



# Learning from 2020

Data relates to the early stages of the coronavirus (COVID-19) pandemic, including the first peak in April 2020.

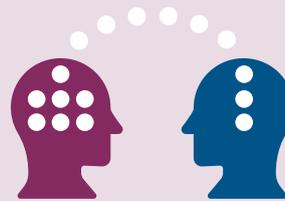
Embedding positive learning and changes from 2020 is important. Changes must be inclusive to support the greatest possible improvements.



Doctors reported positive and potentially sustainable impacts related to autonomy, belonging and competence, areas known to be important for doctor wellbeing.

**BME doctors were less likely than white doctors to report positive changes.**

**44%** of BME doctors identified a positive impact in relation to teamworking, including between doctors (compared with 52% of white doctors).



**Some doctors are concerned about losing training and development opportunities – 41% reported a negative impact in this area. Although informal opportunities did emerge.**

**46%** of BME doctors identified a positive impact in relation to sharing knowledge and skills (compared with 61% of white doctors).

**38%** of BME doctors identified a positive impact in relation to the speed of implementing change (compared with 57% of white doctors).

Increasing the supply and retention of doctors and supporting their wellbeing remain priorities.

## Chapter summary

Despite the terrible human cost of the coronavirus (COVID-19) pandemic and the impact of it on the safety and mental health of health professionals, the response of the medical profession and the health and care system more generally has been very impressive. The changes made – often very rapidly and flexibly – exposed how it is possible to make beneficial changes to the way medical work is organised.

Many doctors reported experiencing positive changes to their work during the first peak of the pandemic, including:

- improved team working – three fifths of respondents (62%) experienced this between doctors and nearly half (48%) experienced this within multidisciplinary teams
- sharing knowledge and experiences – over half of doctors (54%) reported this
- the speed of implementing change – half of doctors (49%) identified with this
- more visibility of senior leaders in patient care settings – nearly two fifths of doctors (38%) saw this.

Many of these positive changes contribute to autonomy, belonging and competence – essentials for doctors' wellbeing, motivation and ability to deliver high-quality patient care.\*

However, experiences of the pandemic have been diverse and not all doctors experienced positive effects equally.

In this chapter, we explore some of the changes doctors experienced and the importance of embedding the learning from the first peak of the pandemic.

Against the backdrop of increasing demand for care and surging workloads, we also consider the ever-growing importance of attracting and retaining high-quality medical professionals. We also look at how greater flexibility in medical education and training is key to adapting for the future.

\* This was identified in the report, 'Caring for doctors Caring for patients',<sup>1</sup> which we commissioned Professor Michael West and Dame Denise Coia to produce.

## Introduction

Doctors and other healthcare workers have been at the forefront of the pandemic dealing with acute patient and system needs. They have continued to show unwavering dedication to patient safety and professionalism despite working in highly uncertain and unsettled circumstances.

There's now an opportunity to build on and embed the learning from 2020 to bring about positive change so that the health and care system can support the greatest possible improvements in health and wellbeing for everyone, well beyond this crisis.

Nearly all doctors and medical students have experienced some degree of change in their day-to-day work or training this year, including:

- being redeployed to different roles
- changes to their working patterns
- medical school adjustments\*
- postponed rotations
- changes to how they carried out clinical duties.

Doctors have created opportunities in the way they have adapted to these changes. Some, for example, have experienced improved team working, more efficient decision making and increased visible leadership. We, together with the health and care system, need to embed these positive changes.

However, as reported in earlier chapters, experiences have been diverse. While some doctors have reported greater satisfaction day to day, the ongoing pandemic has had an adverse effect on the mental health and wellbeing of a third of doctors. And we are concerned that, with the backlog of non-COVID-19 patients, the risk of the resurgence of the coronavirus alongside other winter pressures, there will be an increasing toll on the profession.

On top of this, the pandemic has brought in new challenges around the supply of doctors on the medical register (discussed in chapter 3). It's also highlighted the importance of preparing doctors to meet the needs of diverse communities, alongside system-wide action to prevent or reduce health inequalities.

In this chapter, we reflect on the challenges – present and future – and the opportunities to strengthen areas such as leadership, team working, the sharing of knowledge and experiences, induction, and the speed of implementing change.

\* Medical schools adjusted final assessments and graduation arrangements to allow final year students to graduate amid the disruption caused by the pandemic.

We mustn't lose the innovations, and the resulting gains, that this unprecedented situation has prompted.

We're still in the pandemic and the cumulative impacts and lessons will take some time to unearth. Throughout this chapter we explore some of the most immediate lessons from the initial phase of the pandemic and what this means for us and the wider health and care system.

## Supporting doctors' wellbeing and ability to deliver high-quality care

Before the pandemic, doctors reported widespread burnout and an array of workforce and workplace pressures. This was leading many doctors to consider career breaks and early retirement.<sup>26</sup>

Doctors need positive workplace cultures and environments where team working and inclusive leadership are encouraged to thrive. These attributes support both a doctor's wellbeing and their ability to provide safe, high-quality care. And this, in turn, can help to attract and retain doctors.<sup>1</sup>

Much of this is mirrored in the findings from 'the Barometer survey 2020'. We can see links between satisfaction and wellbeing with experiences of team working, leadership, intentions to leave the profession, and patient safety.

- Almost 9 out of 10 doctors (87%) who said they were overall satisfied in their day-to-day work also agreed they were part of a supportive team.

- 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 of doctors (77%) 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.
- It's much more common for doctors who are dissatisfied to be considering leaving medical practice. A third of doctors (32%) who were overall dissatisfied in their day-to-day work said that they were likely to leave the UK medical profession in the next 12 months.\* This is compared with around one out of ten doctors (12%) who were overall satisfied.
- There is a similar pattern around burnout. One out of ten doctors (11%) with a very low risk of burnout said they were considering leaving the medical profession; this rose to almost two fifths (38%) of those with a high risk of burnout.
- Half of doctors (50%) with a high risk of burnout had seen patient safety or care compromised.
- Dissatisfied doctors were more likely to have seen patient safety or care compromised than overall satisfied doctors – nearly half of overall dissatisfied doctors (45%), compared with a fifth of overall satisfied doctors (22%).

The 'Caring for doctors Caring for patients' report<sup>1</sup> identified that doctors have three core needs to maintain their wellbeing and motivation at work.<sup>†</sup>

\* For reasons other than retirement.

† We commissioned Professor Michael West and Dame Denise Coia to produce 'Caring for doctors Caring for patients' in 2019.

- A Autonomy/control** – the need for doctors to have control over their work lives, and to act consistently with their work and life values.
- B Belonging** – the need for doctors to be connected to, cared for in, and caring of others in, the workplace, and to feel valued, respected and supported.
- C Competence** – the need for doctors to experience effectiveness and deliver valued outcomes, such as high-quality care.

Similar conclusions were reported in ‘The courage of compassion’ report<sup>†</sup> which was led by Professor Michael West and Suzie Bailey to explore how workplaces affect nurses’ and midwives’ practice and wellbeing.<sup>31</sup>

Learning from 2020, we continue to see the importance of autonomy, belonging and competence and some of the ways they might be further embedded in the health and care system.

## Developing visible leadership, autonomy, and a listening culture

### Visible and inclusive leadership

Effective clinical leadership plays a central role in driving positive and inclusive workplace cultures. These, in turn, improve workforce morale, motivation and mental health and wellbeing, as well as having a positive impact on the quality of patient care.<sup>1, 26, 32</sup>

Clinical leadership is multifaceted – it includes both formal leadership roles, such as clinical or medical management, and the everyday leadership doctors deliver in their day-to-day practice.

Visible formal leadership is essential for creating positive and supportive workplace cultures. It can enable quick communication of issues, support wellbeing initiatives and encourage a safer working environment. At a time of crisis and uncertainty, having a trusted senior leader on hand provides immense support and reassurance for all healthcare workers.

There were positive signs of visible senior leadership in ‘the Barometer survey 2020’.

- Three out of five doctors (61%) agreed that clinical leaders were readily available.
- Nearly two fifths of doctors (38%) said they felt there had been a positive impact on the visibility of senior leaders within patient care settings during the pandemic. Of those doctors, half (52%) thought the change could be sustained and 13% thought it couldn’t.
- Trainee doctors reported the biggest improvement, with over half (54%) saying they felt there had been a positive impact on the visibility of senior leaders.

The health system needs to consider how to sustain this positive change.

<sup>†</sup> Commissioned by the RCN Foundation whose aim is to support and strengthen nursing and midwifery to improve the health and wellbeing of the public. The foundation was set up in 2010 by the Royal College of Nursing.

There's some evidence that, overall, more experienced doctors felt more worn out at the end of the day, compared with less experienced doctors. 51% of doctors with more than ten years' experience said they 'always or often felt worn out at the end of the day', compared with 34% of doctors with less than ten years' experience. It's therefore important that employers and the system make sure doctors in leadership roles are sufficiently supported if the positive impact of increased visibility is to be sustained.

A doctor in a more senior role described how the first peak of the pandemic had made them a better leader by being more present and available for their team.

“ ‘Hopefully I’ve become a more compassionate leader, and I’ve taken a lot more trouble to engage with the medical workforce, more than I might’ve done previously, in terms of just listening to them and trying to understand what their world is. And I think realising that I might have a view from my ivory tower that actually is completely wrong and so I’ve engaged a lot more ... I don’t intend going back to the old ways either.’

*Specialist, case study interview*

### Box 7:

## Supporting and improving leadership

The improvements in clinical practice and compassionate leadership seen during the first peak of the pandemic highlight the importance of our ongoing work with others to support leaders.

In February 2020, we hosted roundtables in each of the four UK countries to discuss with senior healthcare leaders how a collective effort could improve workplace environments. Four priority areas were identified for action – and compassionate, collective and inclusive leadership was one of them. This remains a key focus of our work, as outlined in our 'Corporate strategy 2021–25'.<sup>33</sup>

We are supporting leaders with our guidance on leadership,<sup>34</sup> which signposts to stakeholder websites and emphasises the need for clear communication. As well, our Outreach teams have piloted a new training programme designed to help improve doctors' skills and confidence to address unprofessional behaviour.<sup>35</sup>

We want to continue to work with the system to support leaders, who, in turn, can support doctors and help to minimise risk of burnout within the workforce.

## Autonomy and feeling listened to

The pandemic has required healthcare workers to step into unfamiliar roles and trust in their autonomy to implement new initiatives.

Being listened to and being involved in decision making are key to making autonomy effective for doctors. In the national training survey (NTS) 2020, three fifths of trainees (62%) and over half of trainers (52%) felt there was a culture of listening to doctors about working practices in their workplaces – this included discussions related to the pandemic. Although around a fifth of trainees and trainers disagreed with this statement (17% and 20% respectively), it's encouraging to see a step in the right direction for many.

One doctor noted they had seen greater autonomy for doctors during the pandemic.

“ ‘I think [the pandemic] showed how the NHS could work at its best. I think we cut through a lot of red tape. Clinicians were making decisions.’

*Specialty and Associate Specialist doctor, case study interview*

We've seen some great examples where healthcare workers have excelled in leading locally, for example:

- rapid reorganisation of primary care with remote consultations
- splitting acute care wards into 'hot' and 'cold' areas
- redeployment of doctors into new roles and reorganisation of rotas to cope with the demand.<sup>36</sup>

Half of doctors (49%) felt there had been a positive impact on the speed of implementing change so far in the pandemic. This was felt most strongly by GPs, with 59% reporting a positive impact. This is probably due to the extensive changes experienced in primary care, with a huge shift towards delivering most patient care remotely. Reassuringly, a third of doctors (36%) experienced this positive impact and thought the improved speed of change could be sustained after the pandemic.

## Remote working

One clear example where doctors have been able to show autonomy is in remote working and the use of technology to deliver patient care. The first peak of the pandemic has been described as 'the catalyst bringing about the long-discussed digital revolution'.<sup>37</sup> Digital solutions were adopted in very little time and we've seen doctors be flexible and adapt to these changes – 41% of doctors said the pandemic had a positive impact on their ability to provide consultations or clinics remotely.

There are opportunities and challenges in delivering healthcare remotely for patients and for doctors. Several doctors described the benefits of remote working.

“ ‘[Remote working has] given people more flexibility to attend [meetings], rather than having to be in a certain location at a certain time.’

*Doctor in training, case study interview*

“ ‘Homeworking is a massive bonus in terms of wellbeing. I’m saving two hours plus per day of not commuting... The docs who work for me are all young-ish doctors with young-ish families. Of course, their reality is they can’t bring the kids into the surgery, which is undesirable anyway, but sometimes needs must. Actually, having that availability to genuinely work from home and have a rota where there’s somebody on-site with somebody actually off-site is amazing.’

*GP, case study interview*

“ ‘I was wasting about six hours a week, polluting the environment. I’m not going back to that again, and I’ve been able to pack a lot more in ... a major benefit.’

*Specialist, case study interview*

However, delivering care remotely has challenges and risks for both patients and doctors. Communicating bad news or discussing sensitive issues can be much harder over the phone.

“ ‘For me, and a couple of others, that was the hardest bit about it. Just talking to sobbing relatives over the phone.’

*Doctor in training, case study interview*

“ ‘Telephone consultations [are] not the best way for an oncologist to break bad news.’

*Specialist, ‘the Barometer survey 2020’*

Doctors also mentioned risks of patients’ needs being unmet because of reduced or lack of face-to-face contact. As well, there’s a risk some patients are excluded if they’re not able to access the required technology.

“ ‘There is much less face to face patient contact because of all the remote consulting. Most patients like this as being more convenient but it’s time consuming and I’m less certain of any impact that I’m making in terms of moving forward with a patient’s health (and in not missing something significant).’

*GP, ‘the Barometer survey 2020’*

“ ‘I think telephone appointments and maybe Zoom or video conferencing will become more common. I think there are lots of people who will be left behind by that and we need to make sure there are appointments for those people.’

*Specialist, case study interview*

Other doctors noted how they missed face-to-face interaction with colleagues and patients, and that working remotely could be exhausting and left them feeling more dissatisfied day-to-day.

While some doctors discussed the challenges and risks of remote working, overall, the negatives were balanced with positive outcomes and opportunities. Therefore, it’s important that, when incorporating technology to deliver care, considerations are taken into what works best for both patients and doctors.

We hope that it will be possible to expand the use of remote working, given the benefits apparent in our evidence, in a way that mitigates the risks that have been cited.

**Box 8:****Incorporating technology to deliver care**

An urgent recommendation from the 'Caring for doctors Caring for patients'<sup>1</sup> report was for a review of new technologies being used in UK healthcare systems, to increase efficiency, work better with the voluntary sector, and focus on preventative care.

Increased use of technology in providing care has been included in national strategies.

- In England, 'We are the NHS: People Plan for 2020/2021' states that the NHS should commit to offering more flexible, varied roles and opportunities for remote working and online training.<sup>38</sup>
- In Northern Ireland, the 'Rebuilding health and social care services' strategic framework states that both trusts and the primary care sector must consider the continued use and expansion of technology, where appropriate.<sup>39</sup>
- In Scotland, the 2020–21 Programme for Government sets out plans to expand on digital access to care achieved in response to the pandemic. The Scottish government stipulates that, while it recognises that video consultations, via the Near Me video consultation service, will not be appropriate for every patient or situation, the intention is to move to the position where it will be the default option for consultations.
- In Wales, 'A Healthier Wales' sets out plans to expand on the use of technology in consultations.<sup>10</sup> This was initially designed to support rural communities. Since the pandemic, the Welsh government has laid out plans to roll out virtual consultations across the NHS in Wales in the future. It recognises that video consultations will not be appropriate for every patient or situation, but the intention is to create a more blended, holistic approach to healthcare in Wales.

The increase in remote consultations and other changes to the way care is delivered means that good practice in shared decision making is more important than ever. We've recently published updated guidance on 'Consent: patients and doctors making decisions together' to make it easier to apply in everyday practice.<sup>40</sup>

## Strengthening teamwork and a sense of belonging

Effective teamwork is fundamental for doctors to deliver good and safe patient care. We also know that belonging to a supportive and inclusive team is beneficial for a doctor's wellbeing.<sup>1,26</sup> It's therefore encouraging to see that during 2020:

- three fifths (62%) of doctors experienced a positive impact on team working between doctors
- nearly half (48%) of doctors felt there had been a positive impact on team working between multidisciplinary teams.

Conversely, around one out of ten doctors felt there had been a negative impact on teamwork in each of these areas (7% and 13% respectively).

In the NTS 2020, doctors were extremely positive about team working – four out of five trainees (84%) agreed their department, unit or practice encouraged a culture of teamwork between all healthcare professionals.

We need to understand more about the circumstances that led to these positive team working experiences, so they can be extended to all doctors.

Sustaining the positive changes doctors have experienced is important. Seven out of ten doctors (70%) who experienced a positive impact on team working between doctors felt it could be sustained after the pandemic. And 64% of doctors who experienced a positive impact on team working between multidisciplinary healthcare professionals felt the same.

Doctors in training talked about working as part of multidisciplinary teams.

“ ‘Everyone from consultant down through... To everyone on the ward. Nurses, allied healthcare professionals, everyone has been very much looking out for each other and certainly, within general medicine, I felt a real sense of being part of a wider team.’

*Doctor in training (Foundation interim Year 1), case study interview*

One doctor described the sense of camaraderie between different healthcare professionals that they would like to see continue.

“ ‘the camaraderie that I think that there was between those doctors and nurses, of, “We're kind of in this together,” and stuff. I think that's really nice, and I think maybe taking that understanding forward.’

*Doctor in training (Foundation Year 1), case study interview*

The 'Caring for doctors Caring for patients' report identified effective team working as critical in giving doctors a sense of belonging in modern, complex workplaces. The review found that belonging to a supportive and inclusive team can 'offer a significant buffer for doctors from the stresses of their work'.<sup>1</sup> It is therefore crucial that we and others do what we can to encourage inclusive and supportive working environments, as well as good team working.

**Box 9:****Supporting and improving teamwork**

Team working is an important element of the workforce plans across England, Northern Ireland, Scotland and Wales.

- In England, multidisciplinary teams are a key theme throughout the 'Interim NHS people plan'.<sup>41</sup>
- In Northern Ireland, multidisciplinary teams are being rolled out across GP Federations.
- In Scotland, multidisciplinary teams feature in the 'National health and social care workforce plan'<sup>10</sup> and GP contract.<sup>42, 43, 44</sup>
- In Wales, the integrated health and social care plan<sup>10</sup> promotes multidisciplinary team working and includes a theme on seamless workforce models, including 'Work with partners to harmonise governance, regulation and registration arrangements to facilitate multi-professional working.'

A core theme in our new corporate strategy is 'Enabling the profession to provide safe care'. As part of this, we commit to working with healthcare systems to improve working environments and team culture for the medical workforce.

Through current projects and our work with others, we continue to play our part in helping to improve team working. This includes:

- sharing good practice across the health service through our Outreach teams
- including requirements about multidisciplinary team working in 'Outcomes for graduates'<sup>45</sup> and 'Generic professional capabilities'<sup>46</sup>
- participating in discussions about common education standards and inter-professional learning on the inter-regulatory group
- commissioning research into the preparedness of recent medical graduates to meet anticipated healthcare needs – one aspect of this is exploring multidisciplinary teams.

## Inclusive team environments

The 'Fair to refer?' research\* that we commissioned found that some groups of doctors are treated as 'outsiders', which creates barriers to opportunities and makes them less favoured than 'insiders' who experience greater workplace privileges and support.<sup>6</sup> Often the 'outsiders' are non-UK graduates or from a black and minority ethnic (BME) background.

Overall, in 'the Barometer survey 2020' there were few notable differences between the experiences of doctors from a BME background and those from a white background. Some of our findings reinforce the evidence about insider/outsider dynamics.

Doctors from a BME background were less likely to say they had experienced some of the positive changes seen during the pandemic.

- 38% of doctors from a BME background said there had been a positive impact on the speed of implementing change, compared with 57% of white doctors.
- 46% of doctors from a BME background said there had been a positive impact on sharing of knowledge and experiences across the medical profession, compared with 61% of white doctors.
- 55% of doctors from a BME background said there had been a positive impact on teamwork between doctors, compared with 68% of white doctors.
- 44% of doctors from a BME background said there had been a positive impact on teamwork between multidisciplinary healthcare professionals, compared with 52% of white doctors.

Data from the NTS 2020 also found that doctors from BME backgrounds were less likely to agree that their training environment provided a supportive environment for everyone regardless of background, beliefs or identity. 87% of white trainees perceived their working environment as supportive for everyone, compared with 84% of trainees of mixed ethnicity, 82% of Asian or British Asian trainees, and 79% of black or black British trainees.

The events of 2020 have brought to the fore a renewed focus on tackling inequality within society and healthcare.

COVID-19 is affecting patients and doctors in different ways. For everyone, the enduring impacts of deprivation, social inequalities and racial discrimination have been exposed. This has been particularly apparent in the NHS. Medicine is a globalised profession – nearly 40% of UK registrants are from a BME background and there are acknowledged longstanding issues of discrimination and disadvantage.

Our Chair, Dame Clare Marx, has written to the profession<sup>47</sup> setting out our commitment to work to reduce inequalities. We are determined to work with others to take forward the recommendations from the 'Fair to refer?' research and to tackle the long-term issues that shape inequalities. This includes our work on the educational attainment gap, preparedness to practise, and making sure that doctors from all backgrounds have a supportive start to UK practice. See box 10 for more information.

\* We commissioned Dr Doyin Atewologun and Roger Kline to conduct UK-wide research to explore why some groups of doctors are referred to us more than others.

**Box 10:****Fairness and inclusivity in clinical workplaces****Addressing the ethnic attainment gap in medical education**

There is a well-reported ethnic attainment gap in medical education – most strikingly seen in the 12 percentage-point difference in specialty exam pass rates from a UK medical school for white and trainees from a BME background. This variation cannot be explained by factors such as gender or socio-economic status.

Research suggests this is the result of persistent inequities throughout medical education and training.<sup>48</sup> BME doctors report receiving less support and feedback during training and experience more barriers, including being separated from support networks. Our NTS data show that this difference occurs very early in a doctor's career, with F1 doctors from a BME background being less likely to report feeling adequately prepared for their first post than their white colleagues.\*

We continue to shine a light on the multi-layered inequities within medical education and use our regulatory influence to drive local and system-wide change. Since 2019, postgraduate bodies have submitted an annual action plan for tackling inequalities in their regions. We have recently published advice to medical royal colleges and faculties on actions they can take to improve fairness, including ensuring good quality feedback is provided to all medical students following an unsuccessful exam attempt.<sup>49</sup>

We recognise that there's a need to build up a strong evidence base to show interventions can have a real impact.

We are partnering with organisations to evaluate interventions around early personalised learning needs analysis, mentoring and support for educators in response to our 2019 research, which asked doctors in training from a BME background 'What supported your success?'.<sup>50</sup>

This builds on the work of others who have already shown that change is possible, such as Health Education England (HEE) whose educational programme, which was developed in the North West, achieved a significant improvement in Clinical Skills Assessment (CSA) results for GP trainees who had failed the CSA.<sup>51</sup>

**Helping to prepare international doctors for UK medical practice**

We've expanded the reach of our 'Welcome to UK practice' programme by offering virtual workshops to non-UK doctors joining the UK medical workforce. It's important for doctors to have a supportive start to UK medical practice as it can affect their continued practice and experience.<sup>6</sup>

**Preparedness for practice**

One of the key points in exploring the impact of changes to exams as a result of the pandemic is considering any equality implications. We've commissioned research on the experiences of the 2020 UK graduates. This will include how starting clinical practice earlier has affected their preparedness for practice and considering what lessons can be learned from this.

\* Since 2012, there is a persistent 10% difference in responses to the question 'I was adequately prepared for my first F1 post'. See our [NTS progression reports and data](#) for more information.

## Helping doctors to build and maintain competence

### Making the most of all learning opportunities

We know that, when there is a high demand on services, time dedicated to professional development is often the first thing to be deprioritised. It's therefore unsurprising that, as described in chapter 1, some doctors reported a loss of training opportunities as an outcome of the first peak of the pandemic. Two out of five doctors (41%) felt there had been a negative impact on access to development or learning opportunities. Moreover, disruption to formal training meant many trainees missed out on formal opportunities to meet their competencies or to carry out planned rotations.

However, over half of doctors (54%) said there had been a positive impact on sharing knowledge and experiences. And, in the NTS 2020, most trainees (87%) continued to rate the quality of clinical supervision as 'good' or 'very good' – suggesting that aspects of postgraduate education are still functioning effectively. The more informal ways of learning, developing and sharing experiences are important and should be encouraged as part of doctors' lifelong learning.

One 2020 UK graduate described how, while their core training had gone online, they felt there was more time for hands-on teaching on the ward.

“ ‘Everyone I saw by myself was then reviewed by a senior, and that is the best learning experience you can have, because you've just seen a patient, you've gone through a series of thought processes in your head, and then you're with a consultant or a registrar, who's perhaps got a little bit more time, who can go through the same thought process as you've had and pick out perhaps where they might have thought something different or changed something.’

*Doctor in training (Foundation interim year 1), case study interview*

We're currently working with researchers at Newcastle University to understand 2020 UK graduates' motivations and experiences\*. However, interim findings indicate that the key motivating factors for doctors taking a 2020 graduate post were learning, gaining experience, and confidence.

Another trainee described how the pandemic had presented them with the opportunity of becoming the trainer, delivering sessions on donning and doffing personal protective equipment (PPE).

“ ‘I jumped in with trying to help ... I ended up teaching 50-odd people one day about how to put on and off the PPE, things like that.’

*Doctor in training (Foundation interim year 1), case study interview*

\* See chapter 2 for more information.

Finding informal ways to share knowledge and experiences with colleagues can help doctors' overall feelings of competence – a core need for doctor's wellbeing identified in 'Caring for doctors Caring for patients'. Moreover, opportunities to develop outside of formal training was identified as a protective factor to retain more experienced doctors who may be looking to continue working in medicine but who want to change their ways of working.<sup>1</sup>

It's important that workplace cultures embrace and recognise all forms of learning and development to support doctors to grow, so their skills and competence are constantly improving.

## Induction and feeling prepared for practice

A significant reconfiguring of care delivery was needed to help with the pandemic.

For many doctors, this meant being redeployed to a different role. In 'the Barometer survey 2020', two fifths of doctors (42%) said they were redeployed – a quarter (27%) in the same specialty or area of practice, and 15% to a different specialty or area of practice.

As well, we granted temporary registration to 28,076 doctors to boost the available pool of doctors who could help respond to the pandemic.

The high numbers of doctors who were redeployed or returning to practice highlights the importance of good inductions. We've previously noted how crucial this is in a workforce that is likely to be increasingly flexible and mobile in the future.

A lack of a good induction is thought to be a contributing factor to poor patient experience and, potentially, patient safety. Without it, doctors can feel stressed, undervalued and 'out of their depth', leading to treatment delays and possible clinical errors.

On top of this, a lack of suitable induction can affect some doctors more than others. The 'Fair to refer?' research found that doctors who are new to UK medical practice and fail to have a supportive start can then continue to experience further disadvantages as an 'outsider'.<sup>6</sup>

The system has been responding to the need for effective inductions, including signposting doctors to wellbeing materials and to other useful resources related to new ways of working during the ongoing pandemic.

- HEE launched their new 'Wellness Induction' materials, which provide wellbeing and mental health support materials and videos for 2020 graduates and their supervisors.<sup>52</sup>
- The Northern Ireland Medical & Dental Training Agency had a specific induction process for 2020 graduates providing essential information and wellbeing support.<sup>53</sup>
- NHS Education for Scotland (NES) launched guidance for 2020 graduates and other trainees around working during the pandemic and links to wellbeing support.<sup>54</sup>
- Health Education and Improvement Wales (HEIW) launched a suite of resources on wellbeing and FAQs around new working practices.<sup>55</sup>

### Box 11:

## Supporting effective inductions

In June 2020, we published research into the nature and scale of the issues associated with doctors' induction, including those returning to practice.\* This research involved interviews with doctors and stakeholders across primary and secondary care settings, who described the features of safe and effective inductions for doctors.

The findings showed that, too often, positive interventions are down to individuals putting in extra effort outside of their usual working hours, rather than a more systemic approach. A lack of a good induction is perceived to be a contributing factor to poor patient experience and, potentially, patient safety. In its absence, doctors can feel stressed, undervalued and 'out of their depth', resulting in delays in treatment and possible clinical errors.

The research identified some key principles doctors want to see from an induction:

- **tailored** – to their individual circumstances, their specific needs and level of expertise
- **timely** – physical induction is provided at the right time for them, with some information ideally provided in advance of starting
- **focused** – on what they need to do the job and is expertly designed by people who understand their role, ie by both senior colleagues and by those who are currently doing the role or have done so recently
- **engaging** – provides new information in an engaging, interactive way rather than duplicating
- **welcoming and inspiring** – sets the tone for their future career and helps them understand the culture and ethos of the organisation and where they fit within it
- **evolving** – isn't static, ie content is kept up-to-date and is reflective of feedback.

\* The full findings of the research were published in June 2020 and are available [here](#).

## Feeling safe to deliver care competently

We know that a doctor's priority is the welfare of their patients, alongside their own wellbeing and that of the healthcare team in which they work. We don't expect doctors to leave patients without treatment, but we also don't expect them to provide care without regard to the risks to themselves or others.

- Two fifths of doctors (43%) felt that a situation had arisen where they believed their safety or a colleague's safety was compromised while practising.
- Over half of all trainees had concerns about their personal safety, or that of their colleagues, during the pandemic. A quarter (24%) felt their concerns were only partially addressed and 3% reported they weren't addressed at all. However, a quarter of trainees (26%) said that the culture of reporting concerns had improved during the pandemic.

Many frontline workers expressed concerns around the availability of PPE. While access to and supply of PPE have improved, we know this has been a great concern of doctors.

- Four fifths (80%) of doctors said they had experienced a safety compromise, where a perceived lack of suitable PPE was a contributing factor.

Doctors need to feel safe and supported in order to provide the safest care to patients, and to feel able to work competently.

## Attracting and retaining a high-quality medical workforce

### Workload pressures continue to be an issue

We've reported extensively that high workloads continue to be a challenge for doctors. They are a significant cause of pressure, which has implications for wellbeing and burnout.<sup>26, 56</sup> 2020 is no different. Heavy workloads continue to be an issue for many doctors.

As reported in chapter 1, nearly one sixth of doctors (15%) said they were struggling with their working hours and workloads, and a third of doctors (34%) said they had made an adjustment to their work due to the pressure.

Some doctors reported improvements in workloads and burnout in 2020. 51% of doctors in 2020 said they were managing with their workload, compared with 29% in 2019.

Even for those doctors who have seen improvements, we're concerned that, in the latter part of 2020 and in 2021, workloads will increase, and we could see new cycles of unsustainable demand and pressure.

In the short term, the disruption of the pandemic has caused a growing backlog of patient demand for both primary and secondary care. The health systems need to restart and catch up on elective and delayed treatments. On top of this, potential additional peaks of COVID-19 infections and winter pressures are likely to create additional pressures on an already stretched system. This is concerning for both patients and the profession.

Doctors expressed concerns about patient backlog and the impact this will have on both patients and the system.

“ [There is a] huge backlog of patients waiting for non-life-threatening surgery - this is causing massive detriments to patient quality of life and risks emergency presentation later with more significant complications.’

*Specialist, 'the Barometer survey 2020'*

“ Access to secondary care has been extremely restricted so people are not getting consultations or imaging and I think there will be a big price to pay in terms of backlog and delayed diagnoses.’

*GP, 'the Barometer survey 2020'*

Excessive workloads are a key factor affecting poor patient satisfaction, low levels of staff engagement, and failure to innovate.<sup>1</sup> The excessive work demands in medicine can exceed the capacity of doctors to deliver the high-quality patient care they wish to, which affects their feelings of competence.

There are many steps that will be needed to help reduce the workload pressures felt by doctors and other healthcare workers in the system. The greater use of physician associates and anaesthesia associates, who we will be regulating, can be part of the solution.

**Box 12:****Physician associates and anaesthesia associates**

Physician associates and anaesthesia associates\* have played an important role in the response to the pandemic and helped to alleviate pressure on other healthcare workers.

The generalist approach of physician associates has enabled them to be flexible in adapting to supporting the health system's response to the pandemic where needed.

Anaesthesia associates have been making vital contributions in anaesthesia and sedation services, alongside consultants in theatre, and supporting other services where required.

In July 2019, the Department of Health and Social Care (DHSC), with the support of the four UK governments, asked us to regulate both physician associates and anaesthesia associates.

We have been making good progress on developing the regulatory framework for both of these roles with the support of our partners. In September, we published an update on the progress we have made so far and we'll continue to update this as the programme develops.<sup>57</sup>

\* Physician associates and anaesthesia associates are relatively new professional roles, which bring additional support to multidisciplinary teams. They are two of the four groups collectively known as medical associate professions (MAPs).

## Increasing the supply of doctors remains a priority

The long-term pressures on doctors' workloads and the volume of vacancies within the UK health services existed long before the pandemic. As such, increasing the number of internationally qualified doctors and UK-trained doctors must remain a priority for us and others.

In the UK, the number of international medical graduates (IMGs) and doctors who graduated in the European Economic Area (EEA graduates) make up a significant proportion of the UK workforce.

As reported in chapter 3, IMGs joining the UK medical workforce now outnumber both UK and EEA graduates combined. Over 10,000 IMGs joined the UK workforce between 2019 and 2020. And there has also been a notable increase in medical students joining from domiciles in the European Union (EU) in the 2019-20 academic year. These are encouraging signs that the UK continues to be a favourable location for international and EU nationals.

It is important that all new doctors starting work in the UK feel they belong to inclusive teams and supportive working cultures – highlighted earlier in this chapter.

We're beginning a programme of research on the world migration of doctors to better plan for the future. The first project in this programme is due to complete in the first quarter of 2021, following a delay due to the pandemic.

There remain real uncertainties around the UK's withdrawal from the EU and the transitional period. European doctors make a significant contribution to the UK health service, making up 8.7% of all licensed doctors.

From 1 January 2021, amendments<sup>58</sup> to the Medical Act will ensure that most EEA-qualified doctors will continue to be able to access the medical register in a timely and streamlined way, but there are other questions that are not yet answered.

Although the number of EEA doctors in training has increased by almost a third (29%) since 2016, they represent only 4.3% of all doctors in training. For this group, there are still questions about whether the end of automatic recognition of UK qualifications will alter the intentions of EEA doctors in training as well as EEA medical students that would otherwise have come to the UK.

After 31 December 2020, the Directive on the mutual recognition of professional qualifications will no longer apply to the UK. Recognition of UK medical qualifications will be governed by the national policies and rules of each of the EEA member states. This has been confirmed by the European Commission in its official preparedness notice.<sup>59</sup>

We continue to monitor the number and makeup of EEA-qualified doctors licensed to practise in the UK and we have published a series of reports about this group of doctors.<sup>30</sup>

### Box 13: Professional and Linguistic Assessments Board (PLAB)

We've been working with partners in the UK and abroad to resume the PLAB 1 and PLAB 2 assessments, in line with government guidance on social distancing within a workplace setting. This means that, for now, our bookings for the PLAB 2 assessment will be running at about a third of the capacity we would usually expect.

The demand to complete PLAB 2 remains high with all available slots fully booked to the end of 2020. While we anticipate seeing a higher number of IMG graduates applying, travel restrictions, the uncertainty around the pandemic, and cancellation of PLAB 1 dates\* may lead to fewer IMG graduates joining the UK workforce in the near future.

We're now processing a number of registration applications for groups of IMG doctors as there were challenges to obtaining documentation during the initial phase of the pandemic. We're also working with the UK governments to support doctors undertaking PLAB, through initiatives to cut down operational processing and reforming the CESR/CEGPR routes† to registration to make them more accessible.

### UK graduates

There is currently debate about the appropriate proportion of the UK workforce that should be UK graduates and/or have completed their specialty training in the UK. But there is general agreement that the number of doctors graduating from UK medical schools and training in the UK needs to be increased.

Our NTS data show that the pandemic has posed some short-term issues, which have disrupted the provision of formal postgraduate training. This has left most trainees feeling that their opportunities to gain required curriculum competencies for their stage of training were reduced.

Three quarters of trainees (74%) and trainers (78%) said their training, or their role as a trainer, had been affected by the pandemic. Four fifths of trainees (81%) felt the pandemic had limited their chances to gain required competencies. 88% of trainers felt the same.

We have worked with postgraduate training organisations to make sure the pandemic doesn't compromise long-term training needs.

\* Due to rising infection rates in other countries.

† Certificate of Equivalence for Specialist/GP Registration (CESR/CEGPR) provides a route to specialist or GP registration for those doctors who did not undertake formal postgraduate training in the UK leading to a certificate of completion of training (CCT).

**Box 14:**

**Helping to support medical education and training through the pandemic**

Many trainees were redeployed to different specialties or sites as a result of the pandemic. To facilitate this, we approved around 550 additional training locations, so doctors working at them could count this experience towards their training progression.

We also made changes to our approvals process, allowing curricula to change quickly. This meant that assessments could be adapted to new working conditions, while ensuring the same competencies required to attain a CCT.

We supported the introduction of Foundation Interim Year One postings (2020 UK graduates), which have given newly graduated doctors an opportunity to work in approved care settings and support the health service during the pandemic.

We reduced the pressure on the profession by postponing the NTS 2020 and extending the approval of trainers. In addition, we reviewed our quality assurance processes and moved them online where they were required to address particular risks.

We will continue to work with education bodies and postgraduate deans to make sure trainees can catch up on any missed competencies without it being over-burdensome on trainees and trainers.

It's encouraging to see an increase in the number of medical students – a 9% increase from the 2017/18 academic year to the 2018/19 academic year. We'll play our part in making sure that UK education remains of the highest quality. We're introducing the Medical Licensing Assessment to provide a common standard across UK medical graduates. And, as part of our commitment to equality, diversity and inclusion, we'll help to make sure these increasing numbers of doctors are more representative of the communities they care for.

Alongside this, we've presented evidence that longer and more flexible training pathways are becoming more usual. There's also a recognised need for more generalist training and more flexibility in re-training and continuing professional development (CPD) throughout a doctors' career.

**Box 15:****Our commitment to flexibility in training**

Encouraging and improving flexibility in postgraduate medical training was a key recommendation in our 'Adapting for the future' report (2017).<sup>60</sup> Since then, we have worked with the Academy of Medical Royal Colleges, which has recently published guidance for trainees who switch between specialties.<sup>61</sup>

The new guidance will enhance doctors' experiences of training. It will make it easier for them to broaden their experience of different specialties, as well as develop their careers in ways that are tailored to their own strengths, preferences and circumstances. This is all while making sure patients continue to receive high-quality and safe care.

This is one part of our wider educational reforms, which have seen the introduction of outcomes-based training and the review of flexibility in postgraduate training. For example, we have:

- restated our commitment to less than full-time training
- updated our policy for doctors wishing to train in the UK and receive a CCT through the CESR combined programme
- issued comprehensive guidance on support for trainees with health conditions or impairments.

But there is more to be done, by us and by others, to continue to improve the flexibility doctors have during their training.

The pandemic has brought rapid changes to health provision and training, including earlier entry into year one of the Foundation Programme, changes to training and exams, and greater flexibility in the ways in which different specialties and professions are working together. There's a huge opportunity to build on these changes – this relies on building a common agreement among the various bodies across the four nations.

We have recently held an education policy summit with partners from all four countries to consider the future for medical education and training. The discussions focused on:

- assessment and curricula change
- the balance between generalism and specialism
- preparing graduating medical students
- doctors as health leaders.

## Conclusion

As the pandemic continues through 2020 and into 2021, we encourage the learning from this year to be used to promote discussion and change for patients, doctors and all those working in the UK healthcare system.

During the first peak, we have seen areas where doctors have reported positive changes – especially around team working, sharing knowledge, the speed of implementing change and the visibility of senior leaders in patient care settings. These themes are important as they link to doctors' core needs – autonomy, belonging and competence – that are crucial to maintain wellbeing and motivation at work, and patient safety.

As noted throughout this chapter, we and others in the system are already working on improving many of these areas. In particular, our work has focused on leadership, fairness and inclusivity, as well as innovation and teamwork. However, it's important we continue to listen and work with doctors, patients and others in the healthcare system to further reflect and embed learning where we can.

Going forward, we will continue to monitor and track doctors' experiences of training, education and day-to-day work through the NTS and Barometer surveys. In 2021, we'll look at the cumulative impact the pandemic has had on doctors' experiences and wellbeing.