>9</sup> research found that elements of both informal and formal leadership are important to doctors' satisfaction in their roles (figure 14).

Doctors value both taking on leadership responsibilities (providing training) and being recipients of effective leadership (receiving support and guidance).

The barometer survey found that doctors who have a lower risk of burnout were more likely to say they've never felt unsupported by senior medical staff (49%) than their colleagues with a high risk of burnout (25%).

Doctors with a high risk of burnout were much more likely to say that they felt unsupported by senior medical staff every day (13%) than their colleagues with a very low risk of burnout (1%). This shows the disabling impact unresponsive leadership can have, and the potential enabling impact of more supportive leadership.

Effective leadership is especially important in a profession like medicine, where doctors regularly face difficult situations. Leaders must create open and inclusive workplace cultures, where all doctors feel confident to ask for guidance and learn from their mistakes. The importance of such cultures and the role that leaders can play in shaping them are explored further in chapter 6.

In 2020, we are committed to working with partners in the UK health systems to promote and enhance compassionate and inclusive clinical leadership (chapter 7).



# The state of medical education



Challenges around workload and rota design leave over a fifth of trainers and trainees short of sleep at work at least weekly

Where staff treat each other with respect, and focus on teamwork and building confidence, trainers and trainees are more positive and feel their concerns will be addressed

Since 2016 the proportion of trainees who report working beyond their rostered hours every day has halved from 18% to 9%

82%

of trainees rate the quality of their training experience as good or excellent;

92%

of trainers enjoy their role as a trainer



Doctors who pause their training after foundation year 2 reported a lower risk of burnout compared to those who did not

A greater proportion of doctors who felt unprepared for their first foundation post reported higher risk of burnout

## Introduction

In this chapter we look at current trends in the UK medical training pathway (figure 15) and in doctors' perceptions of training environments. While we focus on postgraduate experiences, drawing on our national training surveys and wider education data, we also highlight the significance of the step-up from medical school to work-based learning.

The overall standard of postgraduate education and training across the UK has remained at a consistent level for several years.<sup>12</sup> Most trainers enjoy their role. And most doctors in training recognise and appreciate the high quality of teaching, clinical supervision and experience they receive.

However, the environments in which training takes place can be challenging. Working and learning every day in these pressurised settings can have a short- and long-term impact on doctors' health and wellbeing, as well as on the quality of patient care.

Heavy workloads and poor rota design are showing some welcome signs of improvement; however we have a long way to go to fully tackle the causes and effects of these issues.

### **In this challenging climate, what choices are trainees making?**

More trainees than ever before are choosing to pause their training after foundation year two (F2) – especially those who plan to go on to join programmes in the most pressurised specialties. Since 2016, over half of all F2 trainees have made this decision. It's important to note that most doctors continue to work in the NHS during this

pause, and the majority (around 85%) return to training within three years.

Proportionally, foundation trainees report higher risk levels of burnout, compared with trainees in core or specialty programmes. And our analysis shows that doctors in their first year of core or specialty training who took a pause were, on average, less burnt out than those coming directly from F2.

We're working with medical schools, training providers and employers to better understand and improve foundation trainees' experiences. A good start is key.

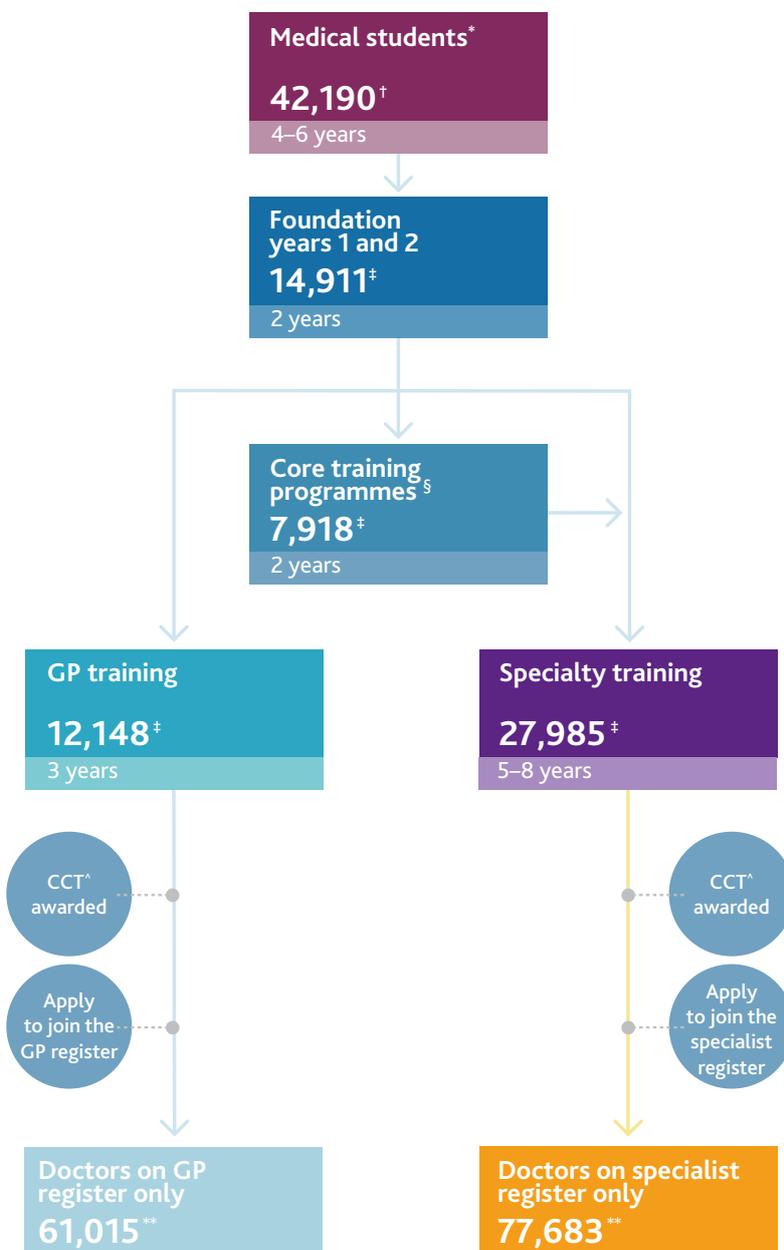
As the analysis in this chapter shows, preparedness at foundation level is associated with positive measures of health and wellbeing throughout postgraduate training. Medical schools need to better prepare undergraduates for work in the NHS. And employers need to provide good inductions and supportive environments for all trainees. We'll continue to share best practice to help achieve this and, where necessary, we'll step in where our standards are not being met.

This chapter first discusses what we know about training environments, and the trend over time in the reported quality of training and experiences

of doctors in training posts. After this, we look at: how the environment around the doctor affects their training; how doctors are changing

their patterns of training; and how a feeling of unpreparedness can affect a trainee.

Figure 15: The training pathway and current population



\* Not all medical students and doctors in training will continue to the next stage – they may pause their training, leave the profession or change their training programme. Doctors who are on both the GP and the Specialist registers are not counted in this figure.

† The chart includes information derived from that collected by the Higher Education Statistics Agency Limited ('HESA') and provided to the GMC ('HESA Data'). Source: HESA Student Record 2018/2019. Copyright Higher Education Statistics Agency Limited. HESA makes no warranty as to the accuracy of the HESA Data and cannot accept responsibility for any inferences or conclusions derived by third parties from data or other information supplied by it.

‡ Census data, 2019 national training survey.

§ Core training programmes include acute care common stem, broad based training, and other core training programmes.

^ Certificate of completion of training (CCT).

\*\* GMC, *The state of medical education and practice in the UK: the workforce report*, 2019.

## The UK medical training pathway

Students in the UK spend between four and six years of undergraduate study at medical school, before applying to enter postgraduate training. This training begins with a two-year foundation programme, often known as F1 and F2.

On completion of foundation training, doctors can apply to enter a specialty or GP training programme (ST1–7). Some specialty training programmes are separated into two stages: core training (CT1, 2 and sometimes 3) and higher specialty training (ST3–7).

### National training survey key findings

- Satisfaction with teaching and supervision remains high, but trainees and trainers experience longstanding challenges around workload and rota design.
- In fully supportive work environments, trainers and trainees are more positive about their experiences and more confident that their concerns will be addressed. A lack of a supportive environment is linked to frustration and higher risk of burnout.
- Compared with trainees in core or specialty programmes, a higher proportion of foundation trainees report feeling burnt out, short of sleep at work, and forced to cope with work beyond their clinical competence.
- Pausing training after the foundation years is now the norm. But most doctors who pause their training continue to work in healthcare in some capacity, and around 85% return to training within three years.
- It's rare for doctors to return to training after a pause of longer than three years. Based on F2s in 2012–2014, only around 5% who paused went on to leave the register or work abroad.
- A pause in training after F2 is associated with a lower risk of burnout on returning to core or specialist training.
- Most doctors feel prepared for their first postgraduate training post, but each year this is declining gradually.
- Preparedness at F1 may signal long-term trends in doctors' perception of training. A greater proportion of doctors who felt unprepared for their first foundation post held long-term negative views of their training environment and reported higher risk of burnout.

## Training environments and experiences

Figure 16: Issues affecting trainees and trainers: headline findings, national training surveys 2019

	Trainee	Trainer
 <b>Workload</b>	<b>45%</b> work beyond their rostered/contracted hours on at least a weekly basis 59% and 58% in surgery and medicine posts said this	<b>72%</b> work beyond their rostered/contracted hours on at least a weekly basis 88% of GP trainers said this
	<b>39%</b> rated the intensity of their work, by day, as heavy or very heavy	<b>68%</b> rated the intensity of their work, by day, as heavy or very heavy 81% of GP trainers said this
	<b>21%</b> felt short of sleep at work on at least a weekly basis	<b>23%</b> felt short of sleep at work on at least a weekly basis 39% of emergency medicine trainers said this
 <b>Workload</b> (out of hours)	<b>45%</b> described the intensity of their work by night as heavy 83% in emergency medicine posts said this	<b>27%</b> described the intensity of their work by night as heavy
 <b>Rota design</b>	<b>29%</b> said it wasn't rare to lose training opportunities due to rota gaps	<b>27%</b> said it wasn't rare for their trainees to lose training opportunities due to rota gaps
	<b>17%</b> said there weren't always enough staff to make sure all patients were treated by someone with the appropriate clinical experience	<b>18%</b> said there weren't always enough staff to make sure all patients were treated by someone with the appropriate clinical experience
 <b>Reporting concerns</b>	<b>80%</b> said, in their post, there was a culture of positively reporting patient safety concerns and of lessons being learned	
	<b>10%</b> weren't confident a concern about education and training would be addressed	<b>12%</b> of those working in primary care weren't confident their trust/board would act effectively in response to education concerns

	Trainee	Trainer
 <b>Handover</b>	<p><b>84%</b> said handover arrangements always guaranteed continuity of care for patients between shifts</p>	<p><b>82%</b> said handover arrangements always guaranteed continuity of care for patients between shifts</p> <p>15% said that handover arrangements between departments did not always ensure continuity of care for patients</p>
	<p><b>33%</b> said handovers weren't always used as a learning opportunity</p> <p>A greater proportion of those in medicine, psychiatry and surgery posts felt this way</p>	<p><b>15%</b> said handovers weren't always used as a learning opportunity for trainees</p>
 <b>Supportive environment</b>	<p><b>82%</b> said their working environment was fully supportive</p>	<p><b>75%</b> of trainers in secondary care specialties said their working environment in their trust/board was fully supportive</p> <p>97% of GP trainers said the working environment in their practice was fully supportive</p>
	<p><b>73%</b> said their working environment fully supported doctors' confidence building</p>	<p><b>69%</b> said their working environment fully supported doctors' confidence building</p>
 <b>Overall satisfaction</b>	<p><b>82%</b> rated the quality of their experience as good or excellent</p>	<p><b>92%</b> said they enjoyed their role as a trainer</p>
	<p><b>89%</b> believed their post would be useful for their future career</p>	<p><b>74%</b> in secondary care specialties were satisfied with the training opportunities offered to them as a trainer</p> <p>87% of GP trainers can access learning and development opportunities when they need to</p>
 <b>Supervision</b>	<p><b>88%</b> rated the quality of their clinical supervision as good or very good</p>	
	<p><b>16%</b> said they felt forced to cope with clinical problems beyond their competence or experience on at least a monthly basis</p> <p>40% of trainees in their first year of foundation training posts said this</p>	

*n* = 53,477 (trainees); 21,812 (trainers, of which 3,074 are primary care/GP trainers). N/A responses excluded for 'Workload (out of hours)' questions. Trainees in non-secondary care specialty posts (*n* = 5,957), GP trainers (*n* = 3,074) and N/A responses excluded from handover and rota design questions.

## Satisfaction with teaching and supervision remains high, but doctors in training and trainers experience challenges around workload and rota design

As figure 16 shows, in 2019, trainees and trainers were positive about many aspects of their experiences. As we've found in previous national training surveys, most doctors in training are especially satisfied with the quality of teaching and supervision they receive. And they're confident that they are developing the skills and competences they need for their future careers.

However, trainees and trainers face longstanding challenges around workload and rota design. Both groups experience intense workloads and regularly work beyond their rostered, contracted or agreed hours. These working patterns leave over a fifth of trainees and trainers feeling short of sleep while at work on at least a weekly basis.

Gaps in rotas disrupt training, and many doctors are concerned that hospitals and general surgeries may not have enough staff to make sure patients are always treated by someone with an appropriate level of clinical experience.

Poor rota design is often reported in training environments where doctors register low levels of health and wellbeing. Comparing trainees

who reported that rota design in their current post did not help optimise their education and development with those who felt it did, over twice as many (41% to 17%) said they felt burnt out because of their work.

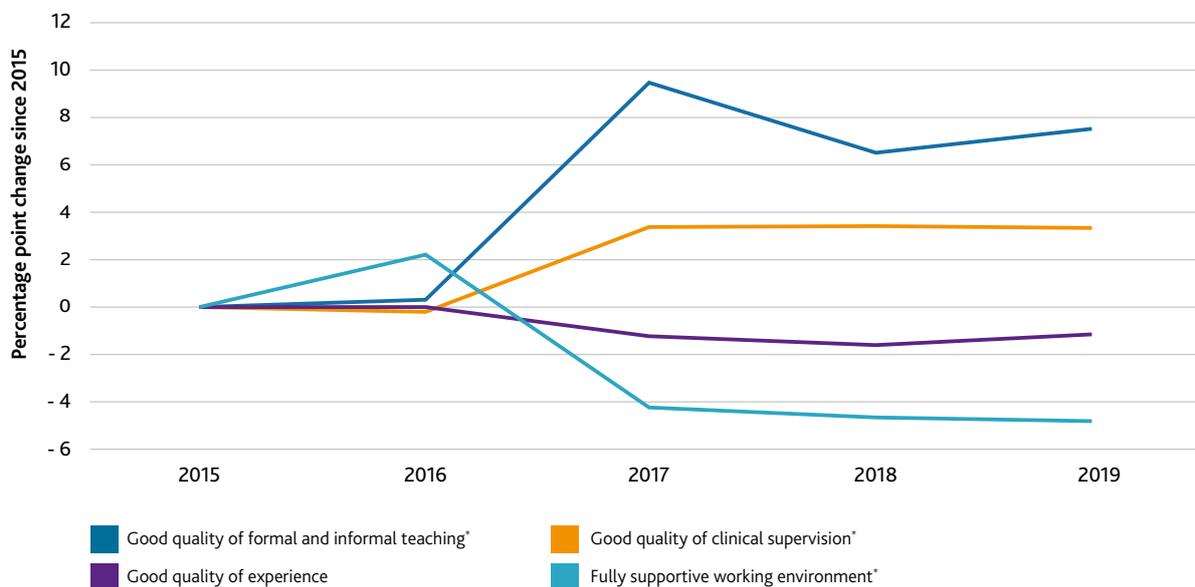
In short, the national training survey results showed that trainees in 2019 receive high-quality education and supervision from their trainers. However, pressures associated with training shape trainees' experiences, and, at worst, disrupt their training and compromise patient care.

## Heavy workloads and poor rota design in training environments are longstanding challenges, but there are some welcome signs of sustained improvement

Comparing national training survey results over time provides us with a high-level overview of how training experiences are changing for trainees and trainers in the UK.

Overall, most measures show little change over several years, as figure 17 shows. Doctors' perceptions of supportive environments, of clinical supervision and of their overall experience have remained stable since at least 2017.

**Figure 17: Percentage point change in trainees' responses for questions on teaching, supervision, experience and supportive environment, national training surveys from 2015 to 2019**



\*Question wording changed in 2017

n = 53,477 (2019); 51,870 (2018); 53,335 (2017); 53,835 (2016); 53,126 (2015).

But some measures are showing signs of improvement (figures 18 and 19).

Since 2016, the proportion of trainees who reported working beyond their rostered hours daily has halved (from 18% to 9%). And the proportion of both trainees and trainers who described the intensity of their work, by day, as heavy or very heavy has also been slowly falling, with a further drop of one to two percentage points since 2018.

Similarly, since we first asked doctors how common it was for educational and training opportunities to be lost due to rota gaps in 2017, trainers and trainees have reported year-on-year improvements of two to three percentage points.

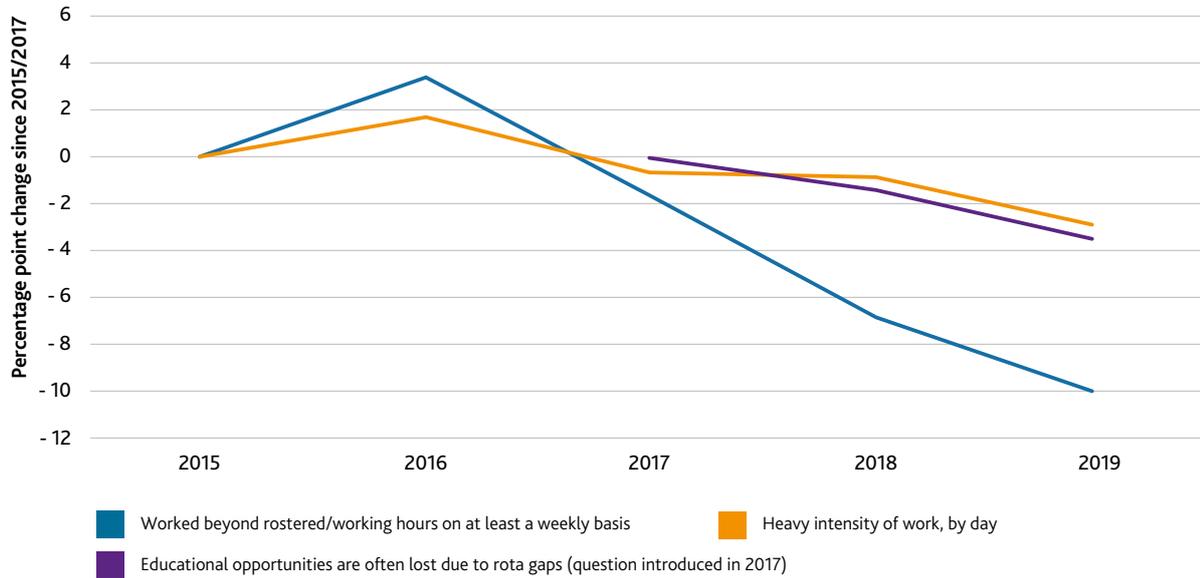
While we welcome the progress made in these areas, there's still some way to go to further reduce the pressures placed on doctors,

by addressing their heavy workloads and rota gaps.

45% of trainees and 72% of trainers said they were working beyond their rostered/contracted hours on at least a weekly basis. This is a general problem for doctors, with 90% of GPs and 75% of specialists working beyond rostered hours on at least a weekly basis (see chapter 2) – but the added cost for trainees is the loss of learning opportunities. Over a quarter of trainees and trainers said that it wasn't rare for training opportunities to be lost due to rota gaps.

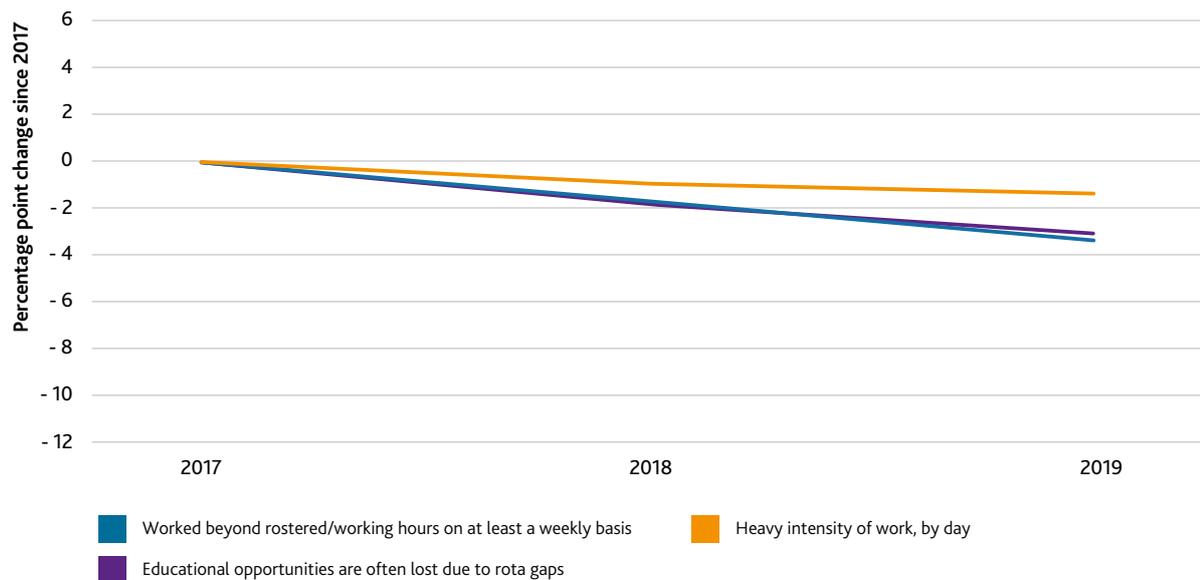
The impact on doctors' health and wellbeing – and potential consequences for patient safety – make it essential for those responsible for the workforce to take action. By this, we mean understanding, acknowledging, and striving to alleviate the longer-term effects of working under these conditions.

**Figure 18: Percentage point change in trainees' responses for questions on workload and rota design, national trainer surveys from 2017 to 2019**



*n* = 53,477 (2019); 51,870 (2018); 53,335 (2017); 53,835 (2016); 53,126 (2015). Trainees in non-secondary care specialty posts (2019 *n* = 5,957) excluded from rota design questions. N/A responses excluded.

**Figure 19: Percentage point change in trainers' responses for questions on workload and rota design, national training surveys from 2017 to 2019**



*n* = 21,812 (2019); 19,193 (2018); 24,577 (2017). Secondary care specialty trainers only (2019 *n* = 18,738) answered rota design questions. N/A responses excluded.

## Where working environments are fully supportive, trainees and trainers are more positive about their experiences, and more confident their concerns will be addressed

The presence or absence of a supportive working environment also has an impact on other aspects of the training experience.

- Trainees who felt their working environment was fully supportive were, on average, more satisfied with their training experience, clinical supervision and teaching (figure 20).\*
- In supportive working environments, doctors have more confidence in the cultures and systems for reporting and acting on educational concerns (figure 21).

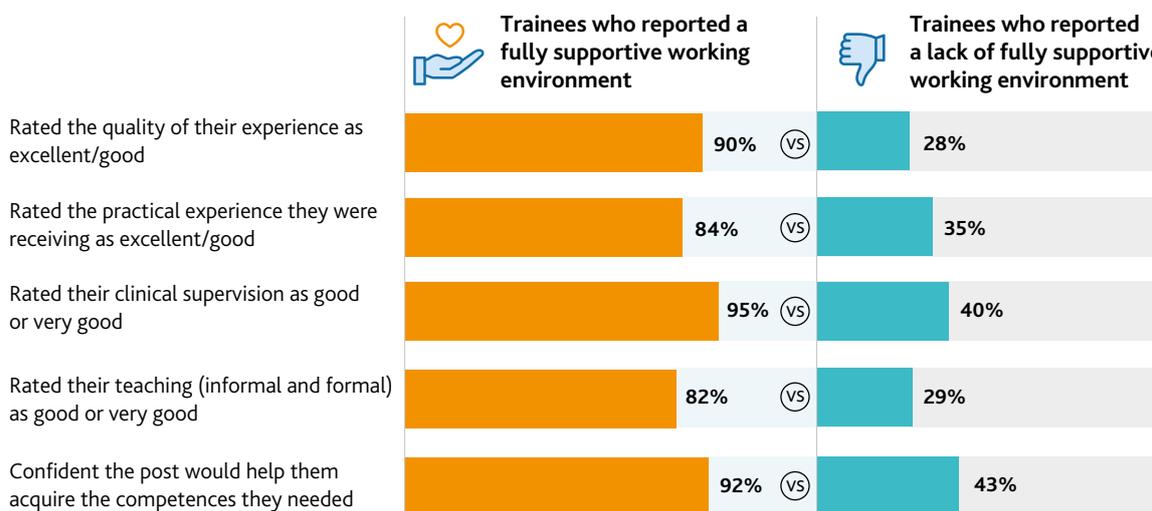
- Trainees often reported a lack of a supportive working environment alongside rota design issues (figure 22).

## Lack of a supportive environment is linked to frustration and higher risk of burnout

The national training survey results 2018 showed an association between risk of burnout and the level of support provided to doctors. This trend continues in the 2019 data.<sup>13</sup>

We compared doctors in training who said they felt burnt out to a high degree because of their work with those who felt burnt out to a low degree:†

**Figure 20: Relationship between supportive environment and satisfaction with practical experience, teaching and supervision, national training survey 2019**

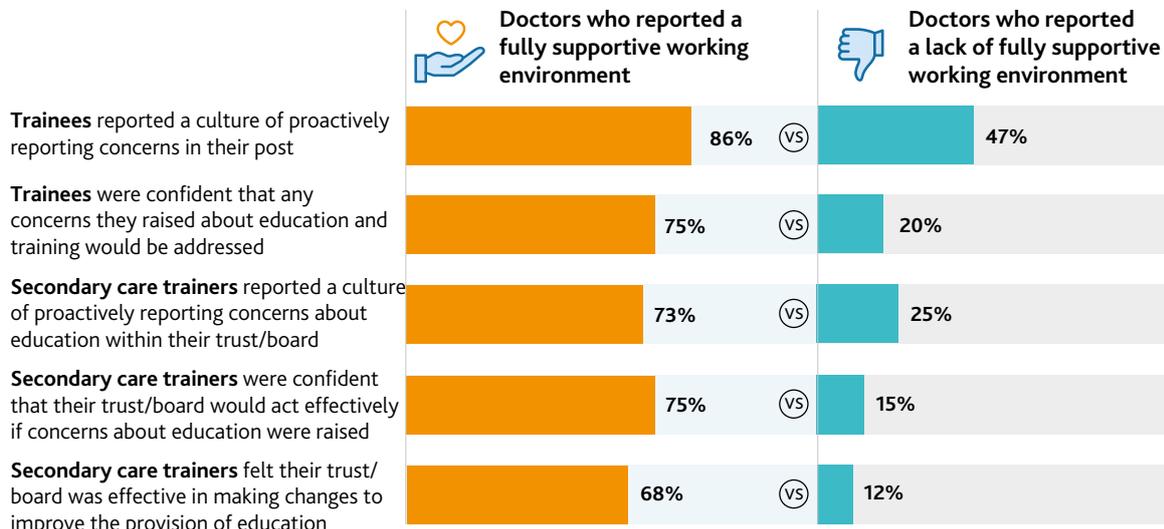


n = 53,477.

\* Doctors in training were asked to agree or disagree with the statement, 'The working environment (in my post) is a fully supportive one.' Trainers were asked the same question but relating to their trust/board, rather than their post.

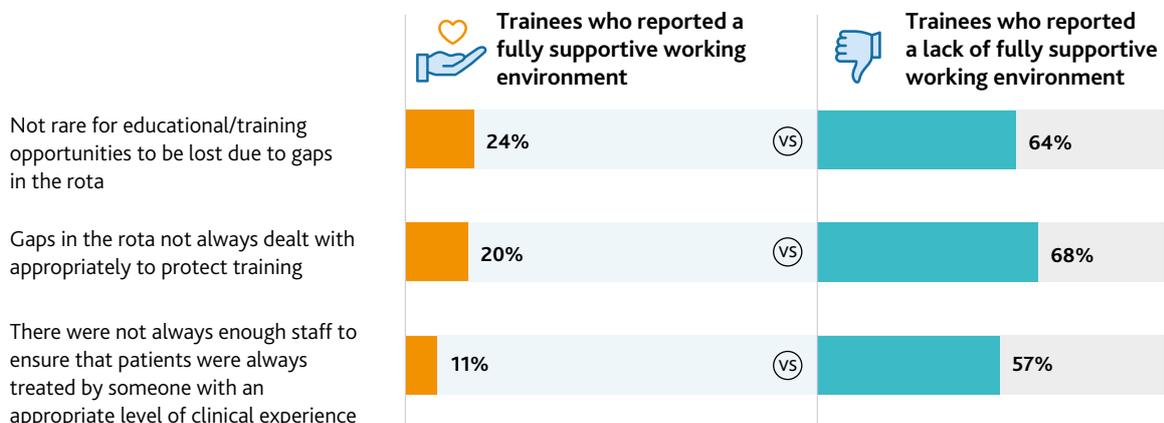
† Both trainers and trainees were asked if they felt burnt out because of their work to a high/very high degree, somewhat, or to a low/very low degree.

**Figure 21: Relationship between supportive environments and satisfaction with cultures and systems for reporting and acting on educational concerns, national training survey 2019**



*n = 53,477 (trainees); 18,738 (secondary care specialty trainers).*

**Figure 22: Relationship between supportive environment and rota design, national training survey 2019**



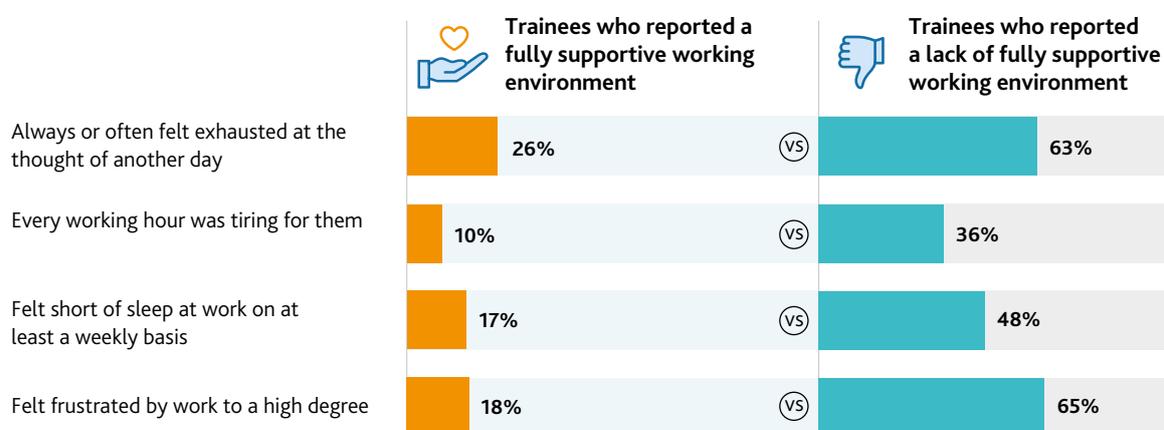
*n = 47,520. Trainees in primary care specialty posts and N/A responses excluded.*

- Four times as many trainees who felt burnt out to a high degree felt their working environment didn't fully support the confidence building of doctors (23% to 5%).
- Four times as many trainees who felt burnt out to a high degree felt that staff were not always treated fairly (24% to 6%).

- Almost three times as many trainees who felt burnt out to a high degree felt their working environment was not fully supportive (55% to 20%).

A greater proportion of trainees who didn't experience a supportive environment also reported characteristics of burnout, such as frequent tiredness and frustration at work, compared with those who experienced a supportive environment (figure 23).

**Figure 23: Relationship between supportive environment and selected burnout questions, national training survey 2019**



*n = 35,739. National training survey burnout questions were voluntary.*

Professional behaviour and working relationships between colleagues are also important factors. Almost three times as many trainees who felt staff didn't always treat each other with respect felt frustrated with their work (54%), compared with those who felt staff treated each other with respect (18%).

## Summary

Postgraduate education and training bodies continue to provide a high standard of teaching and training, and trainers are highly regarded by their trainees. These findings are testament to the ability, hard work and dedication of doctors working in training environments.

However, crucially, the day-to-day experiences of trainees and those who train them are marked by working pressures and demands. The healthcare system needs to think about the impact this has on doctors while still in training, and its potential legacy and resonance throughout their working lives. This is something we have covered in depth in our recent independent health and wellbeing review, led by Professor Michael West, as discussed in chapter 2.

A supportive working environment – one in which staff are treated and treat one another with respect, and where the focus is on teamwork and building the confidence of trainees – is key to alleviating the effects of system pressures and improving doctors' health and wellbeing.

## Making sure training is safe and effective

We're responsible for assuring the quality of education and training and identifying where our standards are not being met.

To do this, our primary evidence-gathering tool is the national training surveys – annual surveys for all trainees and trainers in the UK. Their views on training environments and experiences help us check that all doctors have access to high-quality training in a safe and effective clinical environment, and that trainers are well supported in their roles.

Each year, we share the survey results with those responsible for training environments – including postgraduate deans, royal colleges and faculties, and employers – so improvements can be made where local concerns have been raised. It's also an opportunity to explore and learn from examples of good practice.

### Enhanced monitoring

When deaneries and local offices are concerned about training, they work with trusts and health boards to make improvements. If the situation doesn't improve, they tell us. We then work with all the organisations involved to improve the quality of training through enhanced monitoring.

Through enhanced monitoring we closely monitor and support medical training organisations with concerns about the quality and safety of training. Issues that require enhanced monitoring are those that could

affect patient safety, or training progression or quality.

We require more frequent progress updates from those responsible for managing these concerns. We take part in locally led visits to investigate a concern or check on progress, and we share this information with other healthcare regulators where appropriate. We publish information on enhanced monitoring cases on our website.<sup>14</sup>

From 1 December 2018 to 14 October 2019, there were between 40 and 44 enhanced monitoring cases open at any one time. In this period, two cases were closed, and eight cases were resolved. We continue to monitor the 43 cases that are currently still open – a higher proportion of which relate to obstetrics and gynaecology (14%) and general internal medicine (12%) departments.

### Case study: How do we use data from national training surveys to quality assure training?

Foundation trainees in trauma and orthopaedic surgery and general surgery posts at Leeds General Infirmary and in general surgery at St James's University Hospital faced many challenges around clinical supervision and poor access to education. We intervened with enhanced monitoring to help Health Education Yorkshire and Humber work with the hospitals to make improvements. In 2019, national

training survey results supported the positive findings on visits, and we were able to bring enhanced monitoring to a close.

In December 2012, Health Education Yorkshire and Humber found that foundation trainees in general surgery posts and trauma and orthopaedic surgery posts at Leeds General Infirmary (LGI), and doctors in foundation training in general surgery posts at St James's University Hospital (SJUH), faced several challenges around clinical supervision and poor access to education.

Visits to the trust in 2014 showed they had made significant progress in addressing the issues. However, visits in 2015 and 2016 found that there remained ongoing concerns around support for foundation year one trainees.

In the 2018 national training surveys results, there was good feedback from foundation trainees in general surgery at SJUH. But some concerns remained based on the feedback from foundation trainees in trauma and orthopaedic surgery at LGI. Again, lack of support and supervision alongside isolation were recurring themes.

A Monitoring Learning Environment (MLE) meeting was held in January 2019. This meeting highlighted significant progress – rotas had been revised, four locums had been appointed to fill rota gaps, and handover was now registrar led.

At an MLE visit in July, we met with the senior management team as well as with trainees. They told us about a series of changes, which

had been put in place to address the concerns. These included initiatives like 'registrar of the week', the appointment of intermediate grade doctors to enable trainees to attend teaching, and the recruitment of physician associates to share the workload. We also learnt about the support orthogeriatricians gave to trainees, an initiative that was highly praised by all. The department had made successful progress and all trainees reported an improved experience.

Our 2019 national training surveys results showed considerable improvement for the trauma and orthopaedic department. This included significant improvements in workload, rota design and study leave. We closed the enhanced monitoring case in July and will continue to follow this case routinely.

### Case study: How do other organisations use our data to improve training?

From 2014 to 2017, higher anaesthetic trainees in Kent, Surrey and Sussex (KSS) rated regional teaching as significantly lower than the average in the national training survey. In response, the deanery surveyed their trainees and designed a new regional teaching programme, which has been running for the past 20 months. The new programme has received significantly improved feedback in the latest national training survey.

To understand why regional teaching in KSS was rated lower than average, and to get suggestions for what an improved programme could offer, the deanery surveyed higher

anaesthetic trainees (ST4–7) and their college tutors. They also reviewed methods used in other successful deaneries, including North West and Oxford, to see what transferable good practice there might be.

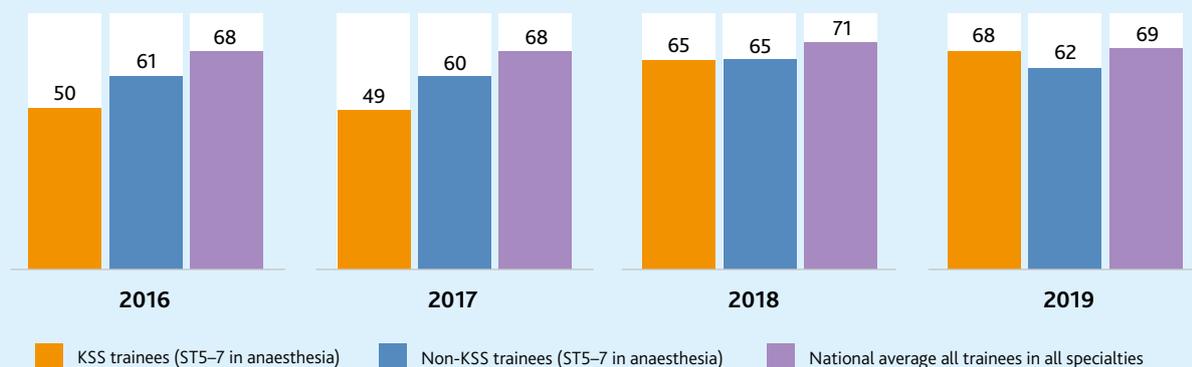
KSS covers a large geographical area, so training days were perceived as difficult to coordinate, advertise and attend. Furthermore, anaesthesia final exams are taken in ST4, so alternative topics were required for subsequent training, to maintain trainee interest and avoid repetition. Using this feedback, a Higher Training Day (HTD) programme was designed and established, offering a varied and comprehensively relevant schedule covering all higher domains of the curriculum while preparing trainees for CCT and beyond.

All trusts in the deanery were invited to participate and lead a day according to a flexible timetable, coordinated by a central trainee committee. Alternating locations

monthly between Kent, Surrey and Sussex increased attendance, as did incorporating travel time into the study day. Alternate days of the week were used to increase attendance from trainees working less than full-time. The aim was also to think beyond traditional lectures and promote alternative styles to information sharing (for example, a Skype Q&A with American professors, a debate, a trip to an air ambulance base, external mediation training). This HTD project aims to provide a biennial rolling programme with topics that are current and relevant to all higher trainees, regardless of sub-specialty.

The national training survey results for 2018 and 2019 (figure 24) showed a significant improvement in how KSS higher anaesthesia trainees rated regional teaching – which was mirrored in evaluation feedback the deanery received on the new programme, which attracts over 90% satisfaction rates.

Figure 24: Mean scores for 'regional teaching' indicator, national training surveys from 2016 to 2019



## More doctors are pausing their training as they progress through a system under pressure

The 2019 national training surveys showed the continuing trend of more doctors pausing their training after the foundation year two (F2). While this will be driven by a variety of factors, there's some evidence to suggest that doctors may be responding to system pressures and pursuing a better work-life balance.

Over the last decade, more doctors have chosen to take pauses in their training, typically after the completion of F2.\* We know that, typically, around 85% of doctors who pause after F2 return to training within three years. Most doctors use this time away from training to gain additional experience working in different roles within the NHS.

The increase in the proportion taking a pause in training may be a response to the pressure of working in difficult conditions. National training survey data showed foundation years doctors reported higher levels of burnout compared with those in core and specialty training. And the decision to pause training after F2 is more commonly taken by doctors planning to go into specialty areas associated with higher risk of burnout, such as emergency medicine and surgery.

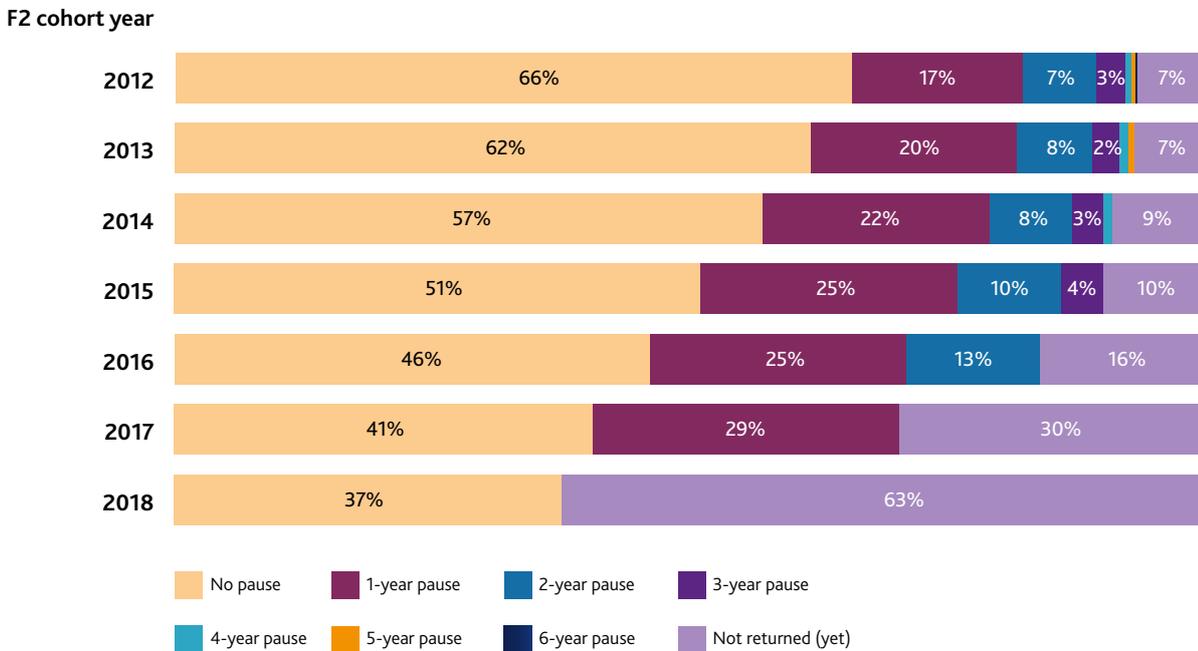
As they progress through postgraduate training in a health service that is modernising and operating under pressure, many doctors are looking for greater flexibility in their training – as well as opportunities for personal and professional development beyond established training and career pathways. The decision to pause may also be driven by opportunities to develop skills and knowledge outside a training setting, or so a doctor can prioritise staying in or moving to a preferred location.

### Doctors pausing their training after their F2 year is now the norm

An increasing proportion of trainees are choosing to pause their training after F2 (figure 25). This trend has been emerging since at least 2012, but 2016 marked the first year where over half of all F2 trainees did not progress straight to core or specialty training the following year. Of the 2018 cohort, three out of five (63%) F2 doctors had paused their training in 2019.

\* National training survey census data 2018–19 showed 63% of 2018's F2 doctors paused their training in 2019. Around 40% of doctors paused their training after their final year of core training (CT2 or CT3) – but this group represents a smaller number of doctors than those in their foundation years. For all other postgraduate training levels, less than 3% of doctors paused their training.

**Figure 25: Trainees pausing or progressing directly on the training pathway after F2, national training surveys from 2012 to 2019**



There's some evidence to suggest the rate of increase of this trend may be slowing. Previous years have seen a relatively stable increase of around 5% of F2 doctors pausing their training. Whereas in 2019, there was around a 3% increase. However, at this stage it would be premature to suggest the trend is approaching a plateau.

The prevalence of pauses at this point now represents an important and enduring change to the training pathway, with potential implications for workforce planning and doctors' wellbeing. It's crucial that employers and education providers recognise pauses as a typical or established step in most doctors' training experience.

We're aware that recent changes to the UK shortage occupation list might increase competition for posts typically held by specialty trainees.<sup>15</sup> And this might have an impact on

future F2 doctors' decision to pause their training. We'll continue to monitor our data on this closely with a view to understanding if and how this policy change affects doctors.

### Most doctors who take a pause after F2 return to training within three years

As figure 25 shows, from 2012–2015, around 90% of trainees who had paused their training had returned within three years. Only around 1% of each cohort paused their training for longer than three years before returning.

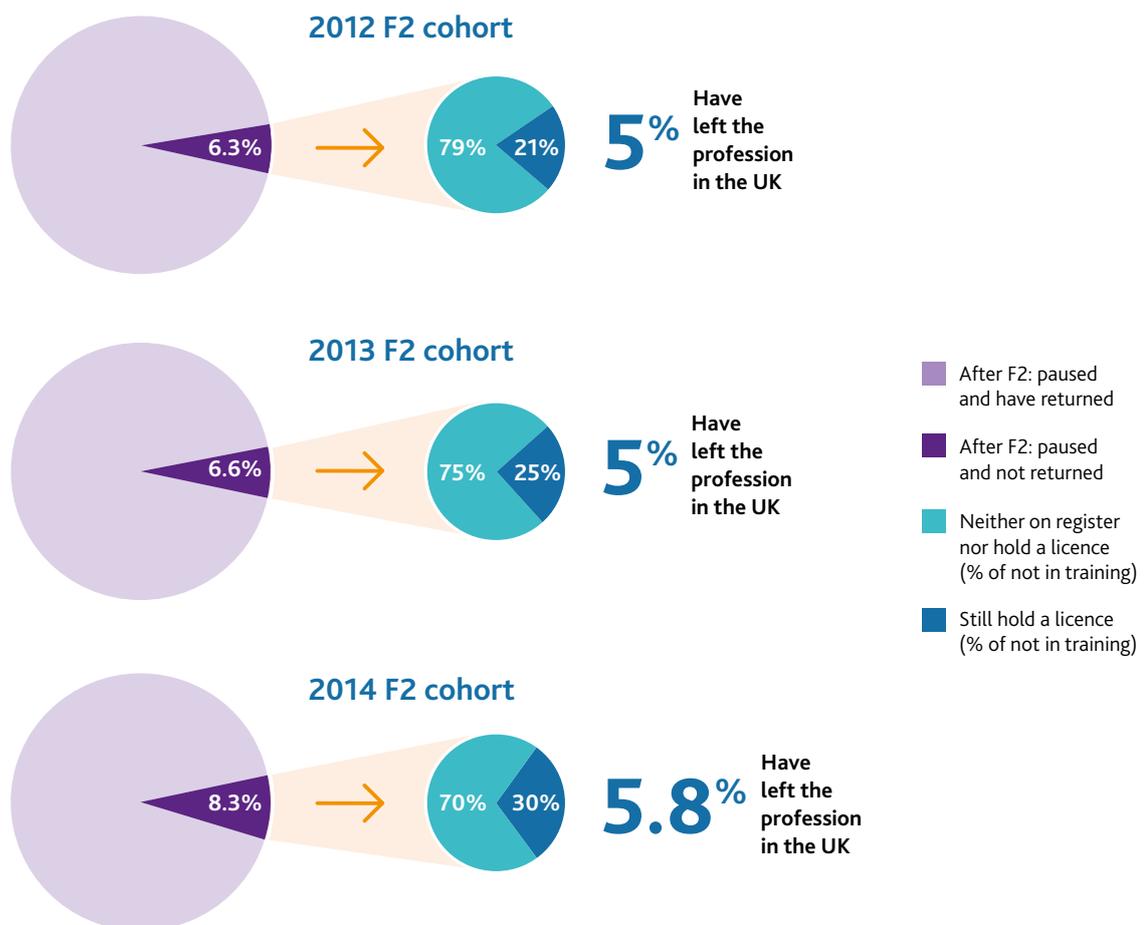
However, the 2019 data showed that just 84% of the 2016 cohort have since returned to training (within three years). This may be an indication that the pattern is changing, with more trainees either taking longer pauses or leaving the profession permanently.

## It's rare for doctors who paused after F2 to return to training after pauses of longer than three years

Focussing on doctors who decided to pause after F2 from 2012 to 2014, most of those who haven't returned to training no longer hold a licence or, as of August 2019, are not listed on the medical

register (figure 26). We know that it's rare for doctors who have given up their licence or left the register to return to practice or training. So it's fair to assume that the approximately 5% of doctors who paused training after F2 and have not, as of 2019, returned to training, have indeed left the profession or are working/training in another country.\*

Figure 26: Professional status of doctors who paused training at F2 and have not returned to training as of 2019, national training surveys from 2012 to 2014 and 2019



\* This ~5% predominantly consists of UK nationality doctors. 2012–2014 cohort: UK = 68% (n = 1,100); European = 12% (n = 200); International = 18% (n = 286); Unspecified = 1% (24).

## A pause in training after F2 does not necessarily – or usually – mean a break from working in medicine

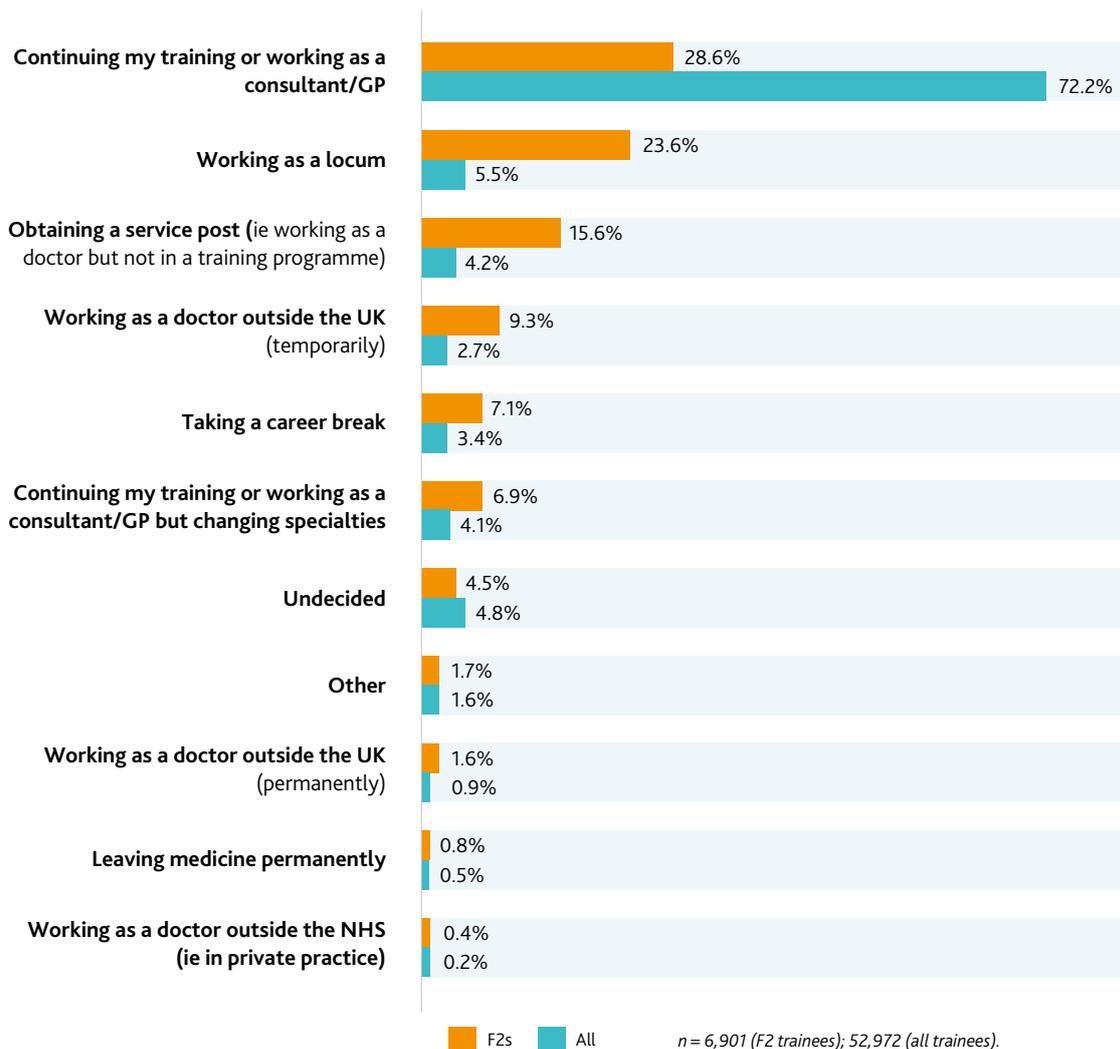
Most trainees continue to work in UK or overseas health services during their pause in training, often as locums or locally employed doctors. This can be an opportunity to gain valuable experience.

Over 1,000 doctors told us what they did during their pause in training in our 2018 research,

*Training pathways 2: why do doctors take breaks from their training?*<sup>16</sup> Of this group of doctors, many gave multiple answers, including:

- around three-fifths continued to work in the NHS
- a third worked or volunteered abroad
- a fifth had carried out further study or research.

**Figure 27: What 2019 F2 doctors see themselves doing in 2020, compared with the average for all doctors in training, national training survey 2019**

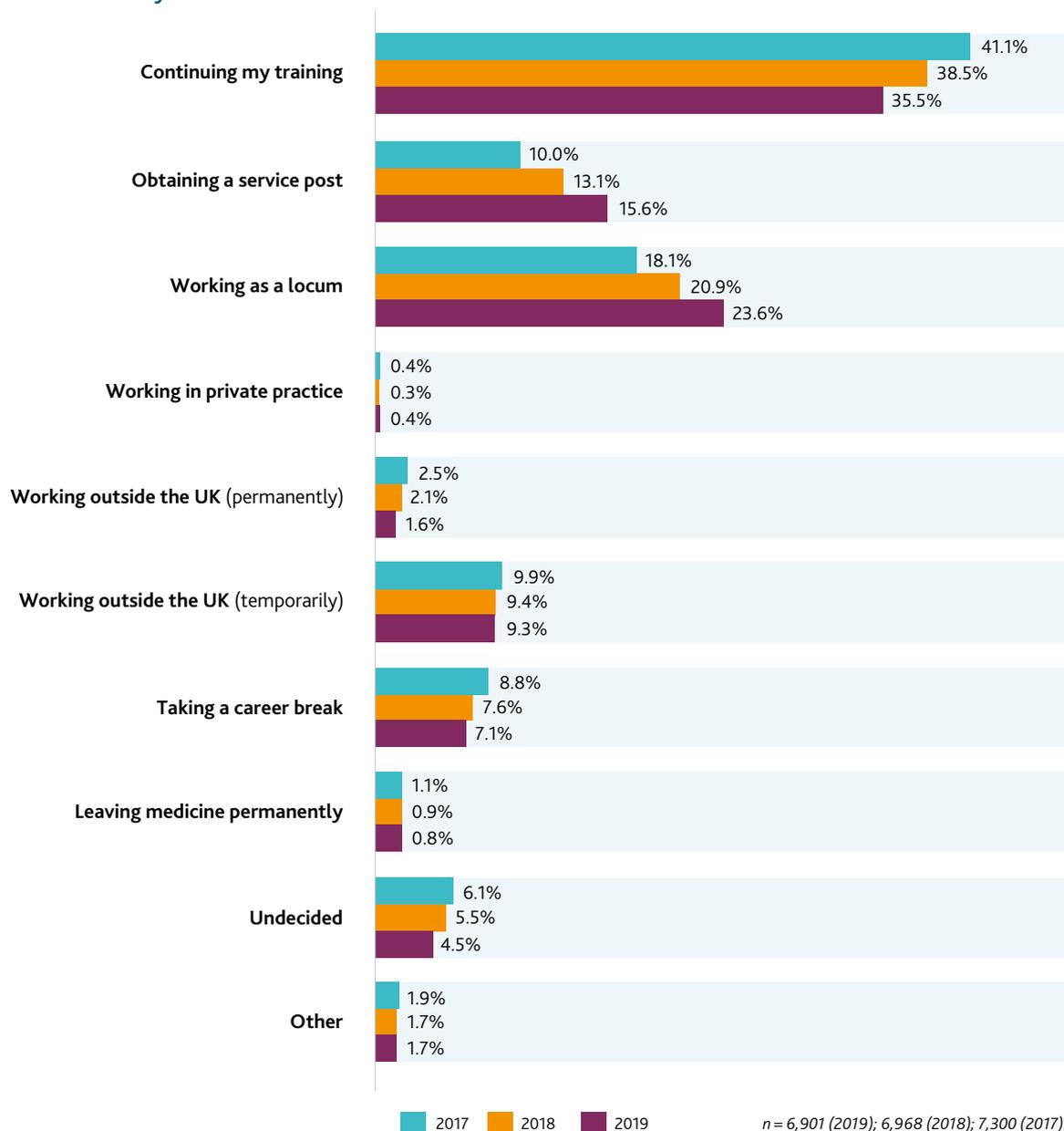


*n* = 6,901 (F2 trainees); 52,972 (all trainees).  
 Trainees in academic posts, pharmaceutical and public health training programmes were not asked this question.

In the 2019 national training surveys, when asked what they saw themselves doing one year from now (figure 27), around half of F2s thought they would be working as a locum, obtaining a service post, or working as a doctor temporarily outside

the UK. The intention or preference to work as a locum or obtain a service post has been steadily increasing among F2 doctors for the past three years (figure 28).

**Figure 28: What F2 doctors saw and see themselves doing the year after their F2 training, national training survey from 2017 to 2019**



## There are several factors influencing doctors' decisions to pause training

The most common reasons for pausing after the second foundation year can broadly be grouped as push and pull factors.<sup>16</sup>

Our research found there are a series of push factors relating to dissatisfaction with the training environment and uncertainty about specialty choice or career direction.

A pause after foundation training is the first, and perhaps only, opportunity for trainees to pause their training – this option is not always available at other points in the pathway.

Some doctors decide to pause because they haven't been accepted by their preferred specialty or location, and so they want to gain more experience before reapplying again in the following year(s).

But many trainees also feel that pressure to deliver the service has a negative impact on their training. The need to prevent or recover from burnout before progressing into specialty/ GP training was often given as a key driver for a pause. For these trainees, a pause has helped them create what they feel is a more effective learning environment than the one they have experienced within a UK training programme.

By pausing a formal training programme to work autonomously, trainees feel they have greater control and flexibility over their hours, can have a break from completing their training portfolio, and can develop stronger working relationships with senior colleagues.

Some doctors we spoke to also thought that the foundation programme didn't always provide

the space for trainees to fully explore different specialties. For many, the application timetable for specialty training comes too soon in their postgraduate career, and they feel under pressure to commit to a long training programme. So a pause from training – while continuing to work in a healthcare environment – can give them the space to think about their career and recharge, as well as giving them experiences of decision-making powers and autonomy for the first time in their career.

Our 2018 research also identified pull factors centred around the personal and professional opportunities that a pause in training can bring about.

Creating a different work-life balance via a pause in training also creates the opportunity for trainees to explore their potential specialty or future career outside the confines of a training programme. It's also being used by some to develop broader professional skills (not just clinical) that will support a long-term career in medicine.

Trainees report a range of positive personal and professional outcomes because of their pause in training, including improvements in:

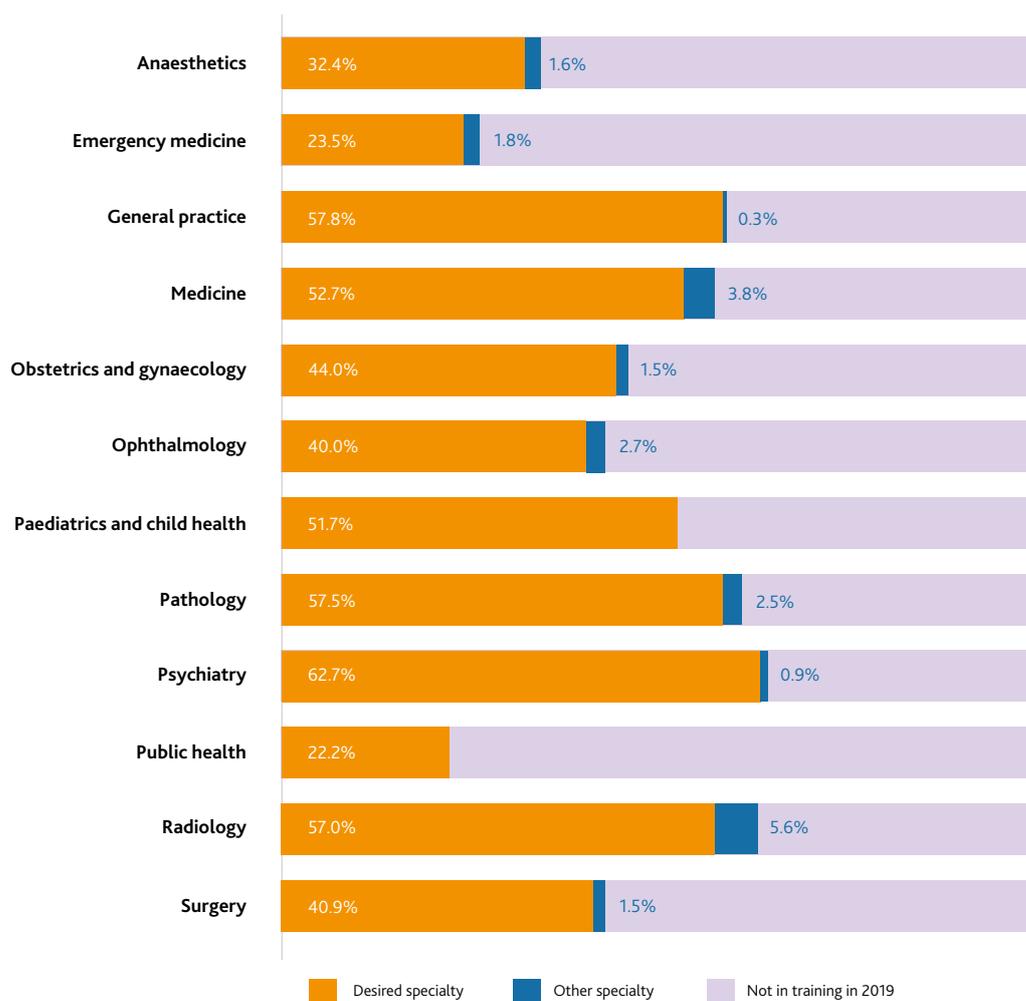
- specific clinical skills
- greater confidence in career choice
- wider professional skills, such as leadership or teaching
- soft skills, such as confidence and time management
- happiness and work-life balance.

## Doctors' preferred specialty can influence their decision to pause their training

In our 2018 national training surveys, we asked F2 doctors what they expected their future medical specialty would be. When we mapped their responses against 2019's data, which showed the specialty they've progressed to, we found most doctors ended up either pausing their training or beginning their chosen specialty (figure 29).

A higher proportion of F2 doctors planning to specialise in emergency medicine and anaesthetics paused their training, compared with doctors who planned to specialise in general practice or psychiatry. Three-quarters of 2018 F2 doctors who planned to pursue emergency medicine were recorded as 'not in training' in 2019 – having paused the training pathway. Whereas, just over a third of 2018 F2 doctors who planned to specialise in psychiatry and radiology were 'not in training' in 2019.

Figure 29: 2018 F2 cohort predicted specialties, mapped against 2019 actual specialties, national training surveys from 2018 to 2019



*n = 4,873 (all specialties). Respondents who indicated that they were undecided or that they intended to take a career break were excluded.*

## Doctors who paused training after F2 had a lower risk of burnout at core or specialist training, compared with those who didn't pause their training

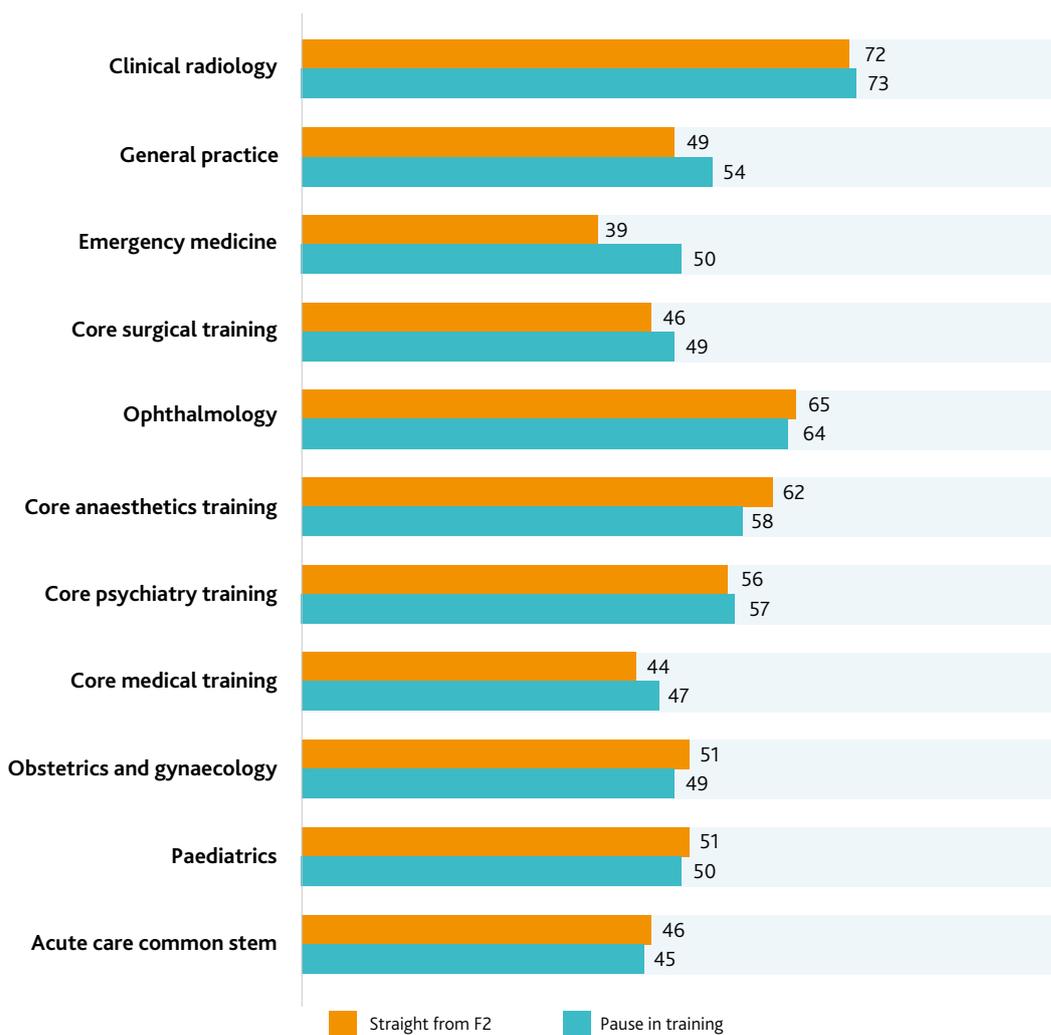
In the 2019 national training survey, the average burnout indicator score, where a higher score equates to lower risk of burnout, for first year trainees in core or specialist training who had progressed directly from F2 was 49. By contrast, the average score of those beginning core or

specialist training after a pause in training was 52 – a difference of 3%.

In other words, doctors who took a pause in training reported a lower risk of burnout than those starting core or specialist training directly from F2. This suggests that pausing the training pathway may help lower the risk of burnout.

It could also be that doctors less prone to burnout are more likely to pause their training.

**Figure 30: Burnout indicator scores (higher score is preferable) of 2019 core and specialist trainees who progressed straight from F2 in 2018, compared with those who paused their training in 2017 (or earlier), national training survey 2019**



*n = 5,028. National training survey burnout questions were voluntary.*

However, based on our current dataset, reporting feeling burnt out is not a statistically strong predictor that trainees will opt to pause their training after F2. There's only a minimal difference in the average burnout score for the 63% of 2018 trainees who paused in 2019 and the 37% who continued straight to specialty training.

As figure 30 shows, this pattern is true for the two most popular specialty training programmes – general practice and core medical training.\*

- Trainees who progressed directly – without a pause – from foundation training to a general practice specialty training programme scored, on average, 5% higher for risk of burnout than those who paused before beginning specialty or core training.
- Trainees who progressed directly – without a pause – from foundation training to a core medical specialty training programme scored, on average, 3% higher for risk of burnout than those who paused before beginning specialty or core training.

And the pattern is also strongest for the specialty programme associated with the highest risk of burnout – emergency medicine:

- Trainees who progressed directly – without a pause – from foundation training to a specialty training programme in emergency medicine scored, on average, 11% higher for risk of burnout than those who paused before beginning specialty or core training.

The burnout questions have only been part of our survey for two years. As such, we don't currently have enough data to track the progress of doctors who reported characteristics of burnout, paused the pathway, and then returned. This will begin to be possible from the 2020 survey. And, with each subsequent year's data, we'll have a greater understanding of how each year's group of doctors experience burnout as their training progresses.

### **Trainees' experiences vary throughout the pathway, but a higher proportion of foundation trainees report feeling burnt out, short of sleep at work, and forced to cope with work beyond their clinical competence**

The proportion of trainees reporting characteristics of burnout peaks in F2 training. As a broad rule, burnout then becomes gradually less prevalent throughout core and specialty training. Figure 31 shows this trend using just one of our burnout questions, but the pattern holds true for all seven measures.†

Doctors in training at the start of the training pathway also feel forced to cope on a more regular basis with clinical problems beyond their competence or experience (figure 32). 17% of trainees in F1 training experienced this on at least a weekly basis, compared with 11% of trainees in F2. In the mid-to-later years of core or specialty training, this figure drops to less than 5% of doctors.

\* It is important to note that figure 30 discusses specialty programmes. Doctors on generalist training programmes undertake a wide range of posts – and so not all trainees on a specific programme will have been in a post of that same specialty at the time of the survey. For instance, a trainee on a GP programme may have been rotated onto an emergency medicine post at the time of the survey – and their responses to the burnout questions may reflect that.

† These measures are based on seven questions taken from the Copenhagen Burnout Inventory, as discussed in chapter 2.

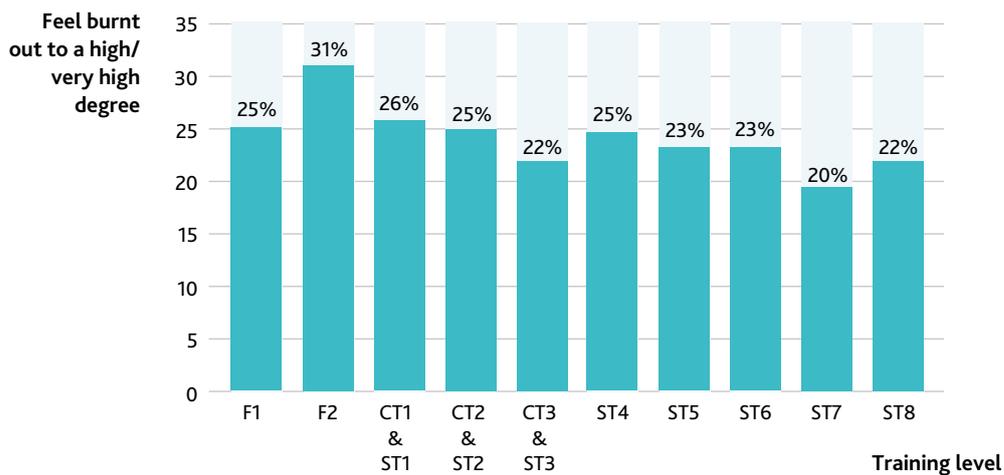
Similarly, a high proportion of trainees in their foundation years said that handovers weren't always used as a learning opportunity, compared with doctors further along the pathway.

A greater proportion of trainees at the beginning of the pathway – over a quarter of those in F1 and F2 posts – felt short of sleep at work due to their working patterns on at least a weekly basis. This proportion declines with each year of the training pathway until the fourth year of specialist

training, at which point it increases again to around 20% and remains relatively stable.

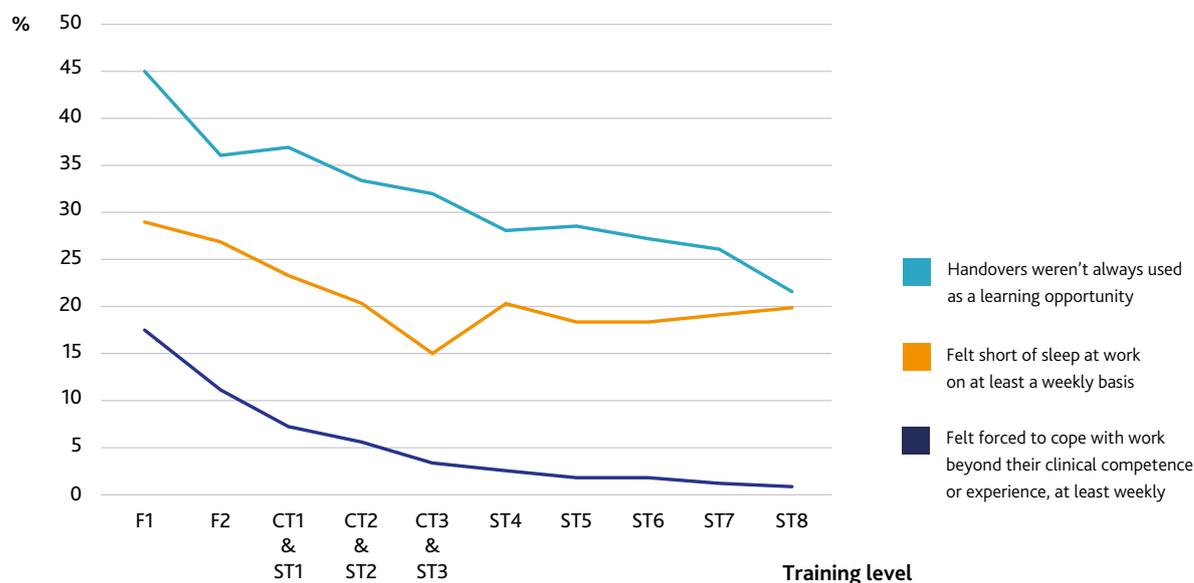
These trends have remained consistent for several years of national training survey results. This may, in part, simply reflect the challenges of starting out on any developmental training pathway. However, these findings present useful context and insight into the foundation trainees' experiences.

**Figure 31: Percentage of doctors who reported feeling burnt out at work to a high or very high degree, by training level, national training survey 2019**



*n = 35,739. National training survey burnout questions were voluntary.*

**Figure 32: Average responses to questions on handovers, workload and supervision, by training level, national training survey 2019**



*n = 53,477. Trainees in non-secondary care specialty posts (n = 5,957) excluded from handover question. N/A responses excluded.*

### More doctors are choosing to train on a less than full-time basis, with potential benefits for their wellbeing and work-life balance

In the 2019 national training surveys, over one in ten (12.6%) doctors in training reported working less than full-time (LTFT). Since we first asked trainees about this, the number of trainees working LTFT has increased steadily from 10.7% in 2017, to 11.5% in 2018, and to 12.6% in 2019. A further 2% had considered working LTFT but had not yet applied to. Together, these groups represent nearly 8,000 doctors.

Of those who are already working or who have considered working LTFT, three-quarters (74%) named childcare as their primary reason for

that decision. Other reasons included: external commitments (9%); other work commitments (9%); disability, illness or health-related reasons (17%); and the responsibility of caring for another adult (5%).

A greater proportion of doctors who work full-time felt burnt out to a high degree (26%), compared with those who work LTFT (17%). An even higher proportion (42%) of those doctors who have considered applying to work LTFT, but who have not yet done so felt burnt out – although the sample size for this group is considerably lower. And 64% of doctors who work on an LTFT basis described their workload by day as ‘about right’, compared with 56% of those who work full-time.

## Summary

Most trainees pause their training after their second foundation year. This has been the case since 2016, and this proportion has grown year-on-year since 2012. With 63% of the 2018 F2 cohort choosing to pause their training in 2019, we can confidently describe this pause as the norm.

A pause in training doesn't necessarily mean a break from working as a doctor. Quite the opposite. Most doctors continue to work in the NHS while pausing their training. Many others work or volunteer in healthcare systems overseas or carry out further study and research. In doing so, they can gain valuable experience and skills – as well as the space and time to consider the direction of their medical career.

The majority of F2 doctors who pause their training return within three years. However, approximately 5% of each F2 cohort who have paused training, and have not returned after

three years, are no longer on the medical register or hold a licence. It's important to understand why most doctors pause their training at this point, to see whether certain aspects of the training environment affect their decision, and ultimately, identify areas for improvement.

There's strong evidence to suggest that doctors who paused their training after F2 were less burnt out at CT1/ST1 than those who didn't. However, while pauses in training and more flexible working arrangements can bring advantages for many trainees, they can also present challenges, particularly for workforce planners.

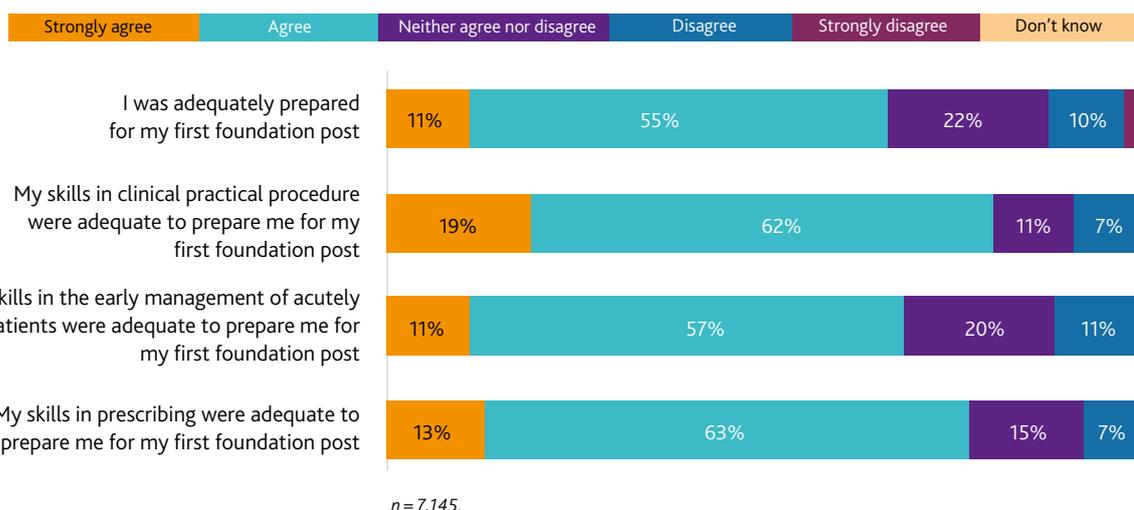
Understanding the wider impact of pauses on the training environment, particularly if certain specialties, countries and regions are affected, is important. We know that some may view training pauses as costly; the challenge is to find a balance between individual doctors' wellbeing and the need for doctors to progress efficiently through training.

## Preparing medical students for foundation training is a key aspect of undergraduate education

We've seen how trainees are increasingly taking pauses from training after their second foundation year, as part of a modern medical career in a system under pressure. And, notably, there's evidence to suggest that preparing trainees for postgraduate training and working is important for their future wellbeing.

In this section, we look at how the system is currently preparing doctors for their first postgraduate roles. And how, where done effectively, this can positively affect trainees' perceptions and experiences of their roles.

Figure 33: F1 preparedness for their first postgraduate training post, national training survey 2019



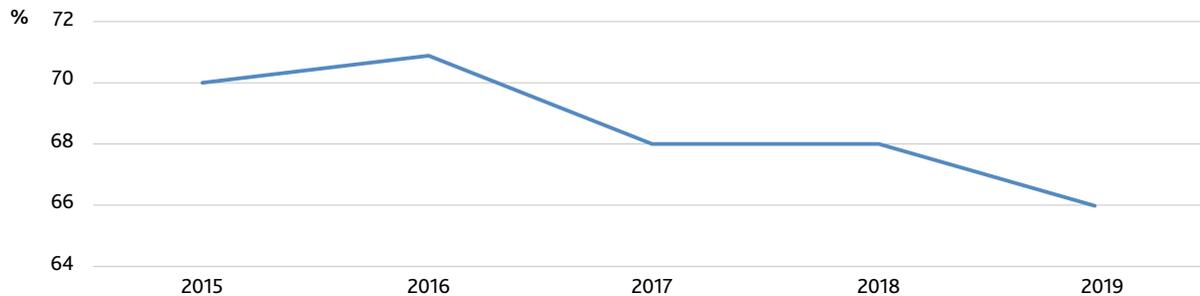
### Most new graduates feel prepared for their first postgraduate training role, but this is declining gradually

The transition from undergraduate to postgraduate medical training is a key point in a doctor's career, bringing increased autonomy, responsibility and specialisation. From this point on, almost all training will take place in a healthcare setting, alongside and throughout a doctor's professional practice. The extent to

which doctors feel prepared during this transition is an important measure of the success of their undergraduate medical education.

Each year, in the national training survey, we ask F1 doctors one general question and three specific questions about how well prepared they felt for their first postgraduate training role (figure 33). Over time, we see that F1 trainees' overall perception of their preparedness has decreased (figure 34).

**Figure 34: Proportion of F1 doctors who agreed they were adequately prepared, national training surveys from 2015 to 2019**



*n = 7,145 (2019); 7,055 (2018); 7,240 (2017); 7,495 (2016); 7,414 (2015).*

The majority of 2019 F1 doctors (66%) said they felt adequately prepared for their first foundation post. Although, one in ten did not. A greater proportion of F1 doctors reported being adequately prepared for clinical practice procedures (81%) and prescribing (76%).

However, since 2016, the proportion of F1 doctors who felt adequately prepared for postgraduate training has decreased by around five percentage points. And, in 2019, one out of eight (12%) trainees didn't feel adequately prepared for their first F1 post.

Our position on this is clear: medical schools must make sure that every student graduates with the knowledge and skills to prepare them for the next step of their career. We know that the step from undergraduate to postgraduate education brings challenges – a new learning and working environment, increased autonomy and responsibility – but trainees should not feel as if they are playing catch up from the outset.

In the 2019 national training surveys, a greater proportion (30%) of F1 trainees with a primary medical qualification from the European Economic Area, excluding the UK, didn't feel

adequately prepared for their first foundation post, compared with around 20% of international medical graduates and about 10% of UK graduates.

### **Student assistantships and shadowing periods help prepare trainees, but their perceived effectiveness is decreasing**

Student assistantships are a type of clinical placement carried out towards the end of a student's undergraduate course. Their aim is to increase the student's preparedness to start practice as an F1 doctor. Since 2015, the proportion of trainees who said this helped them feel prepared has steadily decreased, from 71% to 66%.

Shortly before beginning their first postgraduate post, it's recommended that medical graduates take part in a shadowing period, to familiarise themselves with the site where they'll be working in future. During this, the graduate works with a current foundation trainee at the site.

In 2019, 65% of F1 trainees said their shadowing period prepared them well for their first postgraduate post. However, one out of six (16%) didn't feel it prepared them well. Since 2017, the proportion of trainees who found the shadowing period helpful for their practice has decreased by around two percentage points.

When asked what could have improved in their shadowing period, three-fifths (63%) of trainees said better advice on out-of-hours shifts. Around a third of trainees wanted better knowledge of the site's equipment (40%) and physical environment (34%). A third (34%) also would have liked their shadowing activities to be better aligned with the activities they were due to cover in their first placement.

These data show that, while most trainees find these opportunities useful in preparation for practice at foundation level, year-on-year each successive training cohort is finding them less effective.

### **Preparedness at F1 may signal long-term trends in doctors' perceptions of training**

Analysis over time has shown that doctors who felt unprepared for their first foundation post were more likely to have long-term negative views of their training environment and experience issues with wellbeing and burnout.

We looked at the burnout scores for F1 doctors who said they felt adequately prepared for their first post and compared them with the scores of those who did not feel prepared. We continued this analysis for each subsequent year of their postgraduate training to date.

Doctors who felt unprepared in their F1 year continued to rate all aspects of their training significantly lower in each subsequent year of their postgraduate career. This was consistent across all indicators except workload, and across all cohorts since 2012.

There are several factors and variables that could impact the feeling of preparedness. More detailed research is required to fully explore and understand these findings.

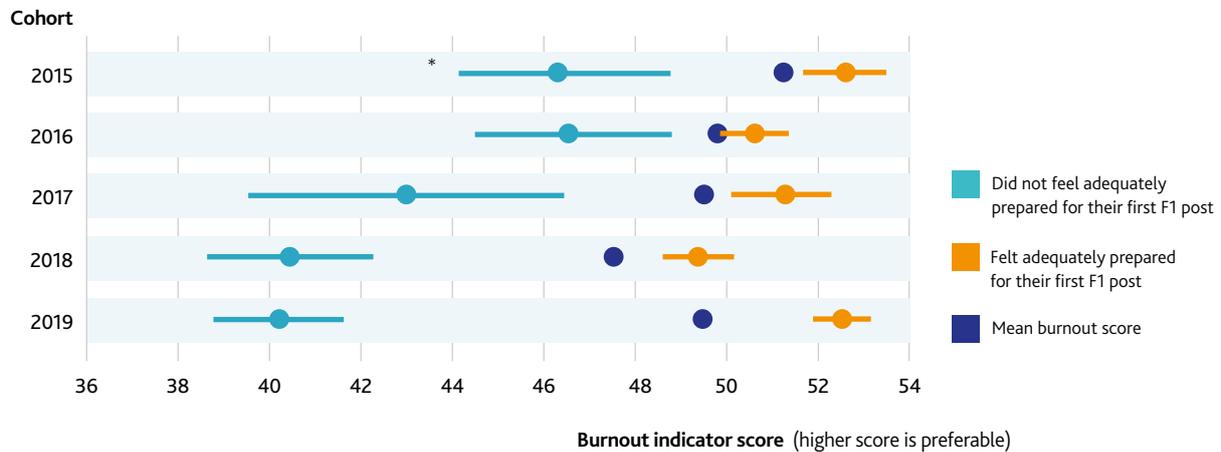
We've published an interactive data visualisation of this analysis on our education data reporting tool, to allow people to explore the data in more detail.<sup>17</sup>

### **Preparedness at F1 relates to a longer-term risk of burnout**

Doctors from each F1 cohort since 2012, who felt prepared for their first post, were, on average, less burnt out in 2019 than those who didn't feel prepared. The inverse of this is also true: doctors who felt unprepared at the start of their postgraduate training reported a higher risk of burnout in the 2019 survey. This effect is still visible for cohorts who reported lower levels of preparedness seven years ago (figure 35).

Looking at each individual annual cohort from 2012 to 2019, we can see this pattern holds true for each one. This pattern also holds true for each of our other national training survey indicators. On average, doctors reporting lower preparedness score lower on all national training survey indicators, compared with doctors reporting higher levels of preparedness. Full data are available on our education data reporting tool.<sup>17</sup>

**Figure 35: Trainees' F1 responses (2015–2019), mapped to 2019 burnout indicator scores, national training survey from 2015 to 2019**



\* Confidence intervals are the range of values that, to a certain percentage of confidence (95% in the national training survey), we are sure the 'true' mean value lies in, accounting for random error. That is, in 95% of confidence intervals, the true mean lies within these range of values.

## Trainees in foundation and acute specialty posts were least positive about inductions

Inductions are a vital part of welcoming trainees to and preparing trainees for a new post.

Effective inductions must cover what is expected of the trainee, and what the trainee should expect of the post. They must also clearly set out the trainee's duties, their team, workplace policies, access to resources, and how to get support from senior colleagues. Doctors in training must also receive an educational induction to make sure they understand their curriculum and how their post or clinical placement fits within the programme.

Almost three-quarters of trainees rated the induction they received in their current post as good or very good. However, one in ten doctors in training said they were not given all the information they needed about their workplace when they started their post. A greater proportion of trainees in F1 posts (18%) and the first year of core or specialist training (16%) reported this in the 2019 national training survey compared to the average for all trainees – as did trainees in surgery (18%) and medicine posts (16%).

Proportionally, almost twice as many F1 trainees who rated their induction as poor reported not feeling adequately prepared for their first foundation post (18.2%), compared with those who received a good induction (9.7%).

## Summary

Our data show the first years of postgraduate training can be the toughest for doctors. A high proportion of foundation trainees reported feeling burnt out, short of sleep at work, and forced to cope with work beyond their clinical competence.

Analysis over time showed doctors who don't feel adequately prepared for F1 will tend to rate many other national training survey measures lower in future years. We haven't established whether there is any causation here, but lack of F1 preparedness may point to trainees who need more support throughout postgraduate training.

High-quality undergraduate training, good inductions, and strong support mechanisms for foundation doctors are important and may have lasting effects. So it's crucial that medical schools and employers give doctors the resources and support they need during this period. This is particularly important as our evidence suggested an overall decline in trainees' perceptions of how

effective some of these mechanisms – student assistantships and shadowing periods – are in preparing them for their first foundation post.

We know that there are several factors and variables that could have an impact on how prepared a trainee feels, and more detailed research is required to fully explore and understand these findings. However, given the strength of our initial findings, we'll explore carrying out a more detailed multivariate analysis next year.

No doctor should begin their postgraduate career feeling inadequately prepared. Medical schools need to develop programmes and experiences that ready undergraduates for the next step, and training providers and employers must make sure that new – indeed, all – postgraduate trainees are given the information and support they need to learn and carry out their professional duties.

## An introduction to our work with UKMED

The UK medical education database, or UKMED, brings together data on medical school selection, fitness to practise, and postgraduate training. It's a collaborative project between us and the Medical Schools Council.<sup>18</sup>

The database currently holds information on the performance of UK medical students and doctors in training across their education and future careers. This includes achievements before medical school entry, admissions tests and graduation point information – as well as our data on postgraduate training, career progression and choices, fitness to practise and postgraduate exam performance.

### Research opportunities

From 2015, the database has been open to research applications, with the view to identifying best practice in the selection, education and progression of medical students. Key themes include:

- finding out if the system is selecting the right people to become the best possible doctors
- evaluating the impact of widening access to medicine for applicants from non-traditional backgrounds
- exploring doctors' career choices to inform workforce planning
- determining the key factors associated with doctors' progression, and the value added by each stage of training.

Researchers apply to access select data, and their proposal is reviewed by an expert panel – the UKMED Advisory Board – who makes a recommendation to us based on this review. If we approve the proposal, we prepare and provide an extract of the requested data, which can only be accessed through a Safe Haven portal provided by the University of Dundee Health Informatics Centre.<sup>19</sup> As the data controller, we comply with the *General Data Protection Regulation (EU) 2016* by de-identifying the data.

We only receive data from organisations wishing to participate in UKMED fairly and transparently. And we cannot use data to make decisions about individual doctors.

Recent projects\* have found that:

- participants pursuing careers in more competitive specialties had significantly higher academic scores than colleagues pursuing less competitive ones. Trainees who came from families where neither parent was educated to degree level had statistically significant lower odds of choosing careers in medical specialties relative to general practice<sup>20</sup>
- measures of undergraduate educational performance and situational judgement tests are both effective selection measures for postgraduate training – but additional degrees and academic publications offer no further insight as to whether an applicant will complete the foundation programme<sup>21</sup>

\* See: [www.ukmed.ac.uk/published\\_research](http://www.ukmed.ac.uk/published_research)

- across all specialties, there were no sex differences in applications for specialty training, but women had increased odds of getting an offer and accepting one. Men were less likely to be offered a place on GP and paediatrics training programmes, and if offered GP were less likely to accept.<sup>22</sup>
- how students on gateway courses progress through medicine, compared with standard entry peers of similar backgrounds
- whether situational judgement tests, educational performance measures and Prescribing Safety Assessment scores predict the likelihood of receiving a sanction.

Current and forthcoming projects\* will look at:

- the potential factors that might influence Prescribing Safety Assessment scores among UK final year medical students, and their predictive validity for performance in early postgraduate training

\* See; [www.ukmed.ac.uk/accepted\\_applications](http://www.ukmed.ac.uk/accepted_applications)

## Chapter summary

### Good training is being delivered in challenging environments

Organisations and employers responsible for medical education continue to provide a high standard of postgraduate teaching and training, and trainers are highly regarded by their trainees.

However, trainers' and trainees' day-to-day experiences are marked by the demands of a system under pressure. It's important that the healthcare system continues to think, not just about the impact this has on doctors while still in training, but about its potential legacy and resonance throughout doctors' working lives.

Key to alleviating the effects of training in a system under pressure is a supportive training environment – one which is founded on mutual respect, and where there is a focus on teamwork and building the confidence of trainees. This is also crucial for improving doctors' health and wellbeing.

### Preparing doctors for future challenges is crucial

There's clear evidence of the challenging environments doctors face when they enter postgraduate training. It's therefore essential that the undergraduate training experience prepares doctors as much as possible for joining the register. But, in response to our 2019 national training survey, one out of eight F1 doctors reported not feeling adequately prepared for their first foundation post.

It's also essential that doctors entering UK postgraduate training feel prepared. Analysis over time showed that not feeling adequately prepared at the start of foundation training is associated with higher risk of burnout and lower perceptions of the training environment. No trainee should begin their postgraduate career with a heightened risk of encountering these issues.

### Pausing the training pathway and having greater flexibility may protect trainees from feeling burnt out

In a sense, trainees have taken it into their own hands to make the training pathway work in a way that is best for them – whether to gain experience outside of a training post or to help secure a post in a preferred specialty or location – or in a way that protects them. On the latter point, evidence suggests that their strategy may be working. Trainees in the first years of core and specialist training who had returned from a pause in training reported lower burnout risk levels than those coming directly from F2.

Post-F2 pauses in training are now the norm, with 63% of F2s in 2018 choosing to pause in 2019, compared with 37% who went straight into the first year of core or specialty training.

The value of our work with partners in each country of the UK to formalise the arrangements for taking a pause in training is clear. We recognise that pausing the training pathway can give doctors the perspective and expertise

of working in non-training roles, which can be valuable at an early stage of their careers.

Working patterns are also changing. In line with wider workforce trends outside the healthcare profession, working less than full-time (LTFT) is now more popular than ever among doctors

in training. In 2019, over one out of 10 (13%) of doctors in training said they were working on a less than full-time basis. And, notably, these doctors reported significantly lower risk of burnout than their full-time colleagues.



# Primary care

The clinical work of GPs is changing with more patients with complex needs. Some doctors feel patient expectations often go beyond what they can provide



The number of licensed GPs is growing faster than the UK population growth but 45% of GPs are contracted to work less than full time, and 36% have reduced their clinical hours in the past year

**Innovative models of medical education and training may encourage more doctors into general practice**



Less than full time working is currently more common among female GPs (61% female GPs compared with 26% male GPs).

But 79% of male GPs aged 30 – 49 are considering reducing their hours in clinical practice in the next year

The proportion of GP trainees over 40 years old has grown to 11%



GPs are consistently reporting higher pressures and are more dissatisfied than other doctors: 65% worked beyond their rostered hours every day and 17% have felt unable to cope with their workload every day

## System pressures affecting primary care

The working environments in primary and secondary care are very different. These differences are clearly acknowledged in how each area of healthcare is designed and carried out. The contractual arrangements for GPs and specialists are based on different models of work, and training routes differ between primary care and the various secondary care specialties. It is appropriate to explore some of the issues facing GPs in this unique context, rather than drawing comparisons across such different environments.

This chapter looks at some of the challenges around maintaining a sustainable workforce in primary care, as well as GPs' experiences and the effect on their future career intentions.

### Pressures persist in primary care

The pressures in primary care have been well documented in recent years. Some improvements and solutions have been proposed but there are now two years of results from *What it means to be a doctor*<sup>9</sup> in 2018 and the 2019 barometer survey, which show that GPs are generally the group of doctors the most dissatisfied in their work and feeling the greatest burden of system pressures.

In England alone, GPs carried out 307 million appointments between April 2018 and March 2019.<sup>23</sup> Appointments with healthcare workers in primary care accounted for over 90% of all patient contact in the NHS in England.<sup>24</sup>

For most patients primary care is the start of their healthcare journey. For many, it is the only calling point. Primary care is a hub of expertise, treating millions of patients every year and signposting those who need additional care further into the system. This process of signposting doesn't always work perfectly – chapter 5 explores some of the experiences of patients who require onward referral.

GPs represent a rare opportunity for truly holistic care. As expert generalists GPs are in a unique position to take a rounded view of the patient and the multiple health and social challenges that affect them.<sup>25</sup> However, the challenges facing primary care are putting pressure on holistic care, with GPs reporting too little time to address all the issues a patient presents with<sup>8</sup> and a sense of helplessness to address the socioeconomic barriers that patients face.<sup>26</sup>

## The GP workforce

The number of GPs continues to grow at a faster rate than the UK population. As discussed in our recently published 2019 *Workforce* report,<sup>3</sup> the increase in the number of GPs in the past year has been greater than expected.

In the 2019 barometer survey almost half (45%) of GPs reported that they were contracted to work less than full-time hours and over a third (36%) had reduced their hours in clinical practice in the past year. The growing number of licensed GPs does not therefore necessarily mean an increase in the overall supply of GP time. Less than full-time (LTFT) working is much more common among GPs than other types of doctors.

When asked in the 2019 barometer survey about changes they were planning in the next year, over two-thirds (69%) of GPs currently working full-time said they were likely to make a change within the next year that would see them working less time in clinical practice.\*

### LTFT working is currently more common among female GPs and those in the middle of their careers

LTFT working is most common among GPs in their 30s and 40s, around the middle of their careers. The barometer survey found that two-thirds (63%) of GPs in their 30s work LTFT and two-fifths (41%) of those in their 40s do so.

It is unclear whether doctors working LTFT in their 30s and 40s is a long-term career adjustment or related to specific life events or transitions at this time, such as starting a family. We do not know if GPs working LTFT in this age range have always done so, or if they will continue to do so.

There is a significant gender divide among GPs working LTFT. Around a quarter (26%) of male GPs are working in this way, compared with nearly two-thirds (61%) of female GPs. This reflects traditional patterns of LTFT working.

However, looking at those who are considering reducing their hours in clinical practice within the next year, the proportion of male GPs is higher than female GPs – almost three-quarters (74%) of men, compared with almost two-thirds of women (59%). A greater proportion of male GPs aged 30–49 years said they were likely to reduce their hours in clinical practice than male GPs over 50 years old. This suggests that, while gender patterns of LTFT working persist, we may be seeing a cultural shift that will see a more gender-balanced LTFT workforce in the future.

\* This includes those who said they were likely to reduce contracted hours, go part time, or take on a role with less clinical workload.

## While GP training continues to be popular, with a particular growth in trainees aged 40 years and over, patient demand appears to be outstripping supply

GP training continues to be popular, with 19% of F2 doctors in 2019 indicating a preference for GP specialist training. The number of doctors in GP training has increased by 6% in 2019, a far larger year-on-year increase than in the preceding six years.

Since 2015, the number of GP trainees aged 40 years or over has grown from 797 to 1,298 doctors. Other age groups have not grown at such a rate, so doctors over 40 years old now account for 11% of all GP specialty trainees, compared with 7.6% in 2015. The growth in this age group is largely made up of international medical graduates.

### Negative perceptions of working in general practice remain, but can be overcome by engaged and motivated trainers

There still appear to be some negative perceptions of general practice among UK medical students, which may be a barrier to bringing more doctors into the specialty.

In 2017, the Royal College of General Practitioners and the Medical Schools Council published their joint report *Destination GP*, which presents the results of a survey of 3,680 UK medical students.<sup>27</sup> The report found that, by their final year in medical school, three-quarters (76%) of students had heard negative comments about general practice from clinicians, educational trainers, and/or academics.

Nine out of 10 (91%) respondents believed that their peers held negative views about general practice. The survey also found that doctors' choices of medical specialty are strongly influenced by their peers, lecturers and tutors.

Encouragingly, the single biggest impact on choosing general practice for specialty training is the interaction that students have with GPs while on general practice placements. A positive interaction with an engaged and motivated GP during medical school may be enough to overcome what appears to be pervasive negativity elsewhere in the medical profession.

### Innovative models of medical education and training are being used to encourage more doctors in training into general practice

In **Wales**, the *Train, Work, Live*<sup>28,29</sup> campaign, introduced in 2016, has been successful in recruiting more GPs to Wales, particularly to rural areas. The campaign was designed to draw on the training, working and lifestyle benefits available in Wales, encouraging doctors at all stages of their career to consider practising in Wales. Recruitment to rural areas has been helped by a financial incentive offered to those who complete their specialty training and work for at least one year in a 'targeted' area. The 'targeted' areas are those that have struggled to fill their GP specialty training places for the preceding three years. A similar incentive scheme is available in **England**

\* Either on all seven measures, or on six out of seven measures.

to encourage doctors to train and work in areas that have recently struggled to recruit.

We have been involved in quality-assuring the new **Scottish** Graduate Entry Medicine programme. The programme is being run and administered between the University of St Andrews and University of Dundee, with involvement from the University of the Highlands and Islands. It is a four-year, graduate entry course developed to help meet the future needs of NHS Scotland. The programme is largely community based and focuses on community

hospitals and health centres, with exposure to remote and rural settings, as well as medicine in areas of deprivation. Years one and two are led by the University of St Andrews, with students spending time in GP settings, alongside experiencing healthcare in more diverse situations, such as secondary care and rural environments. Years three and four are led by the University of Dundee, and students will be largely based in primary care in rural areas, however they will also experience hospital settings and an urban GP environment. The first students began the programme in September 2018.

## GPs experiences of pressures and their responses

The pressures reported by GPs impact on their wellbeing. This has consequences for patient care and the workforce.

Some groups of GPs are relatively satisfied and have good wellbeing. Later, this chapter explores this group further to understand the factors that might mitigate the effects of pressure. However, a significant proportion of GPs are feeling the brunt of pressures, with consequences for their satisfaction, wellbeing, and desire to continue in clinical practice.

### Growing patient demand and more complex cases are increasing pressure on GPs

The nature of work in primary care has changed significantly over the past few years. In the *Everyday leadership* research, GPs reported that their clinical work was changing. While the fundamentals of clinical practice and the essence of the doctor-patient consultation remain the same, the volume and type of clinical cases have changed.

- GPs discussed increasing numbers of patients and unrealistic expectations from those patients. These expectations were either:
  - Patients expecting to be seen by a doctor for issues better dealt with elsewhere (for example, head lice)
  - Patients who were well informed about their health having unrealistic expectations of what the GP could do
- GPs reported increasingly seeing complex cases and comorbidities. They especially

discussed the challenges of addressing mental health concerns and dementia alongside other illnesses, and increasing numbers of palliative care cases in primary care due to limited places in hospices.

A further sign of increasing pressure was evident in the *What it means to be a doctor*<sup>9</sup> survey, reported in *The state of medical education and practice in the UK* report 2018.<sup>4</sup> This showed that over a 28-day period GPs worked an average of 11 days of what they considered to be high or unsustainable pressure. Only around six days were low or moderate pressure. GPs spent around two days which they were not contracted to work catching up on work.<sup>8</sup>

In the 2019 barometer survey, nine out of 10 (90%) GPs reported working beyond their rostered hours every week. Two-thirds (65%) of GPs were doing so every day, more than twice the proportion of doctors overall (32%).

### Workload pressures are affecting GPs' wellbeing, with many feeling dissatisfied

Many GPs enjoy and are fulfilled by their work, but the logistical challenges of working in pressured environments are causing dissatisfaction.

Heavy workloads and long hours are having an impact on how some doctors feel about their work. The findings in the 2019 barometer survey showed similar proportions of GPs felt satisfied in their work (50%) and dissatisfied (45%). The proportion of dissatisfied GPs is significantly

higher than for doctors overall, a third of whom (30%) reported being dissatisfied.

Doctors' satisfaction in their work appears to be driven by their sense of fulfilment, and their work being enjoyable and rewarding. However, the practicalities and logistics of working in a system under pressure appear to drive dissatisfaction. The key reasons GPs gave, unprompted,\* for their dissatisfaction were:

- increasing workloads and long hours (55%)
- finding it increasingly difficult to deal with patient expectations and dissatisfaction (36%)
- the bureaucracy involved in their work (34%)
- the pressure of time constraints (28%)
- care being compromised despite their best efforts, and sometimes feeling that are working in unsafe conditions (26%).

### Most GPs struggle to cope with workloads, and some have taken a leave of absence due to stress

In the *What it means to be a doctor*<sup>9</sup> and *Adapting, coping, compromising*<sup>8</sup> research reported in 2018, and the 2019 barometer survey, GPs stand out as a group who are particularly struggling with their wellbeing. The barometer survey findings showed that nine out of 10 (91%) GPs said they felt unable to cope with their work at some point in the past year. While this might be expected to some degree, over a sixth (17%) of GPs said they felt this way every day.

In the barometer survey, almost a quarter (24%) of GPs gave responses that suggested they were at high risk of burnout. The proportion rises to two-fifths (41%) of those who said they were struggling to cope with their workload at least once a week, compared with less than one out of 10 (7%) of those who said they were struggling to cope less than once per week.

Around one out of 10 (9%) GPs have had to take a leave of absence due to stress in the past year, contributing to a vicious cycle of workforce shortages in an already stretched system (figure 1, chapter 2).

Looking back at figure 12 in chapter 2, half of GPs (50%) are in the 'struggling' group, working over their contracted hours at least weekly and feeling unable to cope at least weekly. By contrast, only one out of 10 GPs are in the 'doing well' group, compared with almost a third of doctors overall.

In the 2019 national training survey, GP trainers reported levels of burnout and workload pressure similar to the levels GPs reported in the barometer survey. Almost half (49%) of GP trainers reported finding their work emotionally exhausting to a high or very high degree.

Those in GP training posts appear much less pressured than trainers. Two thirds (67%) of GP trainees rate the intensity of their work as 'about right', though a third (30%) consider it to be heavy or very heavy.

Over three quarters (78%) of GP trainees say that they are never left short of sleep by their working pattern, with only 5% saying they feel this way

\* Information about the use of free text responses can be found in the data note on page 130.

weekly. This is compared to a fifth (19%) of specialty trainees overall who feel short of sleep while at work every week.

### **Some pressures are specific to working in certain areas, with some GPs working in deprived communities finding their work particularly emotionally draining**

The *Everyday leadership* research highlighted particular challenges when working in certain areas. GPs spoke of specific pressures associated with working in socioeconomically deprived areas. These GPs can have a very high number of distressing and stressful cases, with patients whose health concerns are connected to wider socioeconomic problems and cannot be treated per se. Participants talked about practising in areas where many of their patients are affected by issues associated with poverty, release from prison, or drug and alcohol dependency. This places pressure on GPs, who must manage this complexity in short consultations. The pressure may also be compounded by struggling to recruit locums and salaried GPs to areas with well-known challenges.

In GP practices located in such areas, GPs felt that nurse practitioners and other medical associate professionals were particularly valuable. However, while these roles lightened GPs' overall workloads, it tended to reduce the number of relatively simple health complaints that GPs would see. So they would spend more of the day consulting on the most complex and distressing cases.

### **Working under pressure has consequences for patient care, with some GPs feeling they can't always give patients the level of care they need**

Doctors reported that enjoying their clinical work and patient contact was a significant factor in their job satisfaction.<sup>9</sup> But 92% of GPs have felt unable to provide patients with a sufficient level of care at least occasionally during the past year, and over a quarter (27%) of GPs felt this way every day. This is likely to be a contributing factor for the two-fifths (42%) of GPs who find their work frustrating.

Very concerningly, over a quarter (27%) of GPs have seen patient care being compromised by a doctor's practice in the past year. Pressure on workloads was by far the most common reason given by GPs for compromised care, with three-quarters (74%) of those who had seen care compromised giving this response. GPs also attributed compromised care to inadequate communication with patients (42%) and between medical professionals (42%), as well as to rota gaps and lack of adequately trained staff (39%).

Those GPs whose responses indicated that they were at high risk of burnout were more likely than other GPs to have seen patient care being compromised – almost two-fifths (37%) of those at high risk of burnout, compared with around a fifth (21%) of those with a very low risk of burnout.

The feeling of being unable to provide a sufficient level of care to patients also appears to increase with the risk of burnout, with three-quarters (76%) of GPs who have a high risk of burnout feeling that they were unable to provide a sufficient level of care at least once a week.

## As pressures on the medical workforce persist, doctors may reduce their hours or leave the profession

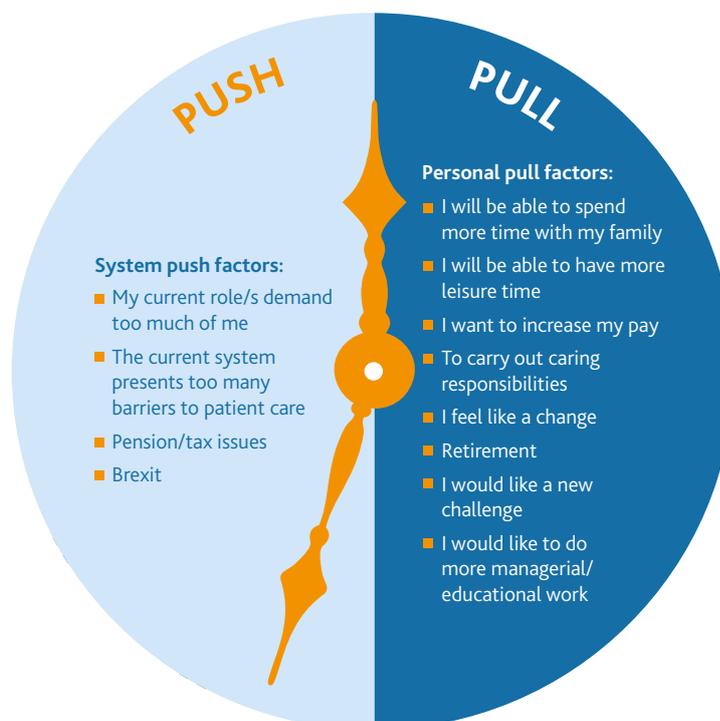
The *Adapting, Coping, Compromising*<sup>8</sup> research found that doctors were reducing their hours or leaving the profession in response to pressure – an adaptation that could have a serious impact on the capacity of the system to deliver high quality care.

A third (36%) of GPs have reduced the time they spend in clinical practice in the past year. Looking ahead, two-thirds (66%) of GPs said they were likely to make a career change in the next year that would see them spending less time in clinical practice. Two-fifths (41%) of GPs said they were very likely to make such a change.

Asked what change they were most likely to make in the next year, GPs' most common response was that they would reduce their contracted hours. Of course, reducing contracted hours does not necessarily mean that additional time won't be spent working in the health sector – a doctor could be reducing their contracted hours to take on an additional leadership role, work some shifts as a locum, or any number of other professional activities.

However, asked why they were considering reducing their contracted hours, seven out of 10 (71%) GPs said that their current role was too demanding. Almost half (46%) said that the current system presented too many barriers to patient care. While these are system factors, lifestyle factors also influenced GPs' changes. Just over half (56%) said they would reduce their

Figure 36: System push factors and personal pull factors for reducing hours



contracted hours to spend more time with family, and almost two-fifths (38%) wanted more leisure time.

Around one out of six (18%) GPs said they were considering leaving medicine entirely within the next year, around a third of whom were considering retirement. Excluding those considering retiring, one out of 10 (11%) GPs said they may be considering a career outside medicine.

GPs looking to leave medicine entirely, excluding those considering retirement, were asked what steps they had already taken towards doing so.

- They had most commonly taken 'soft steps', such as discussing the possibility with others (63%) or doing research into alternative options (50%).
- A fifth (20%) had taken no steps towards leaving.
- Smaller proportions had taken 'hard steps', such as contacting a recruiter (15%), or applying for a role outside medicine (14%).

Individual respondents may have taken a mixture of soft and hard steps, such as discussing with others and contacting a recruiter. However, these findings illustrate that most GPs considering leaving the profession are in the early stages of

Figure 37: Steps taken by GPs towards leaving the profession

What steps, if any, have you taken towards leaving the medical profession ?



*n = 173 (all GPs fairly or very likely (NET likely) to leave the medical profession within the next year), the 2019 barometer survey QB3, values do not add up to 100% as it was possible to select multiple response options.*

acting. It is unclear what proportion of those yet to take harder steps will do so in the future, and what proportion will actually leave.

Looking at doctors considering leaving the profession, it appears this decision has not come out of the blue, with doctors making various adaptations before deciding to leave. The 2019 barometer survey found that of those doctors who said they were likely to leave the profession and who had already taken some 'hard steps' towards doing so:

- almost half (47%) had reduced their contracted hours in the past year

- just over two-fifths (46%) had moved to a role with less clinical practice
- a fifth (19%) had had to take a leave of absence due to stress – a much higher proportion than GPs overall (9%).

The fact that it seems these decisions are not taken suddenly may present opportunities for supportive intervention to keep as many doctors as possible in the workforce.

## Protective factors for GPs

### Around half of GPs are satisfied in their work, largely driven by a sense of fulfilment

Looking at the half (50%) of GPs who said they were satisfied in their day-to-day work, the key reasons they reported for their satisfaction were:

- enjoyment and fulfilment in their work (34%)
- enjoying patient contact (30%)
- liking and respecting the team they work in (15%).

Though there is an overall pattern of GPs making changes that would see them spending less time in clinical practice, it is less common among

satisfied GPs than those who consider themselves dissatisfied – around half (53%) of satisfied GPs compared with over three-quarters (78%) of dissatisfied GPs. Enjoying patient contact is a key element of job satisfaction for satisfied GPs

Much like overall dissatisfied GPs, a quarter (24%) of GPs that were satisfied overall still found increasingly high workloads and long hours to be a cause of dissatisfaction.

Four out of five (79%) satisfied GPs also have a very low or low risk of burnout, suggesting reasons for satisfaction may also be protective factors against burnout.

## **A sense of belonging is important to doctors – the sense that they are part of an effective and supportive team appears to help mitigate stress and avoid burnout**

As discussed in chapter 2, the *Caring for doctors Caring for patients*<sup>5</sup> and *Fair to refer?*<sup>7</sup> research highlighted the importance of belonging for doctors, and the risks that come with social and professional isolation.

It is therefore encouraging that GPs feel relatively well supported compared with other groups of doctors. They are significantly less likely than doctors overall to say that they feel unsupported by a range of colleagues.

Half (51%) of GPs reported feeling unsupported by immediate colleagues in the past year, similar to the proportion of doctors overall (56%).

Less than half (46%) of GPs said that they had felt unsupported by senior medical staff in the past year, compared with six out of 10 (58%) doctors overall.

Non-clinical management is the area where GPs feel the most unsupported, but still relatively well supported compared with other doctors. Over two-thirds (68%) of GPs reported feeling unsupported by this group of colleagues, compared with over three-quarters (78%) of doctors overall.

Across all types of medical and non-medical colleagues, most GPs who felt unsupported reported feeling this way only occasionally. It was very uncommon for GPs to feel regularly unsupported.

## **There appears to be an association between how well supported a GP feels and their risk of burnout**

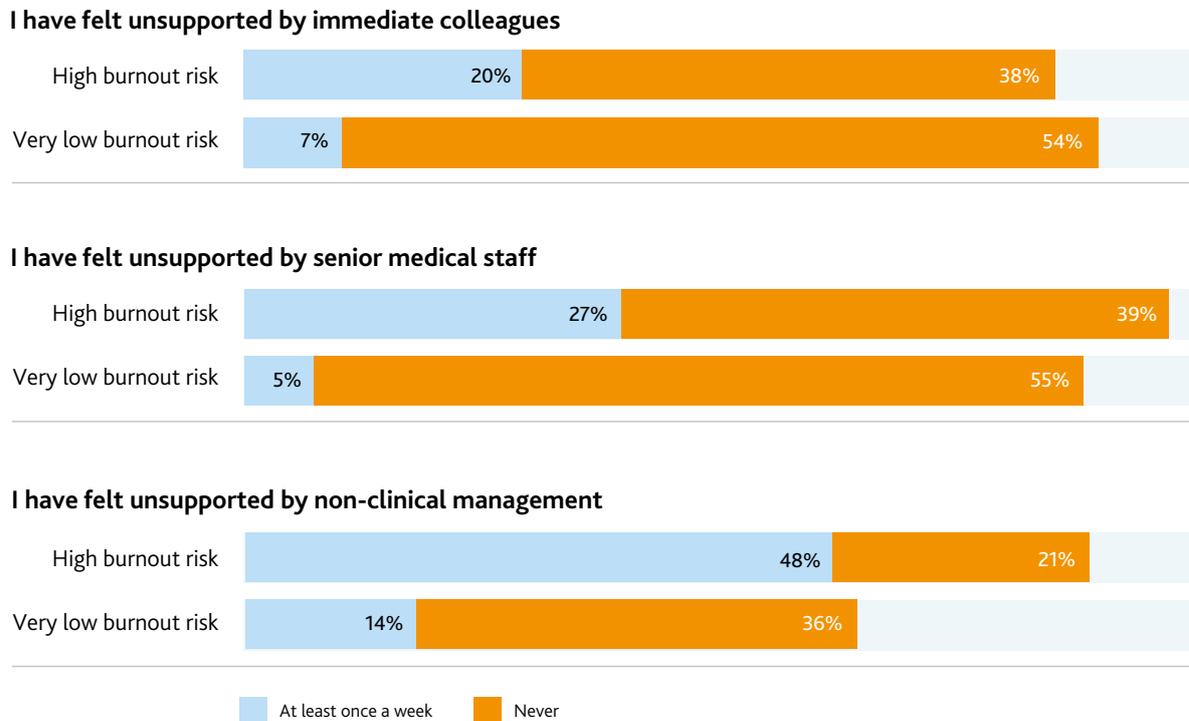
As shown in figure 38, GPs saying that they never feel unsupported by a range of colleagues is much more common among those who have a very low risk of burnout. Conversely, saying they have felt unsupported at least once per week is much more common among those with the highest risk of burnout.

## **There are indications that working less than full time may be a protective factor against the impacts of pressure**

GPs working LTFT are slightly more likely to be satisfied than those working full-time – over half (56%) of those working LTFT were satisfied, compared with just under half (49%) of those working full-time. LTFT GPs are also slightly less likely to be considering leaving the profession in the next year – less than one out of 10 (9%) of those working LTFT compared with almost one out of seven (13%) of those working full-time.

Indication of a very low risk of burnout appears to be similar for those working LTFT and those working full-time; one out of three for both. However, high risk of burnout is slightly less common among those working LTFT – a fifth (20%) – than those working full-time – over a quarter (27%), which suggests working LTFT may be a protective factor against burnout.

**Figure 38: The proportion of doctors who feel unsupported by immediate colleagues, senior medical staff, and non-clinical managers, compared with indications of burnout risk**



*n = 978 (registration type: GP), the 2019 barometer survey QC1\_5/6/7, values do not add up to 100% as not all response options are included.*

## Establishing a sustainable GP workforce, while building on innovations in primary care

With new models of care across the UK, an even greater emphasis is being placed on primary care. As expert generalists, GPs have the knowledge and expertise to provide great patient care in community settings; however we must be mindful of the strain that system pressures are putting GPs under.

It is encouraging that the growth in the number of GPs in 2019 has been greater than expected. However, our 2019 barometer survey showed a continuing trend towards LTFT working for doctors in general, and GPs particularly. This means the growth in absolute numbers of GPs does not necessarily mean an increase in the amount of GP time available.

In a healthcare system in which patient demand is outstripping GP supply, it is important that legislative change allows us to streamline the process of getting internationally trained doctors onto the GP register, so that they can begin practising in primary care. Innovative models of medical education and training also hold promise for bringing more doctors into the specialty area.

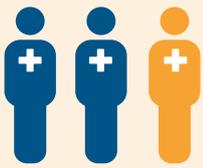
We are committed to exploring how we can bring more expert generalists into the health service, including considering the role that SAS doctors could play in primary care (Chapter 7).

System pressures are affecting doctors' wellbeing, as well as patient care and future workforce supply. As highlighted in the *State of medical education and practice in the UK 2018*,<sup>10</sup> GPs continue to feel the brunt of pressures. In the face of long hours and prevalent burnout, significant proportions are considering reducing their hours in clinical practice or leaving the profession. Our work *Supporting a profession under pressure* aims to address some of the challenges that doctors face in their practice.

But it is encouraging that there are still good numbers of satisfied GPs who feel fulfilled by their work. Exploring the experiences of such GPs has highlighted the importance of a sense of belonging, largely born out of effective team working and professional support.



## Impact on patient care



34% of doctors found it difficult to provide a patient with the level of care they needed at least once a week in the previous 12 months

12%

of doctors who witnessed a patient safety concern said problems around resourcing was the sole contributing factor to the most recent incident

61% of doctors said that communication issues between medical staff or with patients contributed to patient safety being compromised



**Unnecessary referrals are a risk to patient safety. They increase the number of appointments needed and can delay patient treatment or advice**



Most patients are satisfied with their referral experience but some reported issues around inaccurate or lost patient records, administrative problems, and the quality of the doctor-patient interaction

35%

of doctors said they've made a patient referral which wasn't strictly necessary due to

pressures on their workload over the past year. A quarter of GPs did this at least once a month

## System pressures are affecting patient care

Our 2019 barometer survey found doctors reporting that workplace pressures are having implications for patient safety and care.

A third of doctors (33%) agreed that they now make more patient referrals due to high workload pressures. And a similar proportion (31%) agreed that they refer patients more readily than they used to, even when they feel it may not be strictly necessary. This was similarly a strong theme which came out in our research from 2018.<sup>4</sup>

An increase in referrals has implications for the whole health system and the patients and healthcare professionals within it. The second part of this chapter sheds light on the question of how much we should prioritise resolving issues relating to referrals by exploring the first-hand experiences of patients.

Despite the best efforts of staff, patients often have poor experiences of interacting with the NHS system. From difficulty booking appointments and long waits for results, to trouble registering with a GP surgery and corresponding with NHS services.<sup>30</sup> Particularly long waiting times have been recorded in Northern Ireland.<sup>31</sup>

The administrative aspects of the NHS are important to patients' experiences of care. Poor experiences can lead to patients feeling stressed or let down; or positive and cared for when the quality of the administration is good.<sup>32</sup>

Furthermore, system pressures affect the way patients' access to services are rationed. For example, limiting patient access to certain treatments or procedures, or by requiring patients to wait longer to receive a diagnosis or treatment.<sup>33</sup>

Patients and the public are aware of the pressures the NHS is under. A public survey in 2018 highlighted that 79% of the public thought the NHS was underfunded.<sup>34</sup>

Public opinion polls continue to show the NHS is one of the public's biggest concerns.<sup>35</sup> The patient interviews we commissioned for the *Understanding patients' experience of referrals*\* research echoed these views, highlighting that patients are very much aware that healthcare professionals are working in a stretched service.

\* See research and data note on page 130 for more information.

## Most doctors experience times when it is difficult to provide patients with the level of care they need

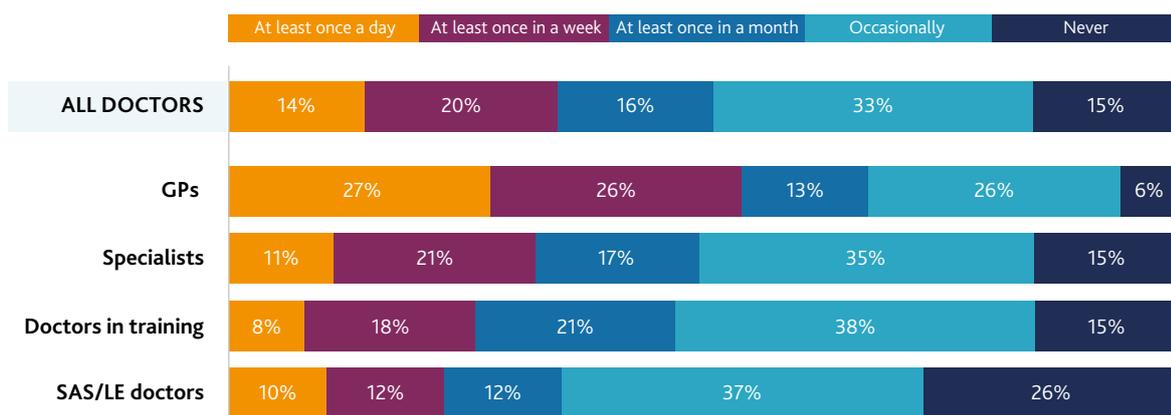
In the past year, four out of five (84%) doctors have experienced times when they found it difficult to provide a patient with the level of care they needed; and just over a third (34%) of doctors have experienced this weekly or more (figure 39). This is in line with findings from 2018.<sup>9</sup> Not only is this concerning for the quality of patient care, but it's damaging for doctors' morale too. For many doctors joining the profession, caring for patients is their key motivation.<sup>4</sup> Results from the 2019 barometer survey showed a correlation between doctors' satisfaction and their ability to be able to provide patients with the level of care they need.

Feelings of burnout are particularly associated with doctors finding it difficult to provide patients with a sufficient level of care. Two-thirds (65%) of the doctors who are at high risk of burnout said they've found it difficult to provide a patient with a sufficient level of care at least once a week.

Similarly, 57% of the doctors who feel dissatisfied day-to-day and 64% of the doctors who regularly feel unable to cope with their workload said they found it difficult to provide patients with the level of care they need at least weekly.

**Figure 39: Frequency with which doctors found it difficult to provide a patient with the level of care they need, in the last year**

*How frequently, if at all, over the last year have you found it difficult to provide a patient with the sufficient level of care they need?*



*n = 3,876 (all doctors), the 2019 barometer survey C1\_4, values do not sum to 100% as some response options have been excluded – see data note on page 130.*

## Doctors are witnessing patient safety or care being compromised

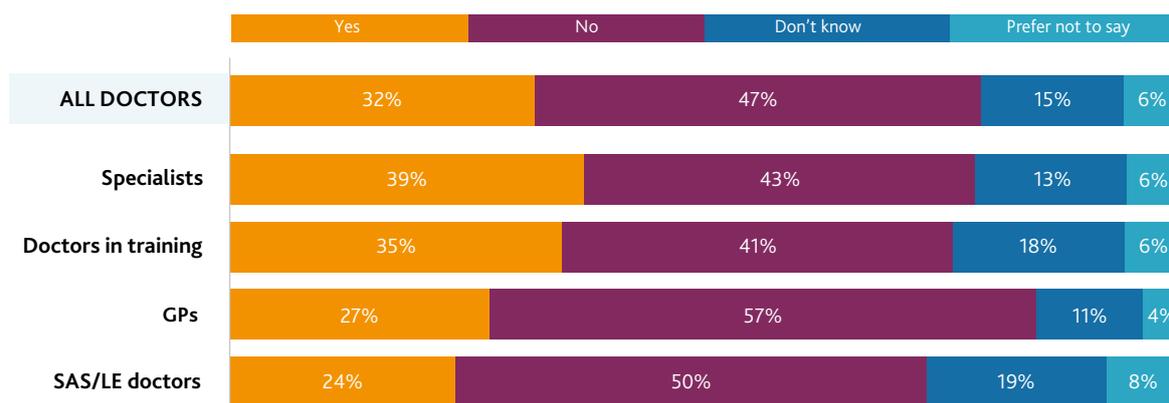
A third of doctors (32%) have witnessed a situation where they believed patient safety or care was being compromised by another doctor’s practice in the past year. A higher proportion of specialists and doctors in training said they have witnessed patient safety or care being compromised (39% and 35% respectively) (figure 40).

Again, there’s an association between a high risk of burnout and a doctor having witnessed patient safety or care being compromised. 45% of doctors who are at a high risk of burnout have witnessed a situation where patient safety was being compromised.

We are committed to encouraging a culture where doctors feel confident and supported to raise concerns. Our *Raising and acting on concerns about patient safety* guidance set out what doctors should do if they think patient safety, dignity or comfort is being compromised.<sup>36</sup> Through our *Supporting a profession under pressure* programme, we continue to work with partners in England, Northern Ireland, Scotland and Wales to make sure doctors at all career stages feel supported to raise and act on concerns.

**Figure 40: Percentage of doctors who said a situation or situations have arisen in the past year where patient safety or care was compromised**

*In the past year, has a situation or situations arisen in which you believed that patient safety or care was being compromised by a doctor’s practice?*



*n* = 3,876 (all doctors), the 2019 barometer survey C6.

## Workload pressures and communication problems contribute to patient safety or care being compromised

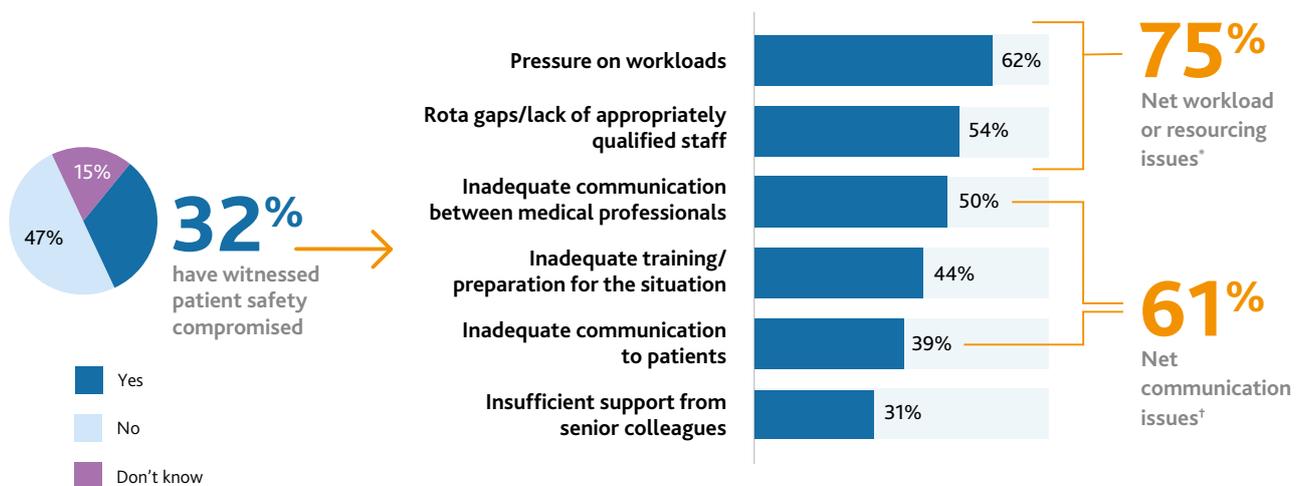
The 2019 barometer survey found the most common contributing factors to patient safety concerns are workloads or resourcing issues, followed by inadequate communication between healthcare professionals. When speaking about the last incident they witnessed (figure 41):

- three out of five doctors (62%) gave workload pressures as a contributing factor

- over half (54%) of doctors said resourcing issues, such as rota gaps or lack of appropriately trained staff, played a part
- half (50%) said inadequate communication between healthcare professionals contributed to patient care being compromised.

We don't know the severity of these patient safety concerns, or whether steps were taken to remedy the issues. However, workload pressures, resourcing problems and communication failures are all having an impact on patient care.

Figure 41: Factors which contributed to patient safety or care being compromised, in the last year



*n = 1,252 (doctors who responded yes to seeing patient safety or care being compromised in the past year, the 2019 barometer survey C6) the 2019 barometer survey C7.*

\* 'Net workload or resourcing issues' includes doctors who selected 'pressure on workloads' and/or 'rota gaps / lack of appropriately qualified staff' in their response to question C7.

† 'Net communication issues' includes doctors who selected 'inadequate communication between medical professionals' and/or 'inadequate communication to patients' in their response to question C7.

## Workloads or resourcing issues

Three out of four (75%) doctors who witnessed a patient safety concern felt that in the last incident they witnessed, pressure on workloads, rota gaps or lack of appropriately qualified staff was a contributing factor. One out of eight (12%) said it was the only contributing factor. This is concerning as it shows that system pressures are resulting in patient safety and care being negatively impacted.

Three-quarters (74%) of GPs identified workload pressure as a factor, compared with 62% of doctors overall, suggesting that challenging workloads are a particularly high-risk factor in GP surgeries. Doctors in training were more likely to identify rota gaps, or a lack of appropriately qualified staff, than other doctors (73% of doctors in training compared with 54% overall).

In January, the *Health Service Journal* reported that, since the introduction of exception reporting\* in England, 63,309 reports have been submitted from around 36,000 doctors in training. This reveals the scale of demands being placed on this group of doctors.<sup>37</sup> And as our liaison and outreach teams in England† hear from doctors that they're often encouraged not to use exception reporting, it's likely that many incidences have gone unreported.

We are working with the Academy of Medical Royal Colleges, the British Medical Association, the Care Quality Commission, Health Education England and NHS Employers to improve the effectiveness and acceptability of exception reporting.<sup>38</sup>

## Inadequate communication between healthcare professionals or between doctors and patients

Three out of five (61%) doctors noted that communication issues – either between medical professionals (50%) or between doctors and patients (39%) – were a contributing factor to patient safety or care being compromised.

Good communication is critical to effective healthcare provision. Communication failures between doctors and patients or between healthcare professionals can lead to patient harm (either psychologically or physically) or substandard care.<sup>39</sup> But we know that workload pressures and resourcing issues can make effective communication difficult.

Communication is one of the key domains of *Good Medical Practice*.<sup>40</sup> We have a clear responsibility to support doctors in communicating effectively with patients and colleagues. We've therefore carried out a programme of work<sup>41</sup> to better understand the different types of communication harm. However, there's still more work needed to identify clear actions or solutions.

\* Exception reporting is a contractual mechanism that doctors in training can use to report patient safety, rostering or training concerns.

† Our liaison and outreach services work with different actors across the UK to improve understanding of our guidance. They also explain how our processes work. And they help us understand the issues faced by doctors and others in the UK's healthcare systems. More information can be found on our website [www.gmc-uk.org/about/how-we-work/liason-and-outreach](http://www.gmc-uk.org/about/how-we-work/liason-and-outreach).

## Workload pressures lead doctors to make more patient referrals

In 2018, we reported that doctors were sometimes making unnecessary referrals to cope with workload pressures. In 2019, the barometer survey showed that this is still prevalent – one out of three doctors (35%) said there have been times over the past year when they've made a referral which was not strictly necessary, due to workload pressures. Around one out of eight doctors (13%) said this happened on a monthly basis (figure 42).

In the 2018 *Adapting, Coping, Compromising* survey, the question was phrased differently, so we can't make a direct comparison. However, the results were broadly similar.<sup>4</sup>

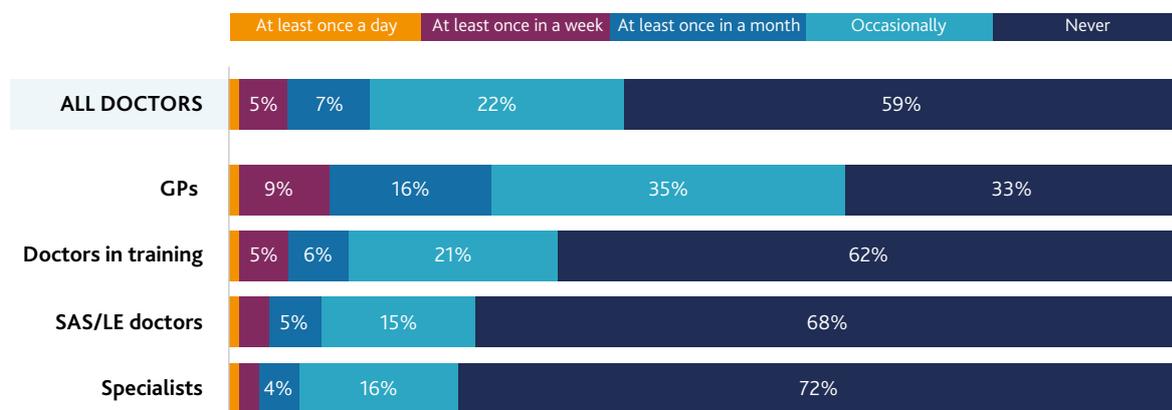
- A third of doctors (33%) agreed they have made more referrals when compared with two years ago due to higher workload pressures.

- A similar proportion of doctors (31%) agreed they referred patients more readily than they used to – even if they sometimes felt it might not have been strictly necessary.

GPs are responsible for directing patients' access to specialty care and therefore, making referrals is a key component of their role. Making an unnecessary referral due to workload pressures is more common among GPs than in other types of doctors. Just over one out of four GPs (26%) said this has happened monthly and about one out of 10 said they do this at least weekly.

**Figure 42: Frequency with which doctors have made an unnecessary referral due to workload pressures**

*How frequently, if at all, in the last year have you referred patients on when it may not have been strictly necessary due to pressures on your workload?*



*n = 3,876 (all doctors), the 2019 barometer survey C4, values do not sum to 100% as some response options have been excluded – see data note on page 130.*

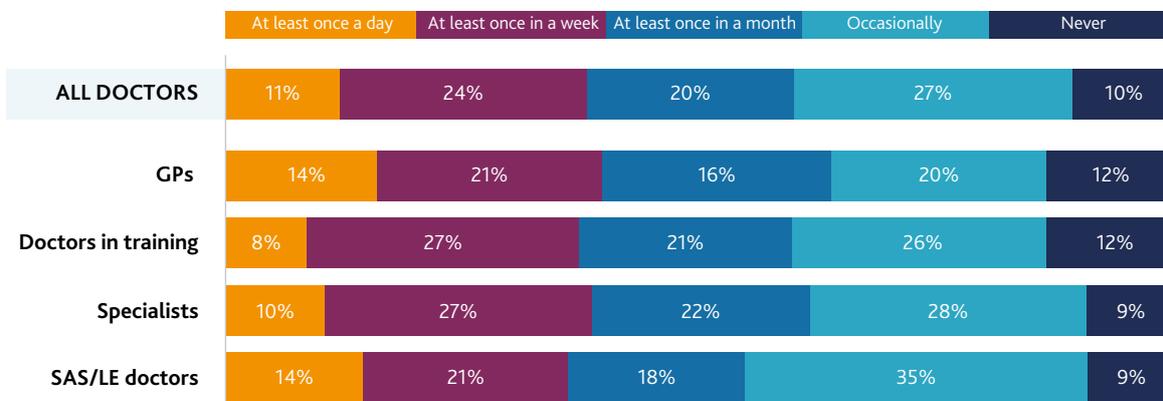
### Four out of five doctors have received a patient referral when it may not have been strictly necessary

A greater proportion of doctors said they've received unnecessary referrals than the proportion who said they've made unnecessary referrals. Four out of five (82%) doctors said there have been times in the past year when they've received unnecessary patient referrals when it may not have been necessary or appropriate. A third (35%) of doctors said they've experienced this once a week or more (figure 43).

Not too much should be made of the discrepancy in the proportion of unnecessary referrals made and those received. Some unnecessary referrals will have gone unreported – either because doctors don't want to admit to them or because only the doctor that received the referral considered it to be unnecessary. Nevertheless, the fact that a quarter of GPs said they've made unnecessary referrals at least monthly due to workload pressures, and a third of all doctors reported they've received unnecessary referrals every week, suggests that pressures are making the volume of referrals greater than they need to be.

Figure 43: Frequency with which doctors have received unnecessary referrals

And how frequently, if at all, in the last year have you received patient referrals when it may not have been strictly necessary or appropriate?



n = 3,876 (all doctors), the 2019 barometer survey C5, values do not sum to 100% as some response options have been excluded – see data note on page 130.

## Referrals can be a source of tension between healthcare professionals

Doctors receiving what they deem to be an unnecessary referral is a significant source of pressure for them.<sup>4</sup> For example, secondary care doctors might refer patients back to their GP for the GP to either write a prescription or make another onward referral.<sup>8</sup> This can cause tension between professionals.

The *Everyday leadership*\* research we commissioned reported that GPs felt secondary care and other community practices, such as dentists and optometrists, referred patients on to them for a host of different problems, some of which may be outside of their expertise. This type of referral was often an informal suggestion to the patient that they see their GP about a problem they have raised rather than a formal referral through the system. On occasions it could lead to increased and unrealistic patient expectations:

“ I get somebody coming in with something they have been led to believe that I will solve, and I simply don't have the skills or the training to do that.’

The results of a self-selecting survey† of 616 GPs in England earlier in 2019 reported that doctors received an average of 6.2 inappropriate referrals‡ a month from the NHS 111 service.<sup>42</sup> While a self-selecting sample cannot provide robust evidence, it supports our findings that doctors are receiving patient referrals perceived to be unnecessary or inappropriate.

While some 111 calls may be adding to GPs' workloads, it's relieving pressure in other areas of the system. NHS England reported that the urgent care advice line saved over 12 million unnecessary A&E visits between April 2011 and September 2018.<sup>43</sup>

A report from the Royal College of General Practitioners (RCGP) found medical students experienced negativity towards general practice from academics, clinicians and/or educational trainers especially related to referrals.<sup>27</sup> Nearly two-fifths (37%) of the students reported they have experienced secondary care clinicians criticising referrals they have received from GPs.

The RCGP has acknowledged that referrals are a complex issue and more needs to be done to improve the quality of referrals between primary and secondary care. They published a report in 2018 detailing recommendations to improve referral quality, including more shared learning and improved relationships across primary and secondary care.<sup>44</sup>

Doctors need to have the freedom to use their professional and clinical judgement when making referrals. However, the proportion of doctors who said they've made referrals due to workload pressures and the number of doctors who have received unnecessary referrals shows that the referral system is not working as effectively as it could be. The research we commissioned for this report suggests this is having an impact on patient safety and care.

\* Please see the research and data note on page 130 for more information.

† A self-selecting survey consists of participants becoming part of a study because they volunteer when asked or in response to an advert.

‡ Inappropriate referrals included cases where GPs felt the patient should have gone to A&E or where patients were incorrectly told they needed to see a GP urgently.

## Unnecessary referrals are a patient safety concern

### Having more patients in the system is detrimental to patient care

An increase in referrals leads to more patients in the system, which leads to bottlenecks in services and longer waiting times. By unnecessarily adding more patients into the system, it creates more demand for a health service already stretched and struggling. This may create more cost and problems for care in the future than apparent short-term savings resulting from a quick referral.

### Unnecessary referrals can delay patients receiving the treatment or advice they need and result in undue harm

If a patient is referred on for further treatments or tests that aren't needed, they could be subject to unnecessary risk or stress and, more worryingly, they could be delayed or stopped from receiving the care they need. Unnecessary referrals are a source of pressure for doctors,<sup>4</sup> an increase in referrals could exacerbate workloads.

## How patients experience the referral journey

In 2019, we commissioned a small explorative study to understand patients' views and experiences of the referral journey. The research, carried out by Trajectory, included an initial survey of 527 patients, as well as in-depth qualitative interviews with 35 patients who'd had a range of experiences. Full details of the research and methodology can be found in the research and data note on page 130.

Making a referral requires clinical judgement, so patients are not in the best position to assess whether a referral was medically necessary. Trajectory, therefore, focused on interviewing a selection of patients who were satisfied and those who were dissatisfied with their referral experience.

This research does not allow for wider generalisations to be made from the findings. However, the research did give a powerful insight into this area of healthcare and it showed the key factors that influence patient satisfaction around referrals.

### Most patients were satisfied with their referral experience but one out of 10 felt their referral was unnecessary

Four out of five patients (83%) were satisfied with the way their referral was handled, with only 6% saying they were dissatisfied. However, one out of 10 (10%) thought their referral was unnecessary. Interestingly, most patients who thought their referral was unnecessary were satisfied with their referral experience overall.

The NHS is widely supported by the public. And any criticisms tend to be directed towards how the service is run, rather than towards doctors or other healthcare professionals. Due to the strong support patients and the public have for healthcare professionals, a patient may need to have had a very bad experience to classify themselves as being 'dissatisfied'.

Moreover, the current pressures the NHS is under are commonly known and patients often expect to have long waits between appointments, or to have difficulty in seeing their GP. Therefore, patients may be more willing to accept a lower standard of service than they would in other sectors. For example, in the interviews, a patient who said they were satisfied with their referral was initially misdiagnosed and delayed receiving the right treatment they needed; however, they were satisfied with their overall referral experience.

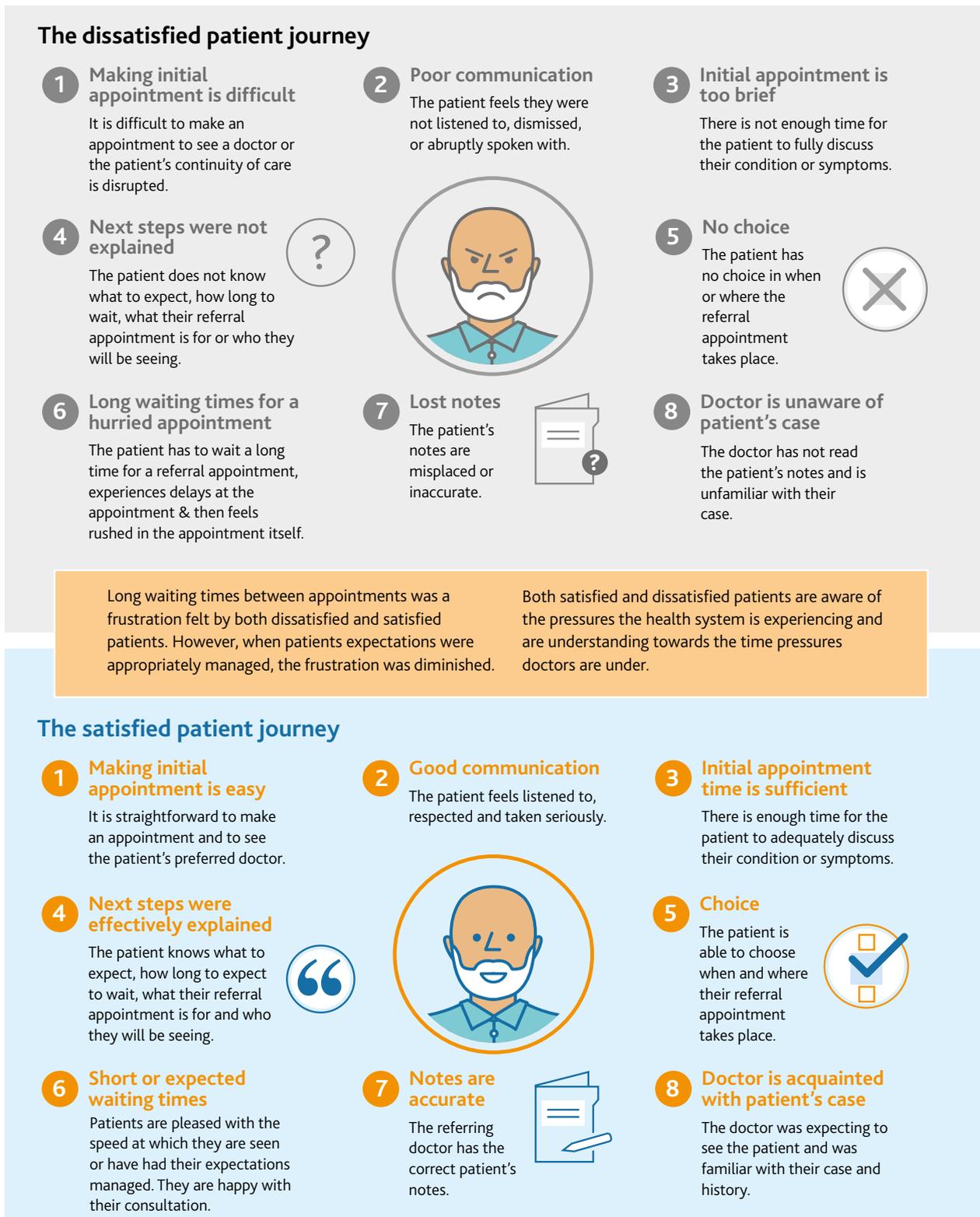
“ Overall, looking at the care I've had from the NHS, I am pleased. I'm not dead!... Once I'd got into the right place and had the right diagnostic tests it was all really really good.' **Male, (satisfied patient)**

## Patients see referrals as reassuring and are happy to be referred

In the interviews, most patients felt happy to be referred. They saw it as reassuring and felt pleased they'd been listened to and taken seriously. While a referral may cause some worry or anxiety, patients said they preferred doctors to take a 'better-safe-than-sorry' approach.

Patients who were satisfied with their referral experienced the health service differently from those who were unsatisfied, although there were some common themes in both groups (see figure 44). For example, there were key differences in whether the practicalities and logistics of the referral worked and in the quality of the patient-doctor interaction. Whereas, both criticism of the speed of referrals and support for the NHS and doctors were common among all patients interviewed.

Figure 44: The dissatisfied patient versus the satisfied patient journey of referrals



## The logistics and practicalities of the referral

### Brevity of initial appointments

Patients were aware of and sympathetic to the time pressures GPs are under and the difficulty of trying to have a thorough discussion in their short appointment. Satisfied patients had no complaints about the length of time they had with their GP. However, among dissatisfied patients not having enough time to fully discuss their condition or symptoms, was a key factor that determined the quality of their experience.

Brief appointments led to dissatisfied patients feeling their GP could have done more for them. Examples included: dietary advice for diabetes, exercises for an injured knee, what to do while waiting to see a consultant or specialist, and providing more information about an illness or condition. The dissatisfaction was exacerbated when there was a very long wait time for a referral.

“ I went in wanting information, not a referral’ **Male, 57 (dissatisfied patient)**

“ No ‘come back and see me in the meantime’...it was ‘go away and wait’ ... He was very matter of fact. He offered no words of advice, support or encouragement to come in again. I was disappointed. I expected that he would have counselled or said come back in’ **Female, 50s, mum of self-harming teen (dissatisfied patient)**

“ He doesn’t talk to you, just refers you. Didn’t examine [my arm] just referred me.’ **Female, 65 (dissatisfied patient)**

In some circumstances, a patient feeling there’s more their GP should have done shows a disconnect between what patients expect and the role of a modern GP. Many of the patients interviewed imagined a ‘one-stop shop’, where their GP could diagnose them or give them more advice about their condition and how to manage it. The UK health system is highly specialised and compartmentalised and therefore it’s entirely appropriate for a GP to act as a gatekeeper and refer patients to other parts of the system. However, it is important that doctors show compassion and recognise when their patients may be distressed or confused and offer advice and reassurance.

The specialised nature of the UK health system means a high proportion of patients are referred to different parts of the system, which – as the evidence demonstrated – may be having an impact on patient care. This raises the issue of the appropriate balance of what might be termed ‘specialist generalists’ and more narrow specialists in the future. We are working with others in the system to consider whether we need to enable a change in this balance, in terms of the structure of medical education.

### Long wait times between appointments are expected

Both satisfied and dissatisfied patients criticised the length of the wait between their initial GP appointment and the referral appointment. However, many patients expected this from a health service under pressure.

A long wait time only seemed to affect a patient’s satisfaction with their referral journey if their expectations at their initial appointment

hadn't been managed well, or if they had some understanding of the way the referral system works.

As patients often had low expectations of wait times, they would wait a while before chasing up an appointment if they hadn't heard anything following their GP's referral. In some cases, when a patient did chase an appointment, they found the referral hadn't been received or had been lost in the system.

“ I chased up after six months of nothing. They [Child and Adolescent Mental Health Services] had lost the referral. We then waited three months for an appointment for triage...I blame myself, I should have chased earlier.' **Female, 50s, mother of a teen, (dissatisfied patient)**

For some patients, the likelihood of a long wait meant they looked at alternative private options outside of the NHS. For example, a patient arranged a private chiropractor appointment after being warned of a six-week wait for physio on her knee, and the mother of a daughter who fainted on the Tube arranged a private consultation after her GP said it might take two months to arrange a specialist appointment.

### Lack of choice of where and when referral takes place

The NHS Choice Framework outlines that patients have the right to choose where to go when they're referred to see a consultant or specialist.<sup>45</sup> Not all patients expected a choice of where the referral would take place and, for many, the appointment time and location they were given were suitable for them.

However, some patients had a lack of choice or flexibility around the timing and location of appointments, and this caused them inconvenience. A patient in Wales had around 20 different hospital referrals for a head injury, but had never been offered any choice of appointment time. And quite often he had to wait between one and two hours at the location of the referral appointments.

There appeared to be more choice around services provided by Allied Health Professions, such as physiotherapists, or hearing assessments.

Some patients were prepared to travel further to get an earlier appointment. Services which were offered on a walk-in basis are convenient to some but less convenient for people with mobility problems or those who are dependent on public transport.

## Patient records and admin issues

### Issues relating to patient records

A common source of frustration for dissatisfied patients were issues relating to their patient records. Lost, deleted or inaccurate notes often lead to delays, or appointments that are inappropriate to case history. And, in extreme cases, they can lead to a patient being given the wrong treatment.

Some patients were very dissatisfied that their notes, scan results or diagnostic results had been lost, or that information had not been shared effectively among healthcare professionals.

“ One department doesn’t seem to know what the other department is doing. They don’t provide information back to your GP. But your GP tends to be your first point of contact. They need the information so that they can tell you.’

**Male, 57 (dissatisfied patient)**

Notes getting lost within the system can be distressing for patients. One patient who had

moved across England, but whose notes did not transfer with them, reported that their new GP refused to believe their pre-diagnosed condition of osteoarthritis. Another interviewee believed that confusion over her notes and hospital records, compounded by doctors not listening and dismissing her, resulted in an unnecessary surgical procedure.

### **Box 3: Case study: system process and admin issues**

Ann, who is in her 60s, was working full time before she had to retire on the grounds of being unfit for work post-surgery. In late 2013, she had a hysterectomy and expected to be off work for three months.

Two months after surgery, she was experiencing continued pain and was referred to physiotherapy. After it was found that physiotherapy was exacerbating the pain, Ann’s GP referred her for an MRI scan on her lower back.

After a 14-week wait, the consultant told Ann she had adhesions and would need further surgery to release them. This was surprising to Ann as this had never been mentioned to her before and she was confused as to how this had been diagnosed. Ann discussed this with her GP who had no idea either. She eventually received a hospital letter with a date for surgery and the instruction to take the medication as discussed in the consultation. No medication had been prescribed or discussed in her consultation.

Ann suspected there was a problem with her notes. She turned to her GP who advised her to either not go for the surgery, or to go but to speak to the consultant beforehand and phone the medical secretary about the medication mentioned in the letter. However, Ann made no headway doing this and the surgery went ahead.

After the surgery, the consultant told Ann he was surprised to find that there weren’t any serious adhesions, ‘but if you get any more problems with your bowels, we’ll get you referred for a colonoscopy’. Ann had never had a problem with her bowels.

Advised by her GP, Ann wrote to the Patient Advice and Liaison Service. It transpired that Ann’s hunch was correct; her notes had been confused with someone else’s. She’d had the surgery based on another patient’s records.

Ann’s had numerous referrals to pain clinics, scans and X-rays but the cause of her pain hasn’t been found. She had to retire from the police as she couldn’t work in such pain and knew she would not pass the fitness test. She’d just been promoted and had loved her job.

## Doctors being unfamiliar with a patient's case

In the interviews with satisfied patients, there were no examples of doctors not having read the notes, or not expecting to see the patient when they arrived. This is in line with broader expectations – once a referral is made, patients expect the referral doctor to have received their notes and records.

Among dissatisfied patients, however, many interviewees said their notes were not read by the doctors they'd been referred to. They felt this was bad practice as it was a waste of time and resources.

Those referred from one specialty to another for the same condition were very frustrated having to 'start all over again' with each specialist. For them, it seemed that no one was reading their notes to see what the issue was and what had happened before.

“ They ask the same questions over and over again. They don't care...they don't check what I've had done. Repeating tests...I'm fed up with telling every doctor from the very beginning. If they read the notes it would be there in black and white. Can they not see all that in their systems and notes? ”

**Female, 28 (dissatisfied patient)**

Medical practitioners can have good reason for asking patients about their case history and symptoms as different practitioners are looking for different things. But, patients do not always feel this is explained clearly. Without this explanation, patients see it as wasteful and evidence that the system is not linked up.

## Quality of the interaction

### Feeling listened to

A key factor influencing patients' experiences of the referral journey was the quality of the interaction in the initial referral appointment. Satisfied patients reported being happy with their interactions and spoke positively about their GP. Dissatisfied respondents, however, were more likely to report challenges with interpersonal communication and interaction. For example, they reported feeling that the GP was abrupt, brusque, or didn't look them in the eye and typed throughout the consultation.

Not being listened to properly and taken seriously was often the most frequent source of dissatisfaction when a patient thought they needed a referral. This was particularly common among female patients, who were more likely to say doctors were rude, and they often felt talked down to, disbelieved, made to feel stupid or dismissed by their doctor.

“ He made me feel like I was making it up. The way he spoke to me was horrible. I'd tell him a symptom and he'd screw his face up. ” **Female, 28 (dissatisfied patient)**

### Box 4: Case study: dissatisfaction with quality of interaction

Megan is a school teacher in her 50s and lives in Wales. For eight months, she's suffered from steadily increasing, and now, excruciating, pain in her groin.

After three visits to her GP, she was given a referral to see a consultant.

She was disappointed with the consultant visit. Without introducing himself, the consultant told her to take her trousers down and felt her groin. He then told Megan that he had no idea what it was, but that he was only

a general consultant and that she'd better have a scan. He left the room before telling Megan what sort of scan she would be having.

Megan was with the consultant for 90 seconds. The nurse had to tell her she was free to go.

The scan results were meant to be back after two weeks. When Megan hadn't heard anything from the hospital, she went back to see her GP, who managed to access the scan results. The results indicated a tumour on her appendix and Megan now has a consultant appointment to discuss this further.

### Knowing what the referral process will involve is important for patient satisfaction

Satisfied patients tended to have clarity about their referral journey – knowing when they would be seen, by whom and what for. Whereas, patients who had a dissatisfactory experience were less likely to feel they had clarity over the referral process. They tended to feel that the referring doctor hadn't given them enough information about what the referral appointment would involve.

For example, some patients arrived at what they expected to be a consultant appointment to find that it was a screening appointment. These patients felt the referring doctor had not explained this clearly enough.

“ I met a physio who further assessed me and said he'd refer me for physio. I explained that I thought this was a physio appointment. He said I had to be assessed by a physio for physio. I had to wait another five weeks for an appointment. I won't say it's a delaying tactic. It's like, yeah, we've got him on the radar. I wasn't best pleased. It's only getting worse'

**Male, 58 (dissatisfied patient)**

Other patients described being confused by the process more generally. For example, one satisfied respondent from Northern Ireland, who was referred for a scan in a Bupa clinic, had not requested a private consultation and was surprised to find himself there. Even in satisfied patients for whom the referral journey has generally worked well, parts of the system remain confusing.

## Improvements that patients would like to see

In the interviews, it was clear that the patients were very much aware of the pressures doctors are under, and that they had a lot of trust and respect for healthcare professionals and the NHS. While most patients retained a positive view, negative experiences can dent this trust.

From the patient perspective, the current referral process is often very slow and inefficient. And patients recognised that, in addition to inconveniencing them, this inefficiency creates a cost to the NHS. For patients there is a cost too – time off work, using large amounts of annual leave, loss of income, loss of lifestyle, an impact on their mental health and wellbeing, an effect on family life and relationships, living with pain, and a loss of trust in the NHS and doctors.

How doctors speak to and behave with patients has a huge bearing on patient satisfaction. A good approach can change how a patient perceives an unsatisfactory outcome of a referral.

Interviewees were asked what improvements they would like to see in the way referrals are handled. Many of their answers are antidotes to the issues illustrated above. They include:

- **communication** – better communication between different parts of the NHS, and doctors listening to patients better
- **treating patients as people and equals** – doctors understanding that a minor medical problem can have a huge effect on a patient's life, displaying more empathy, showing more compassion and understanding, believing patients, being honest, not talking down to patients, and not being defensive
- **clarity about the referral process and reason** – more explanation about the referral process, timings and what to expect, as well as how diagnosis works, and more information about scans and tests
- **doctors being able to refer directly when a condition reoccurs** – some patients were frustrated when the GP was brought back into the process; instead, they would've liked to have been referred directly, without their GP's involvement
- **consistency of care** – seeing the same doctor and not being bounced around the system
- **notes** – more accurate note taking, doctors reading notes, and patients not having to start all over again with every doctor they encounter
- **appointments** – longer appointments, appointments running to time, and appointments in the early morning, evenings and weekends
- **a holistic approach** – treating patients as a whole person – not a series of different conditions, treating the cause and not just the symptoms, and having an independent medically-trained case manager who reviews the situation when a patient is going around the system
- **speed** – above and beyond everything, a quicker referral process.



# Clinical leadership



Effective clinical leadership

is important in shaping positive cultures



Leadership is one of our priorities.

We have an opportunity

and responsibility to help shape effective clinical leadership that supports positive workplace cultures

Progression into formal roles can be haphazard and often unplanned. Doctors rarely undertake specific leadership training, leaving some feeling unprepared

Clinical leadership includes **formal leadership** roles and **everyday leadership** where doctors lead in their day-to-day practice

**Everyday leadership** can be difficult to define, and doctors don't always recognise leadership in their own clinical and professional behaviours

**Formal leadership** roles have both personal and professional benefits for doctors. But they're sometimes seen as expendable and the first thing to be dropped over other clinical priorities



Workplace cultures that are inclusive and compassionate have a positive impact on staff wellbeing and safe patient care

## Leadership and workplace cultures

Effective and compassionate clinical leadership has the power to alleviate some of the challenges within the healthcare system and create positive change.

### Clinical leadership is complex and multifaceted

Clinical leadership has two elements:

- doctors in formal leadership roles, also known as clinical or medical management
- the informal leadership activities that doctors carry out as part of their everyday practice.

These two elements are not mutually exclusive. We recognise all doctors as leaders in their daily practice and publish guidance to this effect.<sup>46</sup> Many doctors will also have some form of additional formal leadership or management role.

In the recently published *Caring for doctors Caring for patients*<sup>5</sup> review of doctors' and medical students' mental health and wellbeing, Professor Michael West reported compassionate leadership as the single biggest driver of positive culture in healthcare. Positive cultures improve workforce morale, motivation, mental health and wellbeing, as well as having a positive impact on the quality of patient care.

The importance of effective leadership in shaping positive cultures is highlighted in four independent research projects we commissioned in 2019.

- *How doctors in senior leadership roles establish and maintain a positive patient-centred culture*<sup>47</sup> – Dr Suzanne Shale, a medical ethicist, explored the lived experiences of doctors in senior leadership roles. The research

looked at doctors' leadership journeys, the everyday challenges they face and how they view their role in shaping their organisation's culture.

- *Everyday leadership*<sup>26</sup> – Newcastle University carried out this UK-wide research, which examined consultants' and GPs' experiences of leadership in relation to their own work, including taking on additional roles and responsibilities.
- *Fair to refer?*<sup>7</sup> – Dr Doyin Atewologun and Roger Kline carried out this UK-wide research to understand why a disparity exists in the referrals we receive from employers and healthcare providers, and to identify recommendations for us and others to act on. Employers and healthcare providers are more likely to make fitness to practise referrals to

us about doctors who gained their primary medical qualification outside the UK, or who are from a black and minority ethnic background, than they are to refer their UK qualified or white peers. This is important as complaints from employers are more likely to result in an investigation being opened. And more likely to result in a sanction being applied, than complaints from other sources.

- *Caring for doctor Caring for patients*<sup>5</sup> – Dame Denise Coia\* and Professor Michael West chaired a UK-wide review of medical students' and doctors' wellbeing. The review focused on:

the working conditions that cause workplace stresses among doctors; the support currently available in healthcare organisations and medical schools to prevent workplace stresses; and how workplace stress and mental health conditions among doctors compare with other professions, both within and outside healthcare.

We'll work with partners to address the findings from these reports, in particular looking at how we shape our work around leadership in the future. We address some of the ways we plan to do this in chapter 7.

## The benefits of good leadership in shaping healthy workplace cultures

### Doctors are more likely to recognise their formal roles as leadership, but these are often the aspects of their work they feel less prepared for

Doctors at all levels across primary, secondary and acute care carry out a range of formal leadership activities. When consultants and GPs were interviewed about their leadership roles as part of the *Everyday leadership* research, many most naturally talked about their formal roles or activities as opposed to their informal duties.

The research found that many of these formal roles were separate from participants' clinical jobs, as an additional role either with the same employer (eg clinical director) or with a different organisation (eg a deanery role, such as training

programme director). These formal roles tended to have dedicated time, and in theory provided a clear separation of time and/or place between jobs, though participants found the 'big mental switch' a challenge when moving between roles.

However, while these roles are separate, they can merge into other areas of clinical practice – some doctors talked about using the leadership skills they have developed in their formal role as part of their clinical practice.

Participants with formal roles in a different organisation felt protected against clinical work spilling into their own time. The separation of having two employers drew a clear line between clinical and leadership time.

\* Professor Michael West and Dame Denise Coia co-chaired this review until May 2019, when Dame Denise Coia stepped down from her role prior to the production of the report because of health problems. Professor West led on the review until its conclusion, but Dame Denise Coia's views up to that point are fully represented in the report.

## Though time consuming, formal leadership roles seem to have personal and professional benefits for doctors

In the interviews, doctors described benefits of having formal leadership roles. Some of these benefits were anticipated and formed part of a doctor's motivation to take on a leadership role, while others were incidental, affecting their enjoyment of the role and desire to stay in it.

One of the key rewards of having a formal leadership role was having a sense of creating lasting change or building a legacy. For these doctors, leadership was about strategic change, not just operational improvement.

Doctors also described how having multiple roles benefited their wellbeing. While participants' clinical areas varied, all spoke of the enjoyment they still gained from patient contact and practising medicine. Many also spoke of the satisfaction and enjoyment of their formal leadership roles.

Some felt they were able to be more imaginative and creative in their leadership roles than they were with direct patient care. Doctors talked about formal roles giving them the freedom to explore their interests beyond clinical practice. Some spoke of enjoying the variety that formal roles brought into their work. And others simply appreciated the break they offered from the pressures of clinical work – they felt this helped them to 'keep fresh' and maintain their enthusiasm for their clinical work.

Although many participants appreciated the opportunity to take a break from clinical practice, almost all interviewed doctors spoke of how valuable their clinical work was to their

formal roles. They talked of the importance of 'understanding what's happening on the ground' to be the most effective leader. Many felt their roles were mutually reinforcing; having a 'foot in both camps' made them both better leaders and better clinicians.

The research did highlight a few negative aspects associated with doctors taking on additional roles. These were largely based around having enough time to get things done. Some doctors described their formal roles as 'thankless', that there was considerable responsibility without the tangible reward of clinical work. Furthermore some suggested that being a formal leader can be a challenge for team working, as at times they may have to exert authority over a clinical colleague in the course of their formal role.

The overall sense was that, while formal leadership roles had a variety of benefits for wellbeing, these roles were expendable. They would be the first thing that doctors would push aside when time had to be prioritised towards clinical practice.

In the *What it means to be a doctor*<sup>9</sup> research reported in *The state of medical education and practice in the UK: 2018*,<sup>4</sup> almost a quarter of doctors (23%) reported they felt increased leadership requirements had a positive impact on their work. A further fifth (21%) said they felt increased leadership requirements had both a positive and a negative effect. This supports the findings from the *Everyday leadership* research, which found that some doctors felt conflicted about their leadership roles – while the roles could be a strain on their time, they offered benefits to their wellbeing at the same time.

## Inclusive and compassionate workplace cultures have a positive impact on doctors' wellbeing and, crucially, on the quality of patient care

The recently published *Caring for doctors Caring for patients*<sup>5</sup> review of doctors' and medical students' wellbeing found that NHS organisations with inclusive and compassionate cultures foster fairness and promote good wellbeing among their staff. The review found that a sense of autonomy, control and belonging, as well as a feeling of competence, were crucial for doctors' wellbeing. By supporting these elements, nurturing cultures enable doctors to provide safe and compassionate care to patients.

Research carried out by Dr Suzanne Shale on senior leadership roles found that there's no single understanding of positive culture among senior clinical leaders. Notions of culture are rich, complex and varied; largely based on individual understandings of organisational culture. Senior clinical leaders tend not to see culture as a 'thing' that they specifically set out to improve. Rather, their everyday leadership activities shape organisational cultures through what is described as cultural housekeeping.

The *Caring for doctors Caring for patients*<sup>5</sup> and the *Fair to Refer?*<sup>7</sup> research both made key recommendations for establishing workplace cultures that are collective and nurturing and that focus on accountability and learning rather than blame. Positive culture is not only good for doctors' wellbeing but facilitates a working environment in which patient care is safe and compassionate.

## Everyday leadership can be difficult to define and often goes unrecognised by doctors, but it's crucial for shaping positive workplace cultures

While doctors seem clear about the leadership inherent in their formal roles, everyday leadership appears less tangible and doctors don't always recognise leadership in their own clinical and professional behaviour (figure 45).

The *Everyday leadership* research found that day-to-day leadership activities weren't always recognised by individuals. One GP described how they had identified an issue with the appointment system in their practice, designed a solution and introduced it to the other partners, yet only during the interview conceded 'I suppose that is leadership'.

Day-to-day leadership may be a function of workplace systems, meaning that GPs and consultants developed their leadership roles because it was what was expected of them. For example, one participant described how they were alerted to errors, which they were responsible for investigating, despite not being aware of this responsibility beforehand. This is illustrative of how some doctors may have additional responsibilities imposed on them by the system, rather than it being their choice. Where a role or activity was imposed, participants didn't always recognise this as a leadership responsibility.

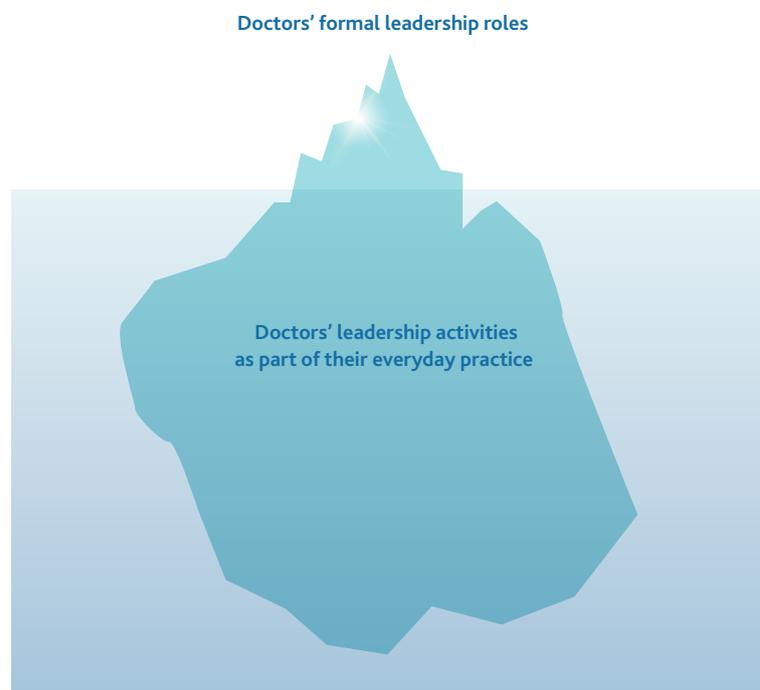
## There are differences in leadership between primary and secondary care

The position of the GP partner is very different from that of a hospital-based consultant. As self-employed contractors, GP partners have significantly more autonomy than consultants in hospitals. It's notable that the consultants who participated in the *Everyday leadership* research identified governance structures as a key barrier to leadership, whereas no GP partners did.

This autonomy makes general practice a fertile ground for innovation. However, particularly in small practices, with greater autonomy can come less leadership capacity.

Across all areas of medical practice, doctors identified a lack of time as the key barrier to leadership. In general practice, GP partners technically have control over the number of clinical sessions they undertake, which should, in theory, allow time for leadership and innovation. However, meeting clinical demand and managing the business side of the practice may eat into this time. Even if the practice has the resources to take on a salaried or locum GP colleague to address some of the time constraints, there's no guarantee that the practice will be able to recruit from an already stretched workforce.

Figure 45: Elements of clinical leadership



## **We must take a multi-professional view of leadership to make sure organisations have inclusive cultures and productivity is maximised**

It's important to have effective leadership from all those working on the frontline of healthcare. By recognising that different professional groups/individuals hold specific knowledge and expertise, it's possible to maximise productivity by making sure that the right skills are brought to the fore with the right people at the right time.

In July 2019, we announced that we'll be regulating physician associates and anaesthesia associates, who, along with other medical associate professionals, make up a crucial part of a multi-professional workforce.

Multi-professional working is becoming increasingly common throughout the health service in all four countries of the UK, particularly with the push for better integrated services in primary and community care.

The *Caring for doctors Caring for patients*<sup>5</sup> report highlights the need for compassionate leadership and effective team working. It also highlighted how beneficial both team working and good colleague relationships can be. However, it stressed that these communities of colleagues must be inclusive of all members of multi-professional teams, or risk isolating some healthcare professionals.

## Current challenges to effective clinical leadership

### Progression into formal leadership roles can be haphazard, and doctors rarely undertake specific leadership training

The *Everyday leadership* research revealed that progression into formal roles is haphazard and often unplanned. In the interviews, doctors discussed being approached to apply for roles, rather than seeking them out. While there were some examples of doctors deliberately pursuing formal leadership progression via intermediate positions (such as progressing from an associate medical director to a medical director) there did not always appear to be a clear career path.

The interviewed doctors in formal leadership roles often described their progression into these roles as being 'opportunistic' and 'random'. Opportunities for new roles often came from ad hoc invitations or suggestions from senior colleagues. Some of these were a function of simply being in the right place at the right time. But others suggested it was about being the right person – a more deliberate, or even strategic, decision on the part of the proposer.

Leadership opportunities vary according to organisational or geographical context. Doctors practising in small and remote communities may have limited awareness of, or very little access to, additional leadership opportunities. But, conversely, it could mean that they have more opportunities available to them because there are fewer possible candidates for the roles.

The interviewed doctors said they often felt underprepared for the leadership elements

of their work, such as chairing meetings, writing a business case, or managing poor staff performance. These responsibilities are generally not part of the specialty training curricula, where clinical skill development is the priority.

Several participants said they had undertaken leadership courses during the latter stages of their training programme, although one noted it would have been more useful had they done it once they had had the experience of working as a consultant. Another felt that some consultants were rushed into formal leadership roles and felt fortunate they had worked as a consultant for a year before taking on a formal role.

Notably, none of the doctors interviewed referred to any education or training in leadership or management before specialty training. Doctors mostly talked about their skills and knowledge evolving through learning in practice once in a leadership role.

### Negative cultures enable unprofessional behaviour, such as bullying, harassment and discrimination, with consequences for doctors' wellbeing

*Caring for doctors Caring for patients*<sup>5</sup> reported the impact of system pressures on negative cultures, with the endemic strain from high workloads contributing to higher levels of bullying, harassment and discrimination. The doctors who participated in the review identified a lack of fair or transparent procedures around bullying and discrimination as a key element of negative workplace cultures.

In a survey carried out in 2018, the BMA found that two-fifths of doctors felt bullying and harassment were a problem in their workplace.<sup>48</sup> In the 2017 NHS England staff survey, a fifth of doctors reported experiencing bullying or harassment in the preceding 12 months. When looking at NHS staff overall, around half of those who had experienced bullying or harassment had reported the issue, compared with only one out of three doctors who did so.<sup>49</sup>

In research to better understand bullying and harassment in the medical profession, the BMA asked doctors why they felt bullying and harassment were an issue in their workplace. The two most common responses were:

- people are under pressure (65%)
- it's difficult to challenge behaviour that comes from the top (58%).<sup>50</sup>

These examples highlight the critical role that system pressures and culture play in enabling unprofessional behaviours. Both the *Caring for doctors Caring for patients*<sup>5</sup> review, and the *Fair to Refer?*<sup>7</sup> research raised the need for compassionate and inclusive leadership, to create more positive cultures that don't validate such behaviours.

When quality-assuring medical training environments, we check that effective leadership and good workplace culture are in place. If we think standards in this area are not being met, and that local action is not adequately addressing the issues, we can use our enhanced monitoring to help drive improvements. Departments under enhanced monitoring are expected to put clear plans in place to show how they will make changes to achieve the specific standards we have flagged up as not currently being achieved. And across the UK we work closely with education and improvement bodies, and deaneries to drive improvements in the departments we have concerns about.

## Systemic opportunities to improve leadership

### Organisations can support doctors in leadership roles by improving the culture of leadership at all levels

Good organisational leadership depends on formal leaders who are effective communicators and who can listen well. In turn, this can help enable staff at all levels to lead effectively.

Part of this is recognising leadership in all its forms – from day-to-day leadership, to formal management roles. And providing support for individual doctors to transition into leadership roles. Providing support to avoid or mitigate pressures associated with transitioning into a leadership role can help doctors' wellbeing and make roles more attractive, and, more sustainable.

While improving leadership culture is important, there must also be guidance and appropriate materials to enable capacity for leadership. In secondary care, this could be the realistic representation of leadership responsibilities in job plans. In primary care, partners have more flexibility and autonomy in how they allocate their time, but not all practices have income to employ salaried GPs to make use of that time. Some areas of practice will require more attention, and resources, than others – whether because of staffing issues or clinical workload – and so equity may not be achieved through equal investment, but rather investment where appropriate.

All doctors need to be aware of the full range of formal and informal leadership roles within medicine. And to be sustainable, access to

those roles must be equal, to capitalise on the motivation that doctors bring to their work. At present, opportunity is often linked to being in the right place at the right time, and while this may be effective, there are risks for individuals or roles being under-served, as well as implications for equality, diversity and inclusivity. There are also questions about whether leadership roles can be more open to a wider constituency, such as SAS and LE doctors and salaried GPs.

### We're committed to taking forward the wealth of recommendations from the research and reviews we've commissioned, ultimately to support doctors

As the reviews and research projects that have contributed to the evidence base for our work around *Supporting a profession under pressure* draw to a close, we are working hard to shape our response to the recommendations made. Culture and leadership have emerged as key themes. It's crucial to recognise the vital role that leaders across the health service play in creating the nurturing cultures that protect wellbeing and enable high-quality patient care.

We believe that our position and regulatory levers – particularly in education and training – afford us a unique opportunity and responsibility to act. In 2020, we will focus on our strategic partnerships with others in the system. In particular we'll work with the Care Quality Commission and NHS Improvement in England on the *Well-led* programme,\* and we'll continue to work with the Faculty of Medical Leadership and Management.

\* *Well-led* is a national leadership development programme for managers of adult social care services working in the private, public or third sectors.



# What needs to be done



Grow the medical workforce to meet current shortages and future demand

Explore more flexible routes onto the medical register and more flexible career paths for an internationally mobile workforce

**Support new models of care, new professions, and multi-professional working**



Make medical education and training more flexible and targeted to priority areas in national workforce strategies

Work together across the healthcare system with effective joined-up regulation

Better planning and resourcing of leadership to achieve inclusive, compassionate workplace cultures everywhere

## Introduction

In this report, we have laid out the issues faced by doctors and regulators in a changing healthcare environment. We have presented research and analysis that adds to the understanding of the daily challenges doctors face. We also highlight factors that can protect doctors and patients from the impact of current pressures.

As we continue to work to keep patients safe and support the medical profession, we are working with doctors and other organisations to identify priorities for action. The challenges are wide-ranging and require many different approaches to address them. National workforce

strategies recognise that a range of these need to be priorities. In this chapter, we highlight some of the work we are currently doing, or are planning to introduce, that will support the national workforce strategies and begin to meet the challenges highlighted throughout this report.

## Action is needed in five key areas

On the supply side, immediate action is needed across the UK in five key areas:

- increasing the size of the medical workforce
- making education and training more flexible and more targeted to areas national workforce strategies identify as priorities
- improving workplace cultures and wellbeing
- working towards joined-up regulation
- supporting multi-professional working.

We are already working with our partners in the health system to address the challenges in these five key areas.

In the long-term, demand on the health service needs to be reduced. Demand can be managed through public health initiatives and clear care pathways, which only involve doctors where necessary. Next year, we will be exploring to

what extent we can support efforts in these areas.

### Workforce supply

Workforce supply issues – highlighted in chapter 2 and in our *Workforce report*<sup>3</sup> – are having a noticeable and negative impact on patients, doctors, and the wider healthcare system.

A sustainable supply of doctors is reliant on:

- increasing the supply of doctors from overseas to fill immediate workforce gaps – medical practitioners have recently been added to the shortage occupation list and we will be monitoring our data closely to understand how this is affecting the workforce
- increasing the proportion of doctors who are expert generalists and developing new professions such as Medical Associate Professions, to support new models of care

- using UK training posts and other routes, expand the number of doctors in specialties that long-term plans anticipate will be in high demand. This is particularly important in psychiatry, emergency medicine, and radiology
- improving retention – particularly through supporting doctors’ wellbeing as described below.

Our contribution to the first three of these is covered in our *Workforce report*. Much of this report has implications for improving medical education and training pathways, and for retention.

## Medical education and training

### Flexible training pathways and continuing professional development (CPD)

We are exploring how to maximise the flexibility of training pathways, enabling doctors who wish to learn new skills to avoid the ‘snakes and ladders’ effect of restarting training. This may help build on the increase in older doctors embarking on specialty and GP training that we have seen recently. A trend that shows doctors are increasingly moving to new areas of practice where they can benefit from additional CPD.

In chapter 2, we highlight the importance of CPD for doctors’ wellbeing, but our data show there is currently insufficient time for it. A greater variety of credentialing is likely to form part of the solution. We are working with five early adopters for GMC-regulated credentials (liaison psychiatry, remote and rural medicine, cosmetic surgery, pain medicine, interventional neuroradiology - acute stroke). If these are successful, we expect to roll out further ones.

### Generic, transferable skills

We are increasingly encouraging medical schools and training providers to focus on generic capabilities – the transferable skills that will give doctors more flexibility in their career, as well as improving standards of patient care. These will be a key part of the new Medical Licensing Assessment that we will be introducing from 2023.

Last year, we updated our guidance on the knowledge and capabilities we expect from newly qualified doctors. This guidance now recognises the importance of generic capabilities. We are also reviewing all medical schools’ curricula to make sure that they reflect the common skills requirements and share curriculum elements where possible and appropriate. Our new *Outcomes for graduates*<sup>51</sup> comes into effect from next year and puts greater emphasis on generic skills. This is not just in terms of medicine, but in areas such as using emerging medical technologies effectively.

### Workplace and wellbeing

It’s crucial that doctors are practising in workplaces that support their wellbeing. The system must work together to:

- better plan and resource clinical leadership
- spread good practice in supporting the wellbeing of a diverse, international workforce
- improve induction and support for doctors new in a role or new to an organisation. This is especially important in the context of a more mobile and flexible workforce with increased focus on multi-professional working.

These improvements will be critical for retention, as well as for doctors’ wellbeing and patient care.

## Supporting a mobile and flexible workforce

Effective communication between professionals is vital, as is induction at multiple levels; for returners, at career transition points, and for doctors new to the UK or to an organisation. Both of these are necessary in an increasingly mobile and flexible workforce. To better understand what's needed to support doctors in these areas, we are carrying out research into issues surrounding both communications skills and induction. We will report the findings in 2020.

In the meantime, we'll continue to play our part in improving induction, through programmes like *Welcome to UK practice*. We've considerably expanded the number and reach of these free sessions, which our Regional Liaison Service run for overseas doctors who are new to practising in the UK. We will publish research on induction more generally next year.

## Wellbeing

In chapter 2, we highlight that many doctors feel unable to strike an appropriate balance between their own wellbeing and delivering the care they wish to. While many people across the UK struggle with work-life balance, it affects a large proportion of doctors.

We recently published the findings and recommendations of *Caring for doctors Caring for patients*.<sup>5</sup> This UK-wide review of medical students' and doctors' wellbeing, jointly chaired by Professor Michael West and Dame Denise Coia formed part of our *Supporting a profession under pressure* programme. The recommendations push for safe, nurturing environments where doctors work in coordinated and well-led multidisciplinary teams. There is an emphasis

on letting doctors have more say in how their teams are run and the work that they do. The importance of good support and supervision as well as a manageable workload is also discussed.

From 2020, we will begin delivering their recommendations. In some cases, we have been asked to use our systems to monitor the areas of concern, such as using our national training surveys to check that doctors in training have access to basic facilities like rest areas and effective IT systems. In other recommendations, we have been challenged to be more proactive, such as producing guidance for multidisciplinary team working, or assuring progress in healthcare teams towards allowing doctors to have more influence in how medicine is delivered.

## Inclusive cultures

Encouraging an inclusive, supportive culture in all work settings is critical. We have established a Strategic Equality, Diversity and Inclusion Advisory Forum in response to recommendations in the *Fair to Refer?*<sup>7</sup> research we commissioned from Roger Kline and Dr Doyin Atewologun. The forum aims to make sure we are more inclusive in the way we engage with the profession, by promoting fairness and equality in regulation.

The report recommended that doctors who are new to the UK and doctors who work in more isolated roles, such as SAS or locum doctors, need more support. We have continued to expand our successful *Welcome to UK practice* programme for doctors from abroad, and offer workshops and support to SAS and locum doctors through our field teams.

The report also recommended that there needs to be more engagement and positive leadership across the NHS, as well as working environments

that prioritise learning over blame culture. We will monitor these through our existing channels, and work to highlight the lessons around leadership and learning culture that are highlighted through the research in this report.

We are also reviewing our efforts to improve the quality of our equality data, which will allow us to better understand the extent to which different doctors are being treated fairly. We will continue to use this more inclusive insight to inform all aspects of our work.

### Medical students

The challenges doctors and the health systems face also affect medical students. We are working with medical schools to explore and reduce differential attainment – the discrepancies in different groups of doctors’ progression and performance at medical schools. We are also focussing on medical student wellbeing. The *Caring for doctors Caring for patients*<sup>5</sup> review considers the needs of medical students. One recommendation is that all educational and training organisations need to have well-trained and compassionate supervisors, using our guidance on *Promoting excellence – standards for medical education and training*<sup>52</sup> as the basis for this support. Another specifically highlights the importance of fair outcomes and flexibility in training – this includes recommendations specifically tailored for undergraduate and postgraduate medical trainees. Our standards require medical schools to demonstrate how they are supporting students, as well as reducing differential attainment.

### Leadership

Leadership has a pervasive importance to both doctors’ wellbeing and workforce retention. Positive leadership can create a fair and inclusive culture that encourages an openness to raise and act on concerns. And in turn, a positive culture enables people to lead more effectively. Doctors can be great, inspiring leaders and they play a crucial role in setting the tone and culture of an organisation.

Good leadership does not happen by chance, but by design. Leaders need support and mentoring from the board or executive level down, as well as upward support from colleagues.<sup>5</sup>

In the coming year, we will continue to work closely with partners in all parts of the UK. In particular, in England we are working closely with the Faculty of Medical Leadership and Management, and with the Care Quality Commission to develop the well-led domain. We are also working closely with the Scottish Government’s Short Life Working Group on Culture in the NHS and the leadership development programme, Project Lift, to consider how we align our work in Scotland.

### Regulation

The UK’s health services and broader systems must work together to address challenges. This includes having regulation that enables the growth of new professions and roles that support new models of care. This could significantly improve the working lives of all those in the UK’s health services, as well as the quality of patient care.

## Aligning regulation

As new models of care develop, bringing with them new professional roles and more multi-professional team working, it is becoming even more essential that regulation is aligned and efficient, avoiding unnecessary duplication. We are positively engaged with the relevant regulatory and quality improvement bodies in all UK countries to achieve this, although in some instances legislative change would improve how far we can go.

## Multi-professional working

### Medical Associate Professionals

We see taking on the regulation of physician associates and anaesthesia associates, two rapidly growing Medical Associate Professions, as a very important contribution we can make to the capacity and productivity of the health services. It also offers these professions important opportunities for progression. Many doctors have reported frustrations both about working frequently outside their professional roles, and not having the right support to deliver the care they would like to. Part of the solution to both issues is more working in multi-professional teams, which include these new professions.

We recognise the concerns that some of the profession have in us taking on this new regulatory role. We will address their concerns as we plan detailed implementation of this new regulation.

## Our path from 2020

The data and insight in this report are helping us develop a ten-year vision for the type of regulation needed to meet the needs of the changing and challenging healthcare environment. We will also be informed by a ten-year historical perspective as we publish our 10th *state of medical education and practice* in 2020. This long-term view will inform our next corporate strategy, which will run from 2021 to 2025.

A key part of this strategy will be maximising our general contribution to system-wide analysis of risks and opportunities. We will continue to make the most of our expertise and regulatory powers to assure medical education and training, register and license doctors.

In addition to these roles, we will continue to pursue regulation that supports the system and profession to prevent medical practice problems occurring, rather than just implementing fitness to practise processes after the problems have happened. The data in this report show that when workplaces are not supportive of professional standards, there is a measurable impact on patient safety. This remains our main responsibility.

Urgent actions need to be taken to tackle some of the issues highlighted in this report, and to build on the progress that various workforce strategies are beginning to make. The coming months and years will see us prioritising activity in the five key areas in which action is required: workforce supply, medical education and training, workplace and wellbeing, multi-professional working, and regulatory development.

# Glossary

BMA	British Medical Association
CCG	Clinical commissioning group
CCT	Certificate of completion of training
CT ( <i>followed by number</i> )	Core training
CDP	Continuing professional development
CQC	Care Quality Commission
F1	Foundation year one
F2	Foundation year two
GMC	General Medical Council
KSS	Kent, Surrey and Sussex
LE	Locally employed doctors
LGI	Leeds General Infirmary
LTFT	Less than full time
MLE	Monitoring Learning Environment
PLAB	Professional Linguistic Assessment Board
RCGP	Royal College of General Practitioners
SAS	Staff grade, specialty and associate specialist doctors
SJUH	St James's University Hospital
ST ( <i>followed by number</i> )	Specialty training
UKMED	UK medical education database

# A note on research and data

Much of the analyses and data in this report have been drawn from primary research and from the information we collect when registering doctors, assuring the quality of medical education and training, and assessing doctors' fitness to practise.

Percentages in all tables are rounded and may not add up to 100%.

## Commissioned primary research

Over the last year, we have commissioned a number of independently delivered research projects exploring the experiences of doctors in the UK. The research methods of each of these are outlined below.

### The barometer survey 2019

This research was carried out by IFF Research and was designed to build on the insights into doctors' perspectives on their practice gained from two studies which fed into *The state of medical education and practice* report 2018 – *Adapting, Coping, Compromising* and *What it means to be a doctor*. The research is intended to provide a baseline for annual tracking of doctors' career intentions, their experiences in the workplace, and any adaptations they are making to cope with pressurised environments. It does this by taking the questions from the two 2018 studies and including some additional questions around scope of practice and intentions to leave the medical profession.

A sample pool of doctors were questioned in this research. This pool was selected to reflect, as far as possible, the characteristics of the UK's overall doctor population. Over June and July 2019, a total of 3,876 doctors currently working in the UK were surveyed via an online survey. The results were weighted against GMC population data on the basis of age, registration status, ethnicity and place in which primary medical qualification was gained.

### Less than full-time working

Due to the complexity of doctors' contracts and working hours, it can be difficult to define how many doctors are working less than full-time.

In the 2019 barometer survey participants were asked to state how many hours they were contracted to work each week. From this, an approximate measure was taken of the proportions working less than full-time or full-time.

Approximates were based on full-time hours as:

- 37.5hrs per week for GPs
- 40hrs per week for Specialists, specialty and associate specialist doctors and locally employed doctors, and doctors in training.

Any doctors who stated that they were working fewer than the full-time hours listed for their register type have been classed as working less than full-time.

These full-time hours are approximate only and will not reflect the contracts of all doctors. They provide an indication of the proportion of workforce who appear to be working less than full-time or full-time.

## Open responses

The 2019 barometer survey asked a number of questions which offered participants the opportunity to make an unprompted, free text response.

For example:

A2. Why do you say that you are satisfied/ dissatisfied in your day to day work as a doctor?		
WRITE IN		
Don't know	1	
Prefer not to say	2	

The free text responses by all participants have been analysed and coded for key themes. Counting the occurrence of these themes forms the basis for the quantification presented in this report.

## Net values

NET values are used when similar questionnaire responses have been grouped to give an overall figure. For example, the values of responses 'satisfied – 20%' and 'very satisfied – 22%' are combined into 'NET satisfied – 42%'.

## The importance of support

Support emerged as a key theme in *Caring for doctors Caring for patients*. For this report, the responses to questions C1\_5/6/7 have been used to explore the relationships between support from a range of colleagues and other experiences in the workplace. In the survey the questions were phrased:

*How frequently, if at all, over the last year have you experienced the following? Felt unsupported by my immediate colleagues/senior medical staff/non-clinical management*

This phrasing was based on doctors' discussions of feeling unsupported in research carried out in 2018. In reporting this year, 'never feeling unsupported' has been used as a proxy for support. This has necessitated using some double negatives in the discussion.

## Understanding patients' experiences of referral

This research was carried out by Trajectory on behalf of the GMC.<sup>53</sup> An initial quantitative phase was carried out during May 2019 via an online survey of 527 patients who had experienced a referral in the previous two years. This was an explorative survey to inform the more substantive qualitative phase.

The qualitative element consisted of 35 in-depth interviews with patients across the UK. This was a mix of face-to-face and telephone interviews. It included patients who were dissatisfied with their referral experiences (25 interviews) and those who were satisfied (10 interviews). This sample was not designed to reflect the population, although there were a range of ages, ethnic backgrounds and long-term disability or impairment, as well as an even gender split. The sample was weighted more towards those who were dissatisfied with their experiences as it was

felt that these views would provide more insight into the challenges faced by the system.

## Everyday leadership

This research was carried out by the School of Medical Education at Newcastle University on behalf of the GMC. Semi-structured telephone interviews were carried out with 22 consultants (10 male, 12 female) and 10 GPs (4 male, 6 female) across the UK, identified by 'snowball' sampling through professional networks. Consultants represented a range of clinical specialties. Participants had been in consultant or GP posts for periods ranging between 1 and 30 years.

Interviews covered the content of participants' work, their perceptions of leadership, how they felt about different aspects of work, and their future plans. Inductive thematic analysis was carried out on the interview transcripts.

## GMC surveys

The GMC has undertaken research to help direct priorities and to keep up to date with the experiences of doctors and doctors in training. As in previous years, this research is used in *The state of medical education and practice in the UK*.

### The national training surveys

Every year, the GMC surveys doctors in training to get their views on their training and the environments where they work. The surveys also ask trainers to report their experience from

their perspective as a clinical and/or educational supervisor. These findings have been included in previous editions of *The state of medical education and practice in the UK*.

The 2019 national training survey was open from 19 March to 9 May. Doctors in training were asked about the post they were in on 19 March 2019. The results were calculated using all valid responses. The results for the indicators for both trainees and trainers are published in an online reporting tool with filters to explore the data for deanery, trust/board and site.

## Our data

Our in-house data in this report were primarily drawn from the information we collect when registering doctors, assuring the quality of medical education and training, and assessing doctors' fitness to practise.

### Data on medical students and doctors in training

Data about medical students by academic year between 2011 and 2019 came from the medical schools' annual reports to us.

The number of doctors in postgraduate training programmes is from data that Health Education England local teams and deaneries in Northern Ireland, Scotland and Wales provided in the 2019 national training surveys – it was accurate on 19 March 2019.

# References

- 1 Nuffield Trust (2019) *Human: solving the global workforce crisis in health care* available at <https://www.nuffieldtrust.org.uk/news-item/human-solving-the-global-workforce-crisis-in-health-care> (accessed 20 November 2019)
- 2 World Health Organization (2017) *Action to avert an 18 million health worker shortfall announced at the 4th Human Resources for Health Forum in Dublin* available at <https://www.who.int/hrh/news/2017/action-to-avert-an18-million-health-worker-shortfall/en/> (accessed 20 November 2019)
- 3 General Medical Council (2019) *The state of medical education and practice in the UK: The workforce report* available at [https://www.gmc-uk.org/-/media/documents/the-state-of-medical-education-and-practice-in-the-uk---workforce-report\\_pdf-80449007.pdf](https://www.gmc-uk.org/-/media/documents/the-state-of-medical-education-and-practice-in-the-uk---workforce-report_pdf-80449007.pdf) (accessed 20 November 2019)
- 4 General Medical Council (2018) *The state of medical education and practice in the UK* available at <https://www.gmc-uk.org/-/media/about/what-we-do-and-why/data-and-research/somep-2018/version-one---0412pm/somep-book-20187pdf?la=en&hash=4368CA4DBF85A811AF171B70C4CD45843COD5E7A> (accessed 01 November 2019)
- 5 West M and Coia D, (2019) *Caring for doctors, Caring for patients* available at [https://www.gmc-uk.org/-/media/documents/caring-for-doctors-caring-for-patients\\_pdf-80706341.pdf](https://www.gmc-uk.org/-/media/documents/caring-for-doctors-caring-for-patients_pdf-80706341.pdf) (accessed 20 November 2019)
- 6 Hamilton L (2019) *Independent review of gross negligence manslaughter and culpable homicide* available at [https://www.gmc-uk.org/-/media/documents/independent-review-of-gross-negligence-manslaughter-and-culpable-homicide---final-report\\_pdf-78716610.pdf](https://www.gmc-uk.org/-/media/documents/independent-review-of-gross-negligence-manslaughter-and-culpable-homicide---final-report_pdf-78716610.pdf) (accessed 10 October 2019)
- 7 Atewologun D and Kline R (2019) *Fair to refer? Reducing disproportionality in fitness to practise concerns reported to the GMC* available at [https://www.gmc-uk.org/-/media/documents/fair-to-refer-report-pdf-79011677\\_pdf-79021583.pdf](https://www.gmc-uk.org/-/media/documents/fair-to-refer-report-pdf-79011677_pdf-79021583.pdf) (accessed 10 October 2019)
- 8 Community Research (2019) *Adapting, coping, compromising* available at: <https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/research-and-insight-archive/adapting-coping-compromising-research-exploring-the-tactics-and-decisions-doctors-are-applying> (accessed 12th November 2019)
- 9 Comres (2019) *What it means to be a doctor* available at [https://www.gmc-uk.org/-/media/documents/what-it-means-to-be-a-doctor-report\\_pdf-79704293.pdf](https://www.gmc-uk.org/-/media/documents/what-it-means-to-be-a-doctor-report_pdf-79704293.pdf) (accessed 01 November 2019)
- 10 General Medical Council (forthcoming) *Barometer Survey*

- 11 Tage S. Kristensen, Marianne Borritz, Ebbe Villadsen & Karl B. Christensen (2005) *The Copenhagen Burnout Inventory: A new tool for the assessment of burnout*, *Work & Stress*, 19:3, 192-207, DOI: 10.1080/02678370500297720
- 12 General Medical Council (2012–2019), *National Training Survey* available at <https://www.gmc-uk.org/education/how-we-quality-assure/national-training-surveys> (accessed 15 November 2019)
- 13 General Medical Council (2018), *Training environments 2018* available at [https://www.gmc-uk.org/-/media/documents/training-environments-2018\\_pdf-76667101.pdf](https://www.gmc-uk.org/-/media/documents/training-environments-2018_pdf-76667101.pdf) (accessed 15 November 2019)
- 14 General Medical Council (2019), *Enhanced monitoring reports* available at <https://www.gmc-uk.org/education/reports-and-reviews/enhanced-monitoring> (accessed 15 November 2019)
- 15 Home Office (2019) *Expansion of the shortage of occupation list* available at <https://www.gov.uk/government/news/expansion-of-the-shortage-of-occupation-list> (accessed 15 November 2019)
- 16 General Medical Council (2018) *Training pathways 2: why do doctors take breaks from their training?* available at [https://www.gmc-uk.org/-/media/documents/dc11392-training-pathways-report\\_pdf-75268632.pdf](https://www.gmc-uk.org/-/media/documents/dc11392-training-pathways-report_pdf-75268632.pdf) (accessed 15 November 2019)
- 17 General Medical Council (2019) *Education data reporting tool* available at <https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/national-training-surveys-reports> (accessed 15 November 2019)
- 18 Dowell J et al., (2018) 'The UK medical education database (UKMED) what is it? Why and how might you use it?' , *BMC Medical Education*, available at <https://bmcmmeduc.biomedcentral.com/articles/10.1186/s12909-017-1115-9> (accessed 15 November 2019)
- 19 University of Dundee (n.d.) *HIC Safe Haven* available at <https://www.dundee.ac.uk/hic/hicsafehaven/>. (accessed 15 November 2019)
- 20 Kumwenda B, Cleland J, Prescott G et al., (2019), '*Relationship between sociodemographic factors and specialty destination of UK trainee doctors: a national cohort study*' *BMJ Open* available at <https://bmjopen.bmj.com/content/9/3/e026961.info> (accessed 22 November 2019)
- 21 Smith D T and Tiffin P A (2018) '*Evaluating the validity of the selection measures used for the UK's foundation medical training programme: a national cohort study*' *BMJ Open* available at <https://bmjopen.bmj.com/content/8/7/e021918.info> (accessed 22 November 2019)

- 22 Woolf K, Jayaweera H, Unwin E, et al (2019) 'Effect of sex on specialty training application outcomes: a longitudinal administrative data study of UK medical graduates' *BMJ Open* available at <https://bmjopen.bmj.com/content/9/3/e025004.citation-tools> (accessed 22 November 2019)
- 23 NHS Digital (2019) *Appointments in general practice* available at <https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice/march-2019> (accessed 01 November 2019)
- 24 NHS England (2013) *Transforming primary care in London* available at <https://www.england.nhs.uk/london/wp-content/uploads/sites/8/2013/11/Call-Action-ACCESSIBLE.pdf> (accessed 01 November 2019)
- 25 Royal College of General Practitioners (2019) *Fit for the future: a vision for general practice* available at <https://www.rcgp.org.uk/-/media/Files/News/2019/RCGP-fit-for-the-future-report-may-2019.ashx?la=en> (accessed 01 November 2019)
- 26 Newcastle University (forthcoming) *Everyday leadership*
- 27 Royal College of General Practitioners and Medical Schools Council (2017) *Destination GP: Medical students' experiences and perceptions of general practice* available at <https://www.rcgp.org.uk/-/media/Files/Policy/A-Z-policy/2017/RCGP-destination-GP-nov-2017.ashx?la=en> (accessed 01 November 2019)
- 28 Health in Wales (2016) *Train / Work / Live – First Minister of Wales launches major new GP recruitment campaign* available at <http://www.wales.nhs.uk/news/43012> (accessed 01 November 2019)
- 29 Health Education and Improvement Wales (2019) *Train, work, live* available at <https://trainworklive.wales/> (accessed 01 November 2019)
- 30 The King's Fund (2019) *Patients' experiences of NHS administration* available at <https://www.kingsfund.org.uk/projects/patient-experiences-nhs-administration> (accessed 18 September 2019)
- 31 Nuffield Trust (2019) *Change or collapse Lessons from the drive to reform health and social care in Northern Ireland* available at <https://www.nuffieldtrust.org.uk/files/2019-07/nuffield-trust-change-or-collapse-web-final.pdf> (accessed 4 December 2019)
- 32 The King's Fund (2019) *NHS admin: how does it affect patient experience?* Available at <https://www.kingsfund.org.uk/blog/2019/09/nhs-admin-patient-experience> (accessed 18 September 2019)
- 33 The King's Fund (2017) *Understanding NHS financial pressures: How are they affecting patient care?* available at <https://www.kingsfund.org.uk/publications/understanding-nhs-financial-pressures> (accessed 18 September 2019)

- 34 Ipsos Mori (2018) NHS at 70: Public perceptions. Poll conducted for the Health Foundation in partnership with The King's Fund, Nuffield Trust and the Institute for Fiscal Studies available at <https://www.health.org.uk/publications/nhs-at-70-public-perceptions> (accessed 18 September 2019)
- 35 Ipsos Mori (2019) *Issues index* available at <https://www.ipsos.com/ipsos-mori/en-uk/ipsos-mori-issues-index-august-worries-about-brex-it-hold-steady-while-concern-about-nhs-and-crime> (accessed 18 September 2019)
- 36 General Medical Council (2012) *Raising and acting on concerns about patient safety* available at <https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/raising-and-acting-on-concerns> (accessed 14 August 2019)
- 37 Health Service Journal (2019) *Exclusive: Tens of thousands of junior doctors working beyond contract* available at <https://www.hsj.co.uk/workforce/exclusive-tens-of-thousands-of-junior-doctors-working-beyond-contract/7023993.article> (accessed 25 September 2019)
- 38 General Medical Council (2018) *GMC signs up to joint approach to addressing concerns raised by doctors* available at <https://www.gmc-uk.org/news/news-archive/gmc-signs-up-to-joint-approach-to-addressing-concerns-raised-by-doctors> (accessed 25 September 2019)
- 39 Nursing, Midwifery and Allied Health Professions Research Unit (2019) *A scoping review of evidence relating to communication failures that lead to patient harm* available at [https://www.gmc-uk.org/-/media/documents/a-scoping-review-of-evidence-relating-to-communication-failures-that-lead-to-patient-harm\\_p-80569509.pdf](https://www.gmc-uk.org/-/media/documents/a-scoping-review-of-evidence-relating-to-communication-failures-that-lead-to-patient-harm_p-80569509.pdf) (accessed 4 November 2019)
- 40 General Medical Council (2013) *Good medical practice* available at <https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice> (accessed 26 September 2019)
- 41 Nursing, Midwifery and Allied Health Professions Research Unit (2019) *A scoping review of evidence relating to communication failures that lead to patient harm* available at [https://www.gmc-uk.org/-/media/documents/a-scoping-review-of-evidence-relating-to-communication-failures-that-lead-to-patient-harm\\_p-80569509.pdf](https://www.gmc-uk.org/-/media/documents/a-scoping-review-of-evidence-relating-to-communication-failures-that-lead-to-patient-harm_p-80569509.pdf) (accessed 4 November 2019)
- 42 Pulse (2019) *GPs in England receive over 250,000 inappropriate NHS 111 referrals per month* available at <http://www.pulsetoday.co.uk/news/all-news/gps-in-england-receive-over-250000-inappropriate-nhs-111-referrals-per-month/20039017.article> (accessed 10 September 2019)
- 43 NHS England (2019) *NHS 111 prevents more than 12 million unnecessary A&E visits* available at <https://www.england.nhs.uk/2019/05/nhs-111-prevents-unnecessary-ae-visits/> (accessed 10 September 2019)

- 44 Royal College of General Practitioners (2018) *Quality patient referrals, Right service, right time* available at <https://www.rcgp.org.uk/-/media/Files/Policy/A-Z-policy/2018/RCGP-referral-management-feb-2018.ashx?la=en> (accessed 22 October 2019)
- 45 Department of Health and Social Care (2016) *The NHS Choice Framework: what choices are available to me in the NHS?* Available at <https://www.gov.uk/government/publications/the-nhs-choice-framework/the-nhs-choice-framework-what-choices-are-available-to-me-in-the-nhs> (accessed 4 November 2019)
- 46 General Medical Council (2012) *Leadership and management for all doctors* available at [https://www.gmc-uk.org/-/media/documents/leadership-and-management-for-all-doctors---english-1015\\_pdf-48903400pdf?la=en&hash=56A6B67C00925DB6A2EE73956E915DEAD3B627AC](https://www.gmc-uk.org/-/media/documents/leadership-and-management-for-all-doctors---english-1015_pdf-48903400pdf?la=en&hash=56A6B67C00925DB6A2EE73956E915DEAD3B627AC) (accessed 11/12/2019)
- 47 Shale S (2019) How doctors in senior leadership roles establish and maintain a positive patient-centred culture available at <https://www.gmc-uk.org/-/media/documents/how-doctors-in-senior-leadership-roles-establish-and-maintain-a-positive-patient-centred-cu-79633866.pdf> (accessed 4 December 2019)
- 48 The British Medical Association (2018) *Caring, supportive, collaborative? Doctors' views on working in the NHS* available at <https://www.bma.org.uk/collective-voice/policy-and-research/nhs-structure-and-delivery/future-vision-for-the-nhs/future-vision-for-the-nhs-survey> (accessed 11 November 2019)
- 49 NHS England (2018) *NHS Staff Survey 2017* available at <https://www.nhsemmployers.org/retention-and-staff-experience/staff-engagement/the-nhs-staff-survey/nhs-staff-survey-2017> (accessed 11 November 2019)
- 50 The British Medical Association (2018) *Bullying and harassment: how to address it and create a supportive and inclusive culture* available at <https://www.bma.org.uk/collective-voice/policy-and-research/education-training-and-workforce/tackling-bullying-and-harassment-in-the-nhs/bullying-and-harassment-policy-recommendations> (accessed 11 November 2019)
- 51 General Medical Council (forthcoming) *Outcomes for graduates*
- 52 General Medical Council (2015) *Promoting excellence: standards for medical education and training* available at [https://www.gmc-uk.org/-/media/documents/Promoting\\_excellence\\_standards\\_for\\_medical\\_education\\_and\\_training\\_0715.pdf\\_61939165.pdf](https://www.gmc-uk.org/-/media/documents/Promoting_excellence_standards_for_medical_education_and_training_0715.pdf_61939165.pdf) (accessed 9 December 2019)
- 53 Trajectory (forthcoming) *Understanding patients' experiences of referrals*

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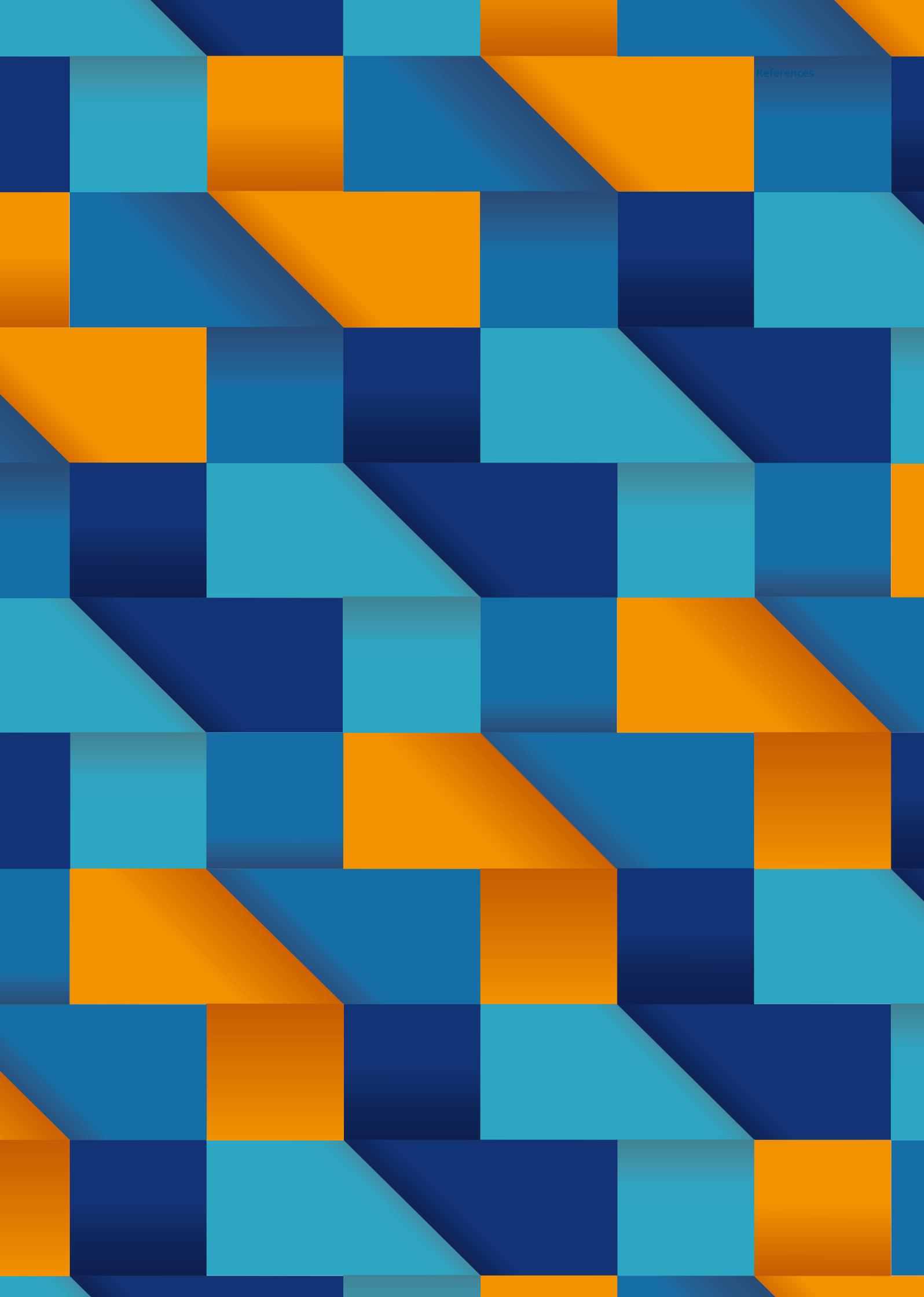
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