

## GMC response to HEE call for evidence – Strategic workforce review

Please contact Naomi Day (naomi.day@gmc-uk.org) with any queries.

### Note on evidence sources

1 The evidence presented here comes from four key sources:

- National Training Surveys (NTS) - a census of 63,000 doctors in training and their trainers completed annually. The data presented here is taken from the 2021 trainee survey, with some reference to findings from previous years. The data covers those training in England only. Further detail can be found on the [NTS webpages](#) where there is a [data reporting tool](#) available.
- Barometer survey - an annual survey of a representative sample of practising doctors which has been running since 2019. The survey has around 3,000 – 3,500 completions annually. The data presented here is UK wide (national differences are insubstantial) and mostly taken from the 2019 and 2020 surveys. Analysis and quality assurance of 2021 data is ongoing and will be available to share in detail from November 2021. A detailed write up of analysis from the 2019 and 2020 surveys and full data tables can be found on the '[State of medical education and practice](#)' webpages.
- [Caring for doctors caring for patients](#) – In 2018 we commissioned Professor Michael West and Dame Denise Coia to carry out a UK-wide review to help tackle the causes of poor wellbeing faced by medical students and doctors.
- [Fair to refer?](#) – The research was commissioned to understand why some groups of doctors are referred to the GMC for fitness to practise concerns more, or less, than others by their employers or contractors and what can be done about it. Employers and healthcare providers are more likely to refer doctors who obtained their primary medical qualification outside the UK and those who are from a black and minority ethnic (BME) background to the GMC than they are to refer their UK qualified or white peers. This is particularly important as complaints from employers are more likely to result in an investigation being opened and, ultimately, more likely to result in a sanction being applied, than complaints from other sources.

## Category: staff and student/trainee expectations

<b>Factor 1</b> – expectations of working life
<b>1A</b> – Flexible working
<p>The overall trend among doctors is a move towards more flexible working than in the past. While this may have a positive impact on individual doctor’s personal and professional wellbeing and a knock-on positive impact on retention, there will need to be higher overall headcount to achieve the same workforce capacity (full time equivalent – FTE). More flexible role definitions will also be needed to facilitate flexible working which works for patients and professionals.</p> <p><b>Evidence:</b></p> <ol style="list-style-type: none"><li><b>1</b> In the Barometer survey 2020, 21% of respondents reported that they were working part-time. However, we are conscious of the challenges and lack of consistency in defining full and part time across different areas of medicine and portfolio careers, so this finding is indicative at best.</li><li><b>2</b> In the NTS survey trainees are asked about Less Than Full Time (LTFT) training. In 2021, 16% of respondents reported formally working LTFT as approved by their deanery/HEE local team. A further 3% had considered applying for LTFT training but decided not to. None reported an application for LTFT training being rejected.</li><li><b>3</b> By far the most common reasons for working LTFT selected by respondents was childcare (55%). 16% reported a disability, illness or health related reason.</li><li><b>4</b> Of those working LTFT, the vast majority worked 0.6 (42%) or 0.8 (43%) of a fulltime contract.</li></ol>

<b>Factor 1</b> – expectations of working life
<b>1B</b> – Burnout and work-related stress
<p>Burnout and stress are a significant consideration in workforce planning due to the risk to the retention of professionals and, potentially, to recruitment if medicine becomes unattractive as a result. Medicine is well known to be a high-pressure, high-responsibility career, but we must ensure that doctors are supported so this doesn’t become unsustainable pressure, risking personal and professional wellbeing. Not only might burnout and stress cause long-term workforce issues that need addressing with future</p>

planning, but also result in short-term absences which are difficult to fill with the current workforce and stretch the capacity in the system.

### **Evidence:**

- 1** The 'Caring for doctors, caring for patients' report found that burnt out doctors were significantly more likely to make a serious medical error than those who were not burnt out. Protecting and supporting doctors' wellbeing is not just good for individual professionals and workforce supply, but fundamental to safe patient care.
- 2** The NTS and Barometer surveys both use the Copenhagen Burnout Index (CBI) to give an indication of burnout risk. The index is made up of 7 questions. In NTS 2021:
  - 59% of trainees reported being often or always exhausted at the end of the working day.
  - 44% reported that their work is emotionally exhausting to a high or very high degree.
  - 37% reported that they often or always felt exhausted in the morning at the thought of another day at work
  - 32% felt burnout by their work to a high or very high degree.
  - 27% were frustrated by their work to a high or very high degree.
  - 19% reported that they seldom or never had enough time for friends and family.
  - 17% often or always felt that every working hour was tiring for them
- 3** Overall, in 2021, 15% of trainees were at a high risk of burnout based on their responses to the indicator questions. This is an increase on 2019 and 2020 when the proportions were 11% and 10% respectively. The proportion of doctors now at a moderate risk of burnout has also increased, from 33% in 2020 to 40% in 2021 (this is a return to 2019 levels).
- 4** The Barometer survey also uses the CBI to give an indication of burnout risk across a representative sample of practising doctors. In 2020 there was a reduction in those experiencing a high risk of burnout – 10% compared to 15% in 2019. It is likely that this improvement was the result of several factors including:
  - The time at which the survey was completed (after the Spring peak of the pandemic had subsided and before things started to build again through the autumn)

- Changes to working patterns, workloads, and supporting administrative tasks being undertaken
- A sense of 'mucking in' and camaraderie across the health service.

- 5 Early indications from 2021 data suggest a return to 2019 levels of burnout risk.
- 6 In the 2019 and 2020 Barometer surveys, GPs were consistently the group the most likely to be at a high or very high risk of burnout. A detailed analysis of burnout risk by registration type can be found in the ['State of medical education and practice'](#) reports from 2019 and 2020.
- 7 In the Barometer survey, respondents are asked how often they have had to take a leave of absence due to stress in the past 12 months. In 2020, 14% of doctors reported that they had taken a leave of absence at some point in the preceding year. This was consistent with 2019 when 12% had taken a leave of absence.

## **Factor 1** – expectations of working life

### **1C** – Tackling bullying and harassment

Bullying, undermining, and harassment have no place in supportive working and caring environments. The scale of bullying and harassment in the medical profession is difficult to determine due to concerns about underreporting. What is clear is that where bullying is present it has a huge impact on individual's wellbeing, wider cultures, and ultimately on patient care and staff retention. Tackling bullying and harassment are key to workforce considerations as failing to address these issues could have serious implications for the retention of staff and make medicine a less attractive career option. Considering how different healthcare professionals work and train together in multidisciplinary teams will also be crucial in developing a cohesive healthcare workforce.

#### **Evidence:**

- 1 In 2021, 37% of trainees reported that they had never experienced any rudeness or incivility in their current training post. However, 14% agreed or strongly agreed that rudeness and incivility were negatively affecting their experience in their post.
- 2 Trainees are also asked about their ability to raise concerns, a crucial element of creating just cultures free of bullying and harassment. 77% of trainees agreed or strongly agreed that their current post has a culture of proactively raising concerns, whereas 5% disagreed or strongly disagreed. 62% agreed or strongly agreed that they were confident that concerns were dealt with effectively.

- 3** The vast majority (80%) of respondents felt that there was a culture of learning lessons when concerns were raised. 57% felt that the actions as a result of raising concerns were fed back appropriately.

## **Factor 1** – expectations of working life

### **1D** – Time to care

Doctors' time is under increasing pressure from the number of patients they must see, the preparatory, administrative and follow-up tasks required of them, and additional roles they take on alongside their clinical work. The Covid-19 pandemic has also brought with it a raft of new challenging processes doctors must follow and care backlogs. All of these mean that the time they have available to care for individual patients is squeezed. This issue is significant to workforce planning in two ways:

- Firstly, it speaks to an issue with overall supply and availability of appropriate professionals (within and outside medicine) to meet patient needs. This needs considering both in terms of the total number of doctors available, where and in what specialities those doctors are practising, and also the multidisciplinary skills mix which best supports system-wide patient care.
- A lack of time to care also impacts doctors' enjoyment of and satisfaction in their work, which in turn affects their professional wellbeing. From this perspective, the issue must be considered as part of a suite of issues (inc burnout and stress and bullying and harassment), which affect retention through doctors' physical and emotional capacity to meet the demands of their role.

#### **Evidence:**

- 1** In both the Barometer survey and NTS, doctors are asked about their workload and working hours. Research carried out in 2018 found that caring for patients was one of the key things which motivated doctors to go into medicine and gave them professional satisfaction. Too often, workloads and working hours prevent doctors from giving the care they want to.
- 2** In the responses to the Barometer survey, analysis of the relationship between working hours and feeling able to cope with workload shows four distinct groups of doctors.
  - Managing – not regularly working beyond rostered hours and coping with workload.

- Normalised – regularly working beyond rostered hours, but not regularly feeling unable to cope with workload. Long hours are a normal part of their working life that they have learnt to cope with.
- Issues unrelated to working extra hours – not regularly working beyond rostered hours but not coping with workload. There are potentially other factors outside of working hours causing these doctors to feel unable to cope.
- Struggling – regularly working beyond rostered hours and not coping with workload.

- 3 In 2019 almost a third of doctors (29%) were ‘managing’, while a quarter (26%) were struggling. In 2020, this shifted substantially with only 15% struggling, compared to 51% managing. Improvements in this area are likely to be as result of similar factors to burnout (Factor 1B). Early analysis of findings from 2021 suggest that the situation has worsened since 2020 but has not returned to 2019 levels. More detailed analysis of the findings around workloads and working hours is available in [‘The state of medical education and practice 2020’](#). In 2019 and 2020, despite improvements, GPs were the professional group the most likely to be in the ‘struggling’ group.
- 4 The NTS asks trainees about the intensity of their workloads. 39% reported that their daytime workload was heavy or very heavy. 46% reported that their workload was heavy or very heavy at night.
- 5 The vast majority of trainees (84%) reported having worked beyond their rostered hours at some point while in their current post. A third (34%) reported this being a weekly occurrence and for 9% it happens daily.

## **Factor 1** – expectations of working life

### **1E** – Career plans

Doctors expectations of how their medical careers will look has changed as a result of generational, societal, and technological shifts. Given the length of time it takes to train a medical trainee to consultant or GP level, it’s important to understand the paths doctors intend to take to get there, and how they intend to practice once they arrive. Workforce planning must take these changes into account and not assume that the doctors training now will practice in the same way as those who trained even just ten years ago. Similarly to flexible working, it is likely that doctors will work in ways which require overall higher headcount to meet the same demand and a more flexible definition of professional roles.

**Evidence:**

- 1** Both NTS and the Barometer survey ask doctors about their career plans within the next year. This gives an indication of doctors' frame of mind and potential plans, but it is very difficult to know how often intentions become reality.
- 2** The Barometer survey asks doctors if they are planning to make any career changes in the following year. In 2019 and 2020 doctors were most likely to report the intention to make a change that would see them working fewer clinical hours (22% in 2020).
- 3** In 2020, 10% reported a planned change that would see them leaving the UK profession entirely – for example through retirement, moving to practice abroad, or leaving medicine prior to retirement. This was consistent with findings in 2019. Early analysis suggests that this is unchanged in 2021.
- 4** However, the survey also asks those who are considering leaving the profession what steps they have taken towards doing so. Early analysis of 2021 data suggest that a larger proportion of those considering leaving have taken 'hard steps' such as contacting a recruiter, undertaking training for a non-medical role, or applying for a role outside medicine.
- 5** The NTS asks trainees what they see themselves doing in a year's time. The majority of respondents (75%) reported that they would be continuing in training or would have progressed to working as a consultant or GP. Very small proportions selected other options such as taking on a service post (5%), working as a locum (4%), or continuing in training (or progressing to work as a consultant or GP) but changing specialities (4%). 4% of respondents reported being undecided.

**Factor 2 – Culture**

Ensuring there is a positive working culture for all doctors speaks to many of the subfactors raised elsewhere in this consultation response – mitigating burnout and stress, tackling bullying and harassment, and supporting flexible working and career options -and their importance for retaining the medical profession. Unfair cultures reduce the pool of knowledge, creative ideas and experience and negatively impact engagement, motivation and wellbeing. Culture may be the most fundamental thing in attracting and retaining doctors into the UK profession, but it is not always easy to change. Workforce planning must consider the enabling and disabling features of cultures and environments, as well as simply the total number of doctors needed to meet service demands.

**Evidence:**

- 1** Open, inclusive, and supportive cultures are vital for the wellbeing of doctors' and the delivery of safe patient care. 'Caring for doctors, caring for patients' identified the ABCs of doctor wellbeing, those core elements crucial to good professional wellbeing.
  - Autonomy/control – the need to have control over our work lives, and to act consistently with our work and life values.
  - Belonging – the need to be connected to, cared for, and caring of others around us in the workplace and to feel valued, respected and supported.
  - Competence – the need to experience effectiveness and deliver valued outcomes, such as high-quality care.
- 2** Belonging speaks to the cultures of doctors' working environments.
- 3** The review found that organisational cultures can have a great impact on the wellbeing of staff. Changes to work organisation such as restructuring, staff reductions and the introduction of temporary work, take their toll on staff. 'Change fatigue' has also been highlighted as work intensifies and increases the risk of burnout that can lead to 'learned helplessness' and feelings of alienation from the healthcare system.
- 4** The review heard consistent feedback about environments where leadership was remote from staff, where pressures fuelled by lack of resources led to bad behaviour that cascaded down the organisation from the top, and where staff did not feel valued by their leaders. There was widespread reporting that the standard response to safety failures was to blame individuals rather than develop systems to avoid recurrence.
- 5** The review recommended that all UK healthcare organisations that had not already done so should commence and implement a programme of compassionate leadership across all healthcare sectors and obtain feedback from doctors and healthcare staff to evaluate its effectiveness.
- 6** Further detail is available in the [full report](#).
- 7** The Barometer survey asks doctors whether they are supported by a range of colleagues. In 2020, doctors were most likely to report being supported by their immediate colleagues – 85% agreed with the statement 'I am supported by my immediate colleagues'. Smaller proportions of doctors agreed that they were supported by more senior colleagues, both clinical (68%) and non-clinical (52%).
- 8** Support is especially important for minimising the risk of burnout. Doctors with a lower risk of burnout were consistently more likely to give a positive response to questions about support and teamwork than those with a higher risk of burnout.



This was particularly true in relation to support from senior medical staff. Over three quarters (77%) of doctors with a very low risk of burnout felt supported by senior medical staff, compared with around two fifths (42%) of those with a high risk of burnout. As previously discussed, research for the 'Caring for doctors, caring for patients' report found that burnt out doctors were significantly more likely to make a serious medical error. Supportive cultures are vital for patient safety.

### **Factor 3** – post-pandemic workforce recovery

- 1** In the GMC, in response to some of the changes brought by the pandemic, we have been considering the right actions to improve the education and training of future doctors (and other groups) that should be taken over the longer term. There are real opportunities to bring in meaningful changes to medical education and training. In the short-term, it is important to balance service without losing sight of training; in the longer term we need to work across the system to manage the pipeline of trainees and ensure that they are able to build knowledge and skills to meet the standards we require. That means that we may need to think differently about how training is organised, how doctors are assessed, and how we manage the balance between service and training.
- 2** We believe that there are four areas that the experience of the pandemic suggests will be crucial to this, and we are working with partners across the system, including HEE, to deliver on them. The areas are:

#### Preparedness

- 3** The Foundation interim Year 1s (FiY1) intervention during the pandemic seems to have better prepared medical students to enter Foundation Year 1, and our research has supported this. We believe that the system as a whole should seek to learn lessons from this in order to better prepare medical students for moving into practice. We are reflecting on research that was commissioned to evaluate medical students' preparedness to enter the Foundation programme as well the outcome of research specifically about the Foundation interim Year One posts that were created in response to the pandemic in spring 2020.

#### Generalism and specialism

- 4** Patients benefit significantly when doctors combine generalist and specialist skills and capabilities. This came into sharp focus during the pandemic when many doctors worked across teams, specialties and work contexts, often, providing complex care to the most vulnerable and ill patients. Learning from this, we need flexible structures that give doctors both the specialist skills they need and the foundation to adapt and learn, in order to get the right balance of skills to meet service and patient needs as they emerge throughout their career. Doctors and

health care professionals increasingly work as part of diverse teams, which include colleagues from different specialties. Whilst we have introduced the generic professional capabilities into our outcomes for approved training, the majority (76%) of doctors at any given time are not in training, so there is a need to support this agenda for the wider medical community.

#### Progression and assessments

- 5 Changes to specialty curricula, college examinations, progression (e.g. ARCPs) and other assessments have been simplified to help doctors move through training despite the disruption caused by the pandemic. In many cases, this has streamlined curricular outcomes and requirements, including reducing the number of assessments and changing their format. We should use lessons learned from this crisis to create a more resilient approach to developing and delivering curricula, assessments and progression that can respond quickly to critical patient and service needs.

#### Leadership

- 6 The crisis has shown the influence that doctors can have in promoting practical, preventative public health. The importance of this leadership and collaboration, both inside and outside work environments, should be built on with training, support and tools available to help doctors to promote broader health literacy and wellbeing in the variety of UK communities throughout their careers. Some groups of doctors, such as SAS doctors, struggle to access leadership roles and opportunities, and the experience that they have can be undervalued. Across the UK, there are several interventions to encourage and support doctors and the multi-profession team to develop their leadership skills, roles and responsibilities. But more could be done to spotlight good practice, which fosters and values leadership in the medical profession.

#### **Factor 4** – Equality, diversity, and inclusion

Working and caring environments are not always fair to and inclusive of all doctors. Unfair cultures reduce the pool of knowledge, creative ideas and experience, and negatively impact engagement, motivation and wellbeing. Thinking about ethnicity specifically, 38% of all licensed doctors in the UK are from minority ethnic backgrounds and growing (61% of new doctors joining the register in 2020, up from 42% in 2017). For the medical workforce – ethnicity is not a minority issue. Doctors' experiences of their roles and the ways in which they practice vary significantly across different protected characteristics. Planning the workforce must consider the diverse routes medical professionals take into UK training and practice, the adjustments some doctors require to be able to practice to the best of their ability, and the career paths which support a range of lifestyle choices and needs. Fundamentally, the current and future

workforce must practice in safe, inclusive cultures, that enable all doctors to thrive irrespective of their personal characteristics.

**Evidence:**

- 1** Working and caring environments must be inclusive, fair, and supportive of all doctors and patients irrespective of their personal characteristics. The GMC is committed to playing our part both as a regulator and employer.
- 2** The 'Fair to refer?' research aimed to understand why doctors from a BME background or who received their primary medical qualification outside the UK are more likely to be referred to the GMC for fitness to practise concerns. The research identified six key factors that help to explain the higher rates of referrals the GMC receive from employers of certain groups of doctors. These factors aren't always present together, but do often compound each other:
  - Doctors in diverse groups do not always receive effective, honest or timely feedback because some managers avoid difficult conversations, particularly where that manager is from a different ethnic group to the doctor. This means that concerns may not be addressed early and can therefore develop.
  - Some doctors are provided with inadequate induction and/or ongoing support in transitioning to new social, cultural and professional environments.
  - Doctors working in isolated or segregated roles or locations lack exposure to learning experiences, senior mentors, support and resources.
  - Some leadership teams are remote and inaccessible, not seeking the views of less senior staff and not welcoming challenge and this can allow divisive cultures to develop.
  - Some organisational cultures respond to things going wrong by trying to identify who to blame rather than focusing on learning. This creates particular risks for doctors who are 'outsiders'.
  - In groups and out groups exist in medicine including relating to qualifications (including by country and within the UK by medical school) and ethnicity (including within BME populations). Members of in groups can receive favourable treatment and those in out groups are at risk of bias and stereotyping.
- 3** Further detail is available in the [full report](#).

## Category: Public, People who need care and support, Patient and Carer Expectations

**Factor 5** – Public, people who need care and support, patient, and carer expectations

**5A** – Patient expectations

As Sir Keith Pearson identified in his [review of revalidation](#), patient expectations are continuously changing - patients are better informed, expecting a dialogue with a doctor, with explanation and discussion about treatment options and risks, and look increasingly to be 'consulted' when it comes to their care. We have adapted and revised our expectations and guidance in relation to education and training with this in mind. When thinking about planning the future workforce, it's important to understand what patients need from their healthcare professionals and what they will need and expect into the future.

Patients, carers, and families expect a good standard of care and an experience of care that is caring and compassionate. Therefore '[Promoting excellence](#)', our standards for the delivery of medical education and training places this at its core, to ensure this is built in from the moment doctors begin to consider patient care.

The evolution of patient expectations and approaches to care in recent years (and particularly during the pandemic as discussed in Factor 3) has highlighted the importance of generic as well as specialist capabilities. This creates a much more flexible and adaptive workforce, able to meet the needs of both individual patients and whole populations at different times. '[Excellence by design](#)', our standards and guidance for postgraduate medical curricula, assessment, and approvals, aims to make sure that doctors are equipped with the broader professional skills that allow them to become and stay good professionals. The Generic Professional Capabilities (GPC) framework covers the broader areas of professional practice such as communication and team working, things we know are important to patients' experiences of their care. Our standards require the GPCs to be embedded in all GMC-approved postgraduate curricula to ensure that these professional skills integral to good patient care are universally learned and assessed by all doctors in training.

'[Outcomes for graduates](#)' set out what newly qualified doctors from all medical schools who award UK primary medical qualifications must know and be able to do. Between the previous version being published in 2009 and the update in 2018, there had been various developments in the organisation of care and pattern of disease meaning an increased need for newly qualified doctors to be able to:

- care for patients in a variety of settings, including the patient's home and community settings as well as general practices and hospitals

- care for growing numbers of patients with multiple morbidities and long term physical and mental health conditions
- provide integrated care, including mental health care, with social care
- apply principles of health promotion and disease prevention at population level to the care of individual patients
- commit to lifelong learning to keep up to date with developments in medical practice and trends in disease at population level.
- Outcomes for graduates also reflects the GPCs so there is a recognisable progression of professional capabilities through undergraduate and postgraduate medical education and training.

Ensuring that the current and future workforce is planned and equipped to meet the needs and expectations of patients not only ensures that patients receive the best care possible, it also insulates professionals against some of the non-clinical challenges of the job, such as feeling unable to provide patients with the care they want or need. This helps to support a sense of professional competence and wellbeing.