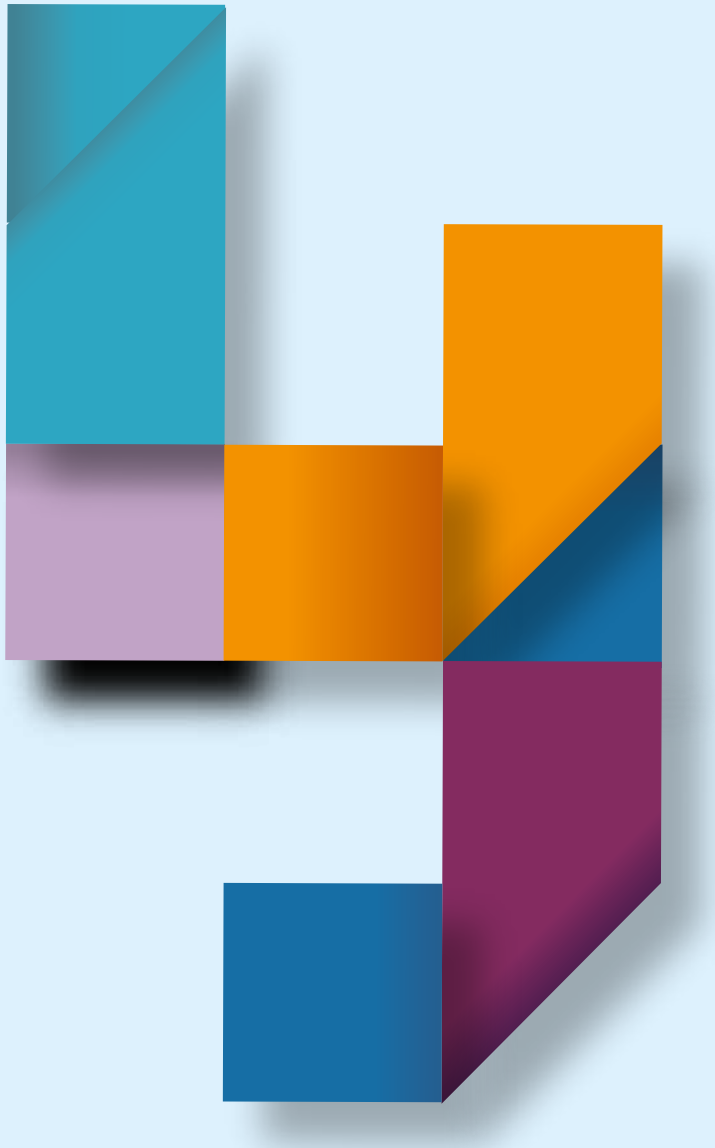
Building towards a positive future



Summary

- Throughout the pandemic a range of innovative new approaches and adaptations has been implemented. Evaluating and learning from these will be vital in ensuring that best practice approaches are identified and retained.
- Ensuring that all healthcare settings are compassionate, inclusive, and focused on supporting workforce wellbeing will continue to play a vital role in ensuring patient safety.
- Multidisciplinary team working has been a vital element of effective working practices during the pandemic and needs to be retained as the healthcare system resets.
- We need to learn from the flexible and adaptable approaches to delivering patient care that have been accelerated during the pandemic, such as using remote consultations, triaging cases to the most appropriate healthcare professional, and sharing knowledge between professionals.
- Visible and accessible leadership will help to underline the lessons of effective multidisciplinary team working and visible leadership learned during the pandemic, and to integrate and make best use of other healthcare professionals in delivering care.

The opportunity to retain positive changes is now

The workplace experiences of doctors working and training during the coronavirus pandemic stand out as the major theme of this report. A worrying return to higher burnout, and its relation to patient safety and staff retention, shines a light once again on issues we have already reported on. These continue to be a concern because of their links both to patient safety and to doctor wellbeing (including increased risk of moral injury and feelings of a lack of psychological safety).

The 'Caring for doctors, Caring for patients'[2] research stated very clearly that 'there is abundant evidence that workplace stress in healthcare organisations affects quality of care for patients'. Although our most recent data say nothing fundamentally new, they serve to underline and reinforce the message that workplace stress affects patient care, and shows the extent to which it remains true in 2021. In this way, the emergence of more compassionate approaches to leadership during the early stages of the pandemic is a positive intention that should be upheld to acknowledge and tackle the issue wherever possible.

In this chapter, we set out again the key statistics from the 2021 Barometer survey that link doctor wellbeing and satisfaction, with patient safety and doctor retention. Then, we explore what doctors and managers have said are the promising changes made during the early stages of the pandemic that could be sustained into the future.

Doctors' satisfaction and manageable workloads are linked to good, safe patient care

The 2021 Barometer survey echoes previous reports in underlining that a high workload is associated both with feeling unable to cope with workloads and with a high risk of burnout.* These factors are also all interlinked – sometimes very strongly – with the following:

- doctor satisfaction
- compromised patient care and patient safety
- intention to leave the profession and taking hard steps to do so
- problems with working environments, visible leadership, and management.

See Box 8 for our evidence about these interrelationships.

* See chapter 1 for more detail.

Box 8: Our data on the relationships between risk of burnout, patient safety and working environments

Doctor satisfaction:

- High workloads/long hours were the most frequent reason given for feeling dissatisfied (33%).

- Doctors at a high risk of burnout were most likely to report being dissatisfied (68%) compared with those with a very low risk of burnout (4%), and more likely to feel unable to cope with their workload at least weekly (44% vs 12%).

Patient care and patient safety:

- 29% of doctors reported seeing patient safety or care compromised while being treated by a doctor over the past year. This was higher for doctors with a high risk of burnout (49%), those who felt unable to cope at least weekly (45%), and for those who were dissatisfied (48%).

- Pressure on workloads and delays to patient care were cited by doctors as barriers to good safe patient care (by 69% and 54% of doctors respectively), and as contributing factors to patient care/safety compromises (by 65% and 54% of doctors respectively).

- Doctors who said that the pandemic had a negative impact on patient care were more likely to report being dissatisfied (45%) than those who said the pandemic had a positive effect on patient care (8%).

Intention to leave the profession, and taking hard steps towards leaving:

55%

- 55% of doctors indicated that they are likely to make a career change in the next year. The changes included reducing hours in clinical practice (24% of doctors), taking a break outside of the profession (5%) and leaving the profession permanently (11%).

7%

- The overall proportion of doctors who have taken hard steps towards leaving has increased from 3% in 2019 and 4% in 2020 to 7% in 2021.

19%

- Having taken hard steps to leave is much more likely among doctors reporting a high risk of burnout (19%), dissatisfaction (17%) and a high number of negative impacts of the pandemic (17%).

Working environments, leadership, and management:

33%

- Doctors at high risk of burnout were more likely to report a negative impact from the pandemic on the visibility of senior leaders over the past year (33%) than a positive impact (16%).

26%

- Doctors at high risk of burnout were more likely to disagree when asked if they felt supported by their senior medical staff (26%) or by non-clinical management (46%) when compared to doctors with a very low risk of burnout (5% and 13% respectively).

40%

- Doctors with a high risk of burnout were more likely to disagree that clinical leaders were readily available (40%) and that their organisation encourages a culture of teamwork (32%) compared to doctors with a very low risk of burnout (9% and 6% respectively).

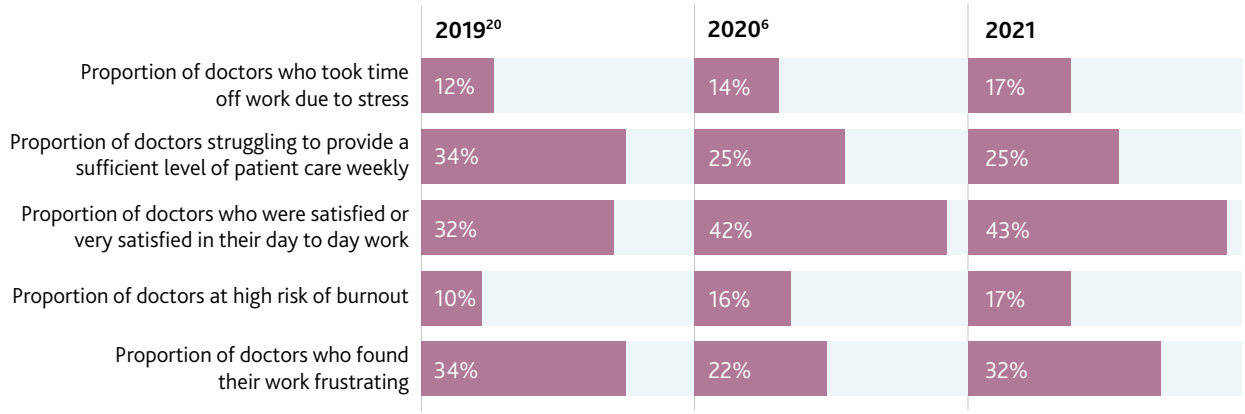
Many of the positives achieved during the first year of the pandemic have been retained and even improved upon, such as the sharing of knowledge and experiences across the medical profession – 60% of doctors in 2021 saw an improvement in knowledge sharing, compared with 54% in 2020. Doctors also feel access to developmental or learning opportunities have improved (30% in 2021 compared with 25% in 2020).[6]

Many aspects of doctors' experiences have changed since well before the pandemic began, but it is a mixed picture (Figure 44).

The clear links between doctor wellbeing, retention, and patient care (see Box 8) make a vital case for prioritising them in the rebuilding and future of UK health services. It is important that the positive changes made during the coronavirus pandemic are retained to support the current workforce and avoid future shortages.

> "The job is still very rewarding but the mess of Covid and the knock-on effects on non-Covid patient care are daunting."
> *2021 Barometer survey, open text response, specialist doctor*

Figure 44: Changes to doctors' experiences between 2019 and 2021



Compassionate cultures help retain the positive changes made during the pandemic

During the early stages of the coronavirus pandemic, many positive changes to working practices were reported by doctors,[21] in particular, improvements in teamwork between doctors, sharing knowledge and experiences across the medical profession, and the speed of implementing change. Some of these, such as the last mentioned, have begun to decrease to pre-pandemic rates.

However, many positive changes have persisted. Focusing on how to retain the most positive aspects of these changes remains important.

Compassionate and visible support from leadership has strengthened supportive workplace cultures

During the early stages of the coronavirus pandemic, many managerial and clinical leaders became more visible and available to the clinical workforce. This availability was broadly viewed positively by doctors and brought with it increased feelings of recognition and clarity about their own roles. This leader visibility happened alongside perceived improvements in how the hierarchy – from consultant to trainee – had been working.

Having been on their own steep learning curves, managers[22] recognise the value of compassionate, visible, and supportive leadership. Regular recognition from leadership figures represents an important ingredient in supporting staff morale, with hospital managers, healthcare organisations, and senior colleagues all having important roles to play.

> "The pandemic has taught me that visible leadership is so important. Wellbeing posters and screen savers aren't the same as putting your hand on someone's shoulder and asking if they're alright. It's as important as having counselling facilities."
> *Changes to Working Practices, NHS Hospital Manager*

An understanding of how these positive changes can be maintained as we move on from reacting to the emergency situation of the coronavirus pandemic is needed, but it is clear that good leadership is critical in ensuring that these shifts in culture are maintained.

Improvements to team working and inclusiveness must be supported to retain them

Our research[1] published in 2019 found patterns of 'insider' and 'outsider' groups of doctors within the UK workforce. Being in an outsider group has negative consequences for doctors, including a lack of supportive induction into new workplaces, not receiving timely feedback on performance, and exclusion from informal social support networks.[2] However, the early stages of the coronavirus pandemic created a sense that 'we're all in this together' which could be consistent with a reduction in the outsider status of some doctors. Many doctors reported positive changes in team working during the pandemic, and feeling supported by immediate colleagues and senior medical staff. This was broadly consistent with data from 2020 and 2021.

We have been repeatedly clear [6, 23, 24] that inclusive workplaces can help reduce patient harm by ensuring doctors receive the support and constructive feedback they need to do their job effectively. When this is lacking, it can lead to a gradual decrease in performance and eventually to breaches of professional standards that require us (the GMC) to take action.[1]

Symptoms that a culture lacks inclusivity can be the observation of a disproportionate number of GMC fitness to practise referrals, or of an attainment gap in groups of doctors with particular protected characteristics (such as disability or ethnicity) as we explained in our commissioned 2019 research.

We have therefore established measures and targets[24] around fitness to practise referrals and closing the attainment gap in medical education. These targets will focus energy across the system on addressing disparities, such as the processes which reinforce 'insider' and 'outsider' experiences.

Supporting workloads and efficient ways of working

In this section, we focus on finding solutions to support the heavy workloads doctors find themselves facing. These solutions have the potential to increase efficiency and capacity for the profession and in turn protect patients and doctors' welfare. As we have reported in chapter 3, 81% of doctors planning to leave the profession (excluding retirement) have cited the adverse effects of their current role on their wellbeing as a reason for wanting to leave. This is clear evidence of the importance of these efficiency gains.

Helping medical practice become more efficient using interdisciplinary team working

The introduction of physician associates and anaesthesia associates, collectively known as medical associate professions (MAPs), was intended to provide more support and expertise within multi-professional teams by enhancing capacity to provide care for patients before, during and after their treatments. There are currently slightly more than 2,500 MAPs but we expect this number to grow. In July 2019 the Department of Health and Social Care – with support from the four UK governments – asked us to regulate these professionals, to support the important role they play and to increase the contribution they can make to UK health services.

In primary care, clinical leads[22] acknowledged that greater teamwork, and a flatter hierarchy which recognises multidisciplinary skills, have allowed general practice to keep functioning through the coronavirus pandemic.

Newer types of team members in primary care are likely to grow in number in the future. These include care coordinators, who ensure patients gain access to the support they need and who sort out missing referrals. There are also social prescribers, who look at the social determinants of health (such as housing, finances and food poverty) and provide a patient with clear, tangible plans to address their problems. Indirect patient care and administration account for more than a quarter of the GP workload.[25]

To enhance understanding among doctors about the MAP roles, the Care Quality Commission (CQC) has issued a 'myth buster'[26] about the responsibilities of physician associates in primary care, to clear up common misconceptions about the responsibilities and accountabilities of those who employ these professionals. As this professional group of MAPs grows, national bodies and workforce planners need to consider how best to deploy MAPs if we are going to make the most of this role being brought into regulation and expanded. Additionally, employers will need to be clear about the responsibilities of MAPs and what is expected of them.

A shift of mindset may be needed. In both primary and secondary care, doctors should not always have to take the lead. Thinking critically about which professional is best placed to provide care, and changing the way teams work together, could benefit patients by making better use of a limited resource. Nurses, pharmacists, physiotherapists, and others have taken on more responsibilities during the coronavirus pandemic. This should be continued, where it is clear that this has been beneficial to patients.

The regulation of MAPs brings opportunities to expand their use and better embed them in multidisciplinary teams. There should be a focus on the skills they bring, allowing doctors to work more effectively and giving MAPs the opportunity to use their skills in a variety of settings. The potential for prescribing responsibilities also enhances the versatility of the role and would allow employers to consider how patient care should best be delivered and by whom. As more new professional roles emerge to meet the changing needs of patients and the health services, it is vital that patients, employers, and other health professionals are confident that those providing care are able to practise to appropriate professional standards, are supported to meet those standards, and are held accountable to them. The role of regulation should be to provide that assurance, support, and accountability, while at the same time facilitating the development of these professional roles to meet the needs of the service.

Remote working can provide efficient ways of working, and help work-life balance, but is not without challenges

Opportunities to work remotely, including from home, have improved wellbeing for doctors, and offered potentially better outcomes for patients. Doctors reported that being able to work at home has reduced their levels of stress and helped them manage workloads better in some circumstances. Some doctors reported that they had been more productive as a result, as they were able to carry on working despite having to shield themselves or family. Some had also been able to reduce travel time or have more focused time to review cases.

> "I have a work laptop connected to VPN, I have got so much done."
> *Case Study, specialist doctor*

We have already described in detail how the shift to providing care remotely has brought benefits in terms of flexibility, better access to consultations, and improved efficiencies.* GPs were particularly likely to have provided most, or all, care remotely (77%) compared with 46% of all doctors.

However, while working remotely has its benefits, practising on-site can also have advantages, such as in improving both multidisciplinary team working, and communication between doctors

* See chapter 1 for more detail.

and management. It will be important to evaluate what mix of home-based and on-site working offers the best outcomes. For example, it may be sensible to allow some administrative work to be done from home, while physical examinations may be better done face to face.

A third of doctors (33%) reported having provided some care remotely when face to face care would have (in their view), been more appropriate or beneficial. Since the beginning of the coronavirus pandemic, face-to-face consultations have been a notable area of controversial media attention.[27, 28, 29] A deeper understanding of what drives these views, and in what situations they are most seen, will be critical to understanding the right balance and future role of remote care provision.

Personal preference plays a part. Some doctors prefer face to face consultations, saying online is more impersonal. Others say it can make patients feel more at ease and give the example of delivering bad news online by video calls when patients can be close to family in their own home. Many patients, however, find the technology difficult or may have limited access to it.

Doctors, clinical leads, and managers have all raised the need for specific clarification to be given on when, and how, to conduct remote consultations. Some clinical leads in primary care highlighted this as a potential gap in the training around consultations in the digital space and the reality of practising in the digital space, particularly as so much history is now gathered digitally before the actual consultation.

The inclusiveness and convenience of online meetings appeal to some clinicians, but others crave personal contact for their mental wellbeing, missing the 'water cooler moments' and the informal debriefs. Teamwork can be more difficult online. A hybrid solution will need to balance both perspectives.

There is a clear opportunity to extend the benefits of flexible working across the workforce, but that will require additional investment, and better organisation and systems. GP practices considering increasing face to face appointments for patients need to be convinced that these changes have been introduced to overcome the downsides of remote working, while also maximising the benefits for both doctors and patients.

We have recently updated our guidance to help keep pace with the increase in general remote working and remote prescribing.[30] In addition, we will include remote and flexible working as part of the review of 'Good medical practice' which we announced in September 2021.[31]

Innovative programmes require clear support and guidance

Programmes such as eConsult* can be effective for administrative purposes – such as sick notes, prescription requests and medication reviews – and provide a communication trail. They can also enable more efficient consultations, as the background and objectives are already made clear, and some patient details are gathered in advance.

However, some aspects of these innovative systems can be demanding, such as the requirement to respond within 48 hours to eConsult requests. Providing such easy access, relative to other routes, may prevent GPs from organising their time as effectively, and may dissuade patients from appropriate self-management of minor ailments. There is also a risk that marginalised groups – particularly some elderly, people with learning difficulties,

* eConsult is software used in GP surgeries that uses online forms to triage and get details from patients.

non-English speakers, and those without Wi-Fi or smartphones – may be excluded from this type of service.

Increasing the demand for GP appointments through otherwise positive innovations puts them in danger of being overwhelmed.

> "I love the job of being a GP but am frustrated and tired due to the 'never full' aspect of primary care. We simply cannot meet patient expectations or demand any more. We have been deluged with eConsults as an additional lane of work entering the practice."
> *2001 Barometer survey, open text response, GP*

Innovative approaches to service delivery are improving patient care

As the UK health service returns to something approaching 'business as usual' after the coronavirus pandemic, new innovative approaches to service delivery continue to be explored to create sustainable ways of managing COVID-19 while also protecting non-COVID treatments.

Forthcoming qualitative research commissioned by the GMC[22] will explore the changes and adaptations to doctors working practices in the UK health service during the coronavirus pandemic. It contains input from doctors, clinical leads, and hospital managers, and discusses how their perspectives may help stimulate thinking about future ways of working in healthcare. It covers areas including:

- improving ways to direct patients to the right area of care first time, through effective digital health, community services, and treatment support.
- Establishing (and protecting) designated 'COVID-19 free' hospitals and treatment sites to limit the spread of infectious diseases, and the possible siphoning of acute and elective treatments to manage treatment backlogs safely during the ongoing pandemic.
- Increasing co-operation, interdisciplinary collaboration and understanding between primary, secondary and community care services at a time of rapid change.
- How widespread adoption of wellbeing initiatives for doctors and healthcare workers across the UK must consider the context of the rapidly evolving multidisciplinary workforce.

Conclusion

The coronavirus pandemic continues to have a wide-reaching impact on the healthcare sector, especially in terms of treatment backlogs and access to healthcare for patients. There are also workforce-focused challenges relating to doctors' wellbeing, securing a sustainable future workforce, managing workloads, and ultimately ensuring that good, safe patient care is protected.

Across the UK's health services, strategic workforce-centred plans have been developed, giving a hopeful signal of future improvements. These plans represent a real combined commitment to the following goals:

- improving health and wellbeing support
- tackling discrimination and improving the sense of belonging
- evolving new ways of working and delivering care effectively
- increasing the workforces for the future across England,[32] Scotland,[33] Wales,[34] and Northern Ireland[35] to ensure that patient safety and high-quality clinical services are maintained.

They must, of course, be properly funded, prioritised, and embedded in the long term to achieve the scale of change that our report suggests is needed.

We, along with other organisations, are working alongside the national bodies to help turn these plans into working programmes – either directly where it is within our remit, or by providing support or evidence to those who can put into practice some aspect of change.

We can do this by:

- setting standards and effective monitoring of new UK medical schools and new overseas programmes
- ensuring that education and training capacity is protected and quality assured, while also encouraging flexibility in training to help meet service targets, and equality, diversity and inclusion goals
- working with others across the system to build on the lessons from the pandemic around preparedness, progression in training and support for doctors in training
- working towards achieving our equality, diversity and inclusion targets for employer referrals to the GMC and also tackling differential attainment in medical education through our 'fairer training cultures' programme of work.

The coronavirus pandemic has presented significant challenges to workloads, with the risk of burnout growing alongside treatment backlogs. However, improvements to interdisciplinary and multidisciplinary teamwork have helped mitigate some of these difficult circumstances. Inclusive workplaces are part of the solution and can help break down the insider/outsider dynamics in the workforce that cause disparities in support for some doctors. The ultimate aim is for doctors to receive the workplace support they need to achieve high professional standards and deliver good patient care. This is further addressed by our 'Fair to refer?'[1] research which made a clear recommendation that senior leaders engage more regularly with staff to listen and take action, in particular to better support some 'out groups' of doctors such as those in ethnic minority groups.

Doctors' satisfaction and ensuring a sustainable workforce are linked with positive working environments that foster a compassionate and constructive working culture. These goals are best managed through visible and compassionate leadership which works to ensure that all positive culture changes observed are permanently incorporated into the working environment.

Lessons can be learned from the rapid evolutions and adaptations of doctors' working practices over the course of the coronavirus pandemic, but manageable workloads remain a key factor in providing good and safe patient care. New ways of working – such as delivering remote care, working from home, and virtual training and meetings – have acted as catalysts for welcome improvements in doctor wellbeing and efficiency. Clear support and guidance from the health system is needed to ensure that these positive aspects become permanent features.