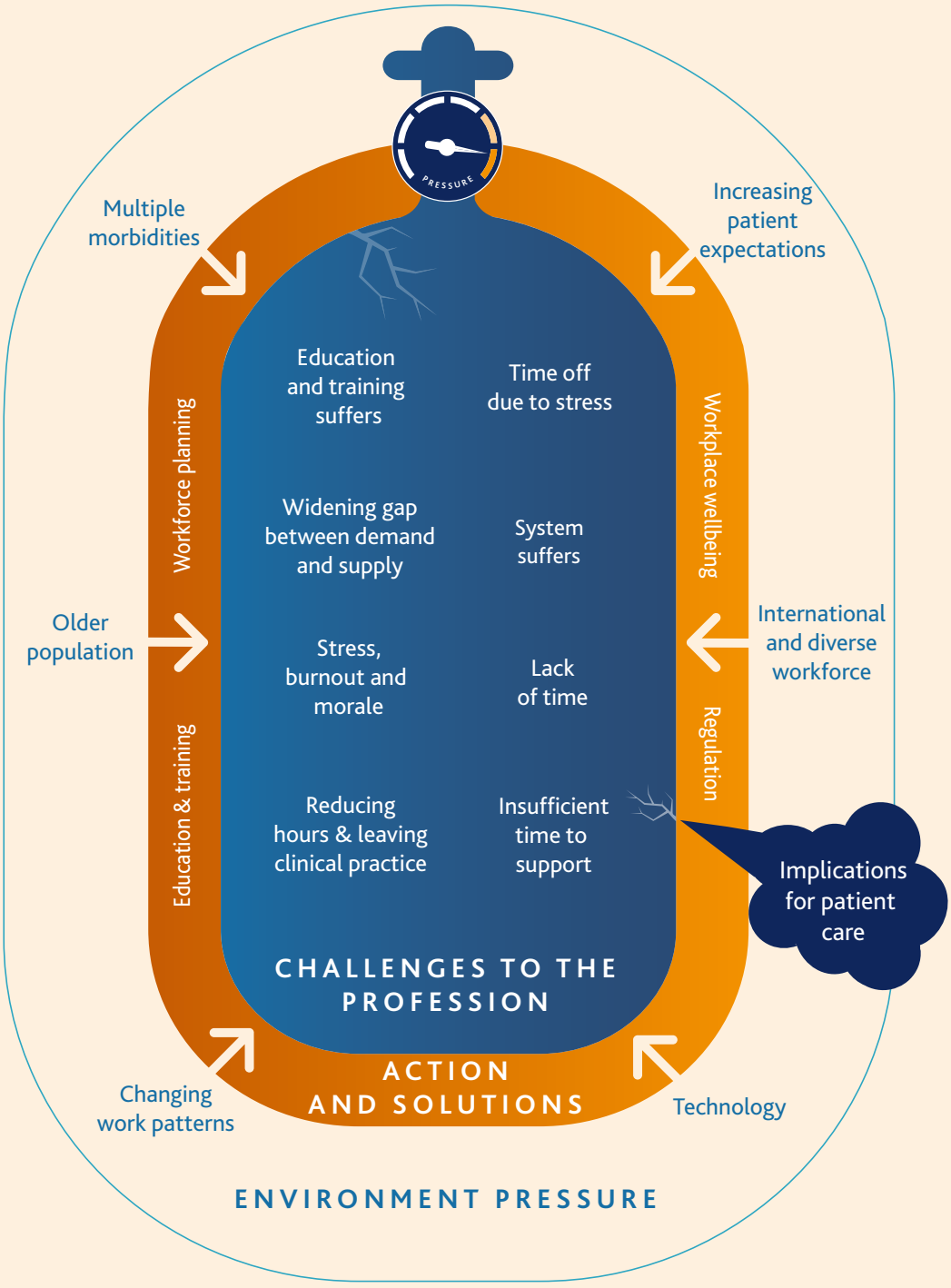
Supporting a profession under pressure



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.[1, 2] 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*[3] 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 years' 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*.[4]

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*[5] 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.[5, 6, 7] 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.