The state of medical education and practice in the UK

Workplace experiences 2023

General Medical Council

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Foreword

This is a time of unparalleled pressure in the healthcare sector.

The testimony we've heard from doctors is stark. Workloads are up, stress-related absence and risk of burnout have increased, and large numbers of doctors feel unable to cope. This not only has a damaging impact on clinicians, but also on the patients in their care. In 2022, 44% of doctors found it difficult to provide patient care at least once a week, compared to 25% in 2021.[1]

It's not surprising, then, that more doctors told us they had taken steps to leave UK practice. As clinicians vote with their feet, the gap they leave behind compounds workload pressures, feeding into a vicious cycle.

The coronavirus pandemic was hugely challenging and left those who worked through it with deep-seated and painful memories, which mark them to this day. But, in many places, it also disrupted the vicious cycle and showed that things could be done differently. In 2021, 60% of doctors reported that the pandemic had had a positive impact on teamwork. 40% felt there had been a positive impact on the visibility of senior leadership. Since then, the long-term problems and pressures we observed in 2019[2] have returned in full force, alongside the additional demands of the treatment backlog.

Long-term actions are needed to address structural challenges in the service. Steps to better understand future workforce needs, and increase training numbers for doctors and other professionals, are long overdue and welcome. But, in the short term, our focus must be on retaining and better supporting the medical staff we already have. Without urgent changes now, the vicious cycle will intensify, patients will suffer and doctors increasingly risk burnout, fatigue, and moral injury.

We know that being part of a supportive team and having a strong sense of belonging lead to higher satisfaction and better patient safety. These protective factors must be treated as a priority now, with good practice being shared and scaled up.

While the root causes of inadequate staffing, waiting lists, and unprecedented demand are tackled on a larger scale, local changes can be made today to improve doctors' working lives and make them feel that they belong and are valued. Improvements in areas such as fair and timely rota design, facilities for rest breaks, and provision of food and drink could make a huge difference to staff on the ground. They could also be instrumental in creating more virtuous cycles and helping us retain the healthcare professionals that we need to provide safe patient care.

While there are difficulties across the board, our research shows that certain groups report worse workplace experiences and require targeted support. Crucially, trainers face added pressures compared to non-trainers, being more likely to work beyond their rostered hours and more likely to describe their days as high intensity. It will not be possible to deliver the much-needed expansion of training capacity without both an increase in trainer numbers and concrete steps to support their specific needs. Investment in this area must be a priority as governments across the UK define plans to address longer-term workforce challenges.

Addressing these concerns requires concerted action across the UK healthcare systems. Improving doctors' wellbeing must lie at the heart of shared efforts to bridge the gap until long-term solutions are implemented. This is crucial not only to their satisfaction and desire to remain in the service, but also to the safety of those in their care.

We are committed to playing our part in that endeavour. Whether it's our induction programme for overseas doctors to help them thrive in UK practice, our targets to eliminate disproportionate referrals and differential attainment, or our work with employers to improve local resolution of concerns, we're committed to improving doctors' working lives, so they can give the best possible patient care.

Patient safety is protected when doctors feel supported. In an increasingly pressurised environment, a sustained focus on compassionate leadership and culture must be centre stage, as we navigate the challenges ahead.

Professor Dame Carrie MacEwen
Chair

Charlie Massey
Chief Executive and Registrar

Executive summary

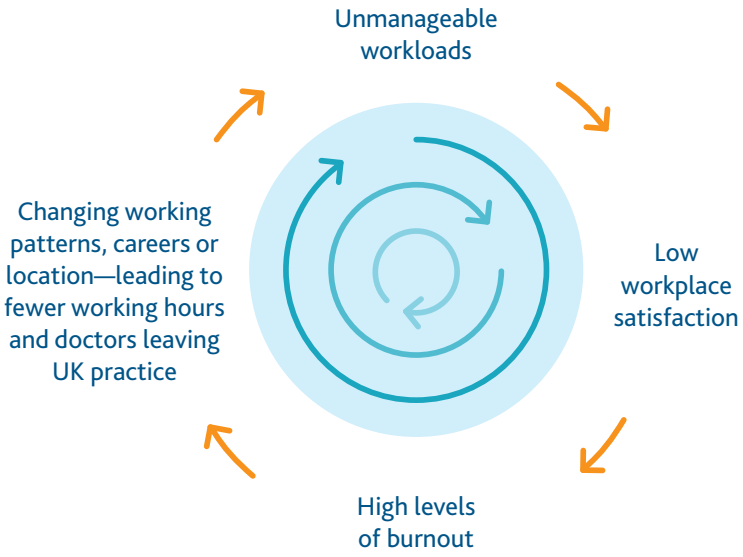
The state of medical education and practice in the UK: Workplace experiences 2023 is published at a time when the UK health systems face extensive challenges. This report shares concerning data about the experiences of doctors and the challenges to providing adequate care to patients. In this context, careful and constructive exploration of the practical, evidence-based steps that can be taken to improve the situation is critical, to protect both patients and the doctors who care for them.

This report sets out our insights on doctors' workplace experiences and the effects of these experiences. These insights are drawn from our Barometer survey 2022 and qualitative research that involved interviews with doctors, trainers, and senior stakeholders from UK healthcare organisations. Views on patient care are the perceptions of doctors and stakeholders, this report does not include research with patients.

Doctors' working environment is increasingly challenging

In 2018,[3] we first identified that doctors were affected by vicious cycles relating to workforce pressures and lack of time for patients, development, and personal wellbeing. The COVID-19 pandemic was an enormous shock to UK health systems and caused tremendous pressures and struggles. But, in many areas, it also disrupted the vicious cycles, often in temporary and localised ways.

Figure 1: Vicious cycle affecting doctors



Alongside the necessary prioritisation of treatment were beneficial innovations relating to service design and ways of working, and in 2020 doctors reported a range of positive changes. But, as the UK health systems dealt with the considerable treatment backlog, 2021[1] saw higher levels of burnout risk, growing workloads, and declining levels of job satisfaction.

Now, as well as dealing with the treatment backlog and the persistence of COVID-19, the long-term problems and pressures we explored in 2019[2] have returned in force. Our latest Barometer survey of doctors, conducted in 2022 to inform this report, revealed that more doctors are dissatisfied, at higher risk of burnout, considering leaving the profession, and have experienced compromised patient safety or care and risk of moral injury.

Support is key to reducing burnout and increasing satisfaction

Our Barometer survey findings highlight the importance of team working and inclusion to good, safe patient care. The development of supportive teams may have been affected by a rapid change towards online working, and shift work and rapid rotation of trainees may contribute to difficulties in establishing relationships. Effective induction of doctors is important, and particular challenges are associated with integrating doctors arriving from overseas and incorporating locum and bank staff into teams.

Our findings show doctors feel less supported by colleagues and managers, with some of the improvements in this area seen during the pandemic being eroded. The UK health systems prioritise protection of patients, often over the wellbeing of staff, but, in the long term, patient care and safety depend on staff wellbeing. Many staff and senior stakeholders believe some beneficial workplace changes are possible even within the current challenges and constraints.

Urgent action is needed by employers

While long-term solutions to underlying issues are being implemented, the detrimental impact on doctor wellbeing needs to be mitigated as much as possible in the short term. This will involve taking immediate action to improve working conditions for all healthcare staff, and working to improve inclusion and belonging in order to enable effective team working.

Making progress on these issues will contribute to improving retention, helping reduce workplace pressure, and so help to protect patients as well as staff. These issues also cross professional and organisational boundaries, and our influence as the GMC is limited. The delivery of urgently needed solutions demands collaborative action across the UK health systems.

Chapter 1: Doctors' workplace experiences in 2022

We have tracked doctors' workplace experiences via our Barometer survey since 2019. The Barometer survey 2022 shows a deterioration in doctors' experiences since 2020 and a continuation of the vicious cycle reported in previous years. Doctors' experiences are now worse than at any time since we began the Barometer survey.

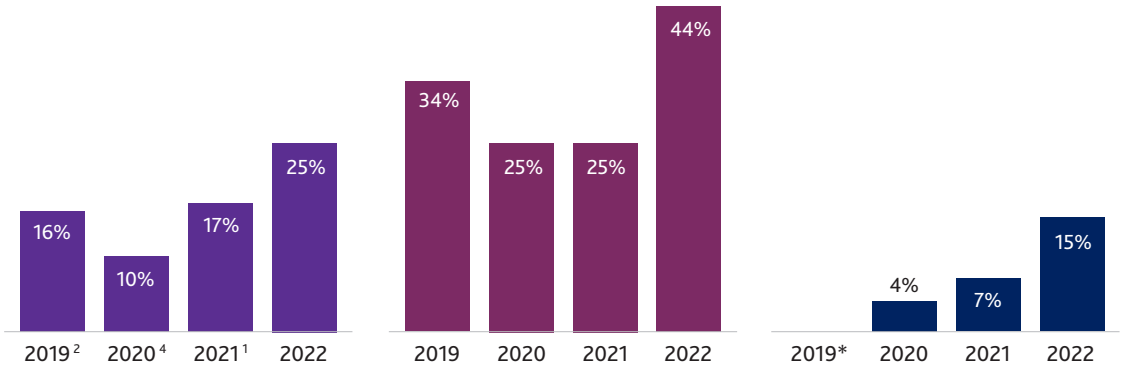
Half of doctors (50%) were satisfied in 2022, down from 70% in 2021.[1] In 2022, more doctors reported working beyond their rostered hours on a weekly basis (70%, up from 59% in 2021), having difficulty taking breaks each week (68%, up from 49% in 2021), and feeling unable to cope with their workload each week (42%, up from 30% in 2021). A quarter of doctors surveyed (25%) were categorised as being at high risk of burnout in 2022, compared with 17% in 2021.

In 2022, more than two-fifths of doctors (44%) said they found it difficult to provide sufficient patient care at least once a week. This is a significant increase from 2021, when a quarter of doctors (25%) reported this, and more than 2019,[2] when a third of doctors said this (34%).

Moral injury is distress caused by people acting, or seeing others act, in a way that goes against their values and moral beliefs. We do not measure moral injury at present, but there is a risk that many doctors and other staff have suffered moral injury due to their work experiences. Possible causes could include not being able to provide patients with the level of care they would have wished, having to prioritise some patients over others due to a lack of time or resources, or being unable to support colleagues as much as they would like.

More doctors than ever said they were likely to leave the UK profession and had taken hard steps towards doing so (excluding doctors of retirement age who were planning to retire). 15% of doctors said they had taken steps to leave, up from 7% in 2021. We added new response options that count as hard steps to the Barometer survey 2022, and this has had some effect, but even if these are excluded the increase is significant.

Figure 2: Percentage of doctors at high risk of burnout, regularly finding it hard to provide sufficient care to patients, and taking hard steps to leave, 2019–2022



n = 3,876 (all doctors), the Barometer survey 2019 QD1/D2/D3-9/B3.
n = 3,693 (all doctors), the Barometer survey 2020 QD1/D2/D3-9/B3.
n = 3,386 (all doctors), the Barometer survey 2021 QD1/D2/D3-9/B3.
n = 4,269 (all doctors), the Barometer survey 2022 QD1/D2/D3-9/B3

* Comparable data for this metric not available in 2019

GPs

GPs had poor workplace experiences, causing issues filling vacancies and reducing service capacity. In 2022, 38% of GPs said they were satisfied, fewer than other doctors and down from 51%[1] in 2021. Over half of GPs (55%) were categorised as struggling with their workload, compared with 38% of all doctors. 45% of GPs reported experiencing compromised patient safety or care, and 62% found it difficult to provide sufficient patient care each week.

Trainers

Doctors who were trainers had more negative experiences than those who were not. For example, 18% of trainers disagreed that they were supported by senior medical staff, compared with 10% of non-trainers. Half of trainers reported experiencing compromised patient safety or care (51%) and having difficulty providing sufficient patient care each week (49%), compared with two-fifths of non-trainers (39% and 43% respectively).

Doctors with a disability

Doctors with a disability had a less positive experience across multiple measures. This is likely to prevent these doctors making the full contribution to healthcare service delivery of which they are capable, despite their workplace challenges being potentially remediable.

As in previous years, fewer disabled doctors were satisfied in their work, 44% compared with 51% of non-disabled doctors. Almost half (47%) of disabled doctors were categorised as struggling with their workload, compared with 37% of non-disabled doctors.

SAS doctors and LE doctors

Specialty and associate specialist (SAS) doctors and locally employed (LE) doctors are an essential and diverse group, and the fastest-growing part of the UK medical workforce. Changes to the Barometer survey mean that, for the first time, we can report on SAS and LE doctors separately, based on the Barometer survey 2022, and look at their particular challenges. However, comparison with earlier years is not possible because previous Barometer surveys grouped SAS and LE doctors together.

Our data show particular concerns are associated with LE doctors who gained their primary medical qualification (PMQ) in the UK. This group is relatively young, and 58% had seen or experienced compromised patient safety or care, a higher proportion than other groups of SAS and LE doctors and doctors of other registration types.

Another group of interest is SAS doctors with a PMQ from outside the UK. 44% of this group were doing well in terms of workload, but they may be underutilised; 29% often carried out tasks usually completed by a more junior doctor.

Given the significance of our analysis of distinct groups of SAS and LE doctors, we are sharing our initial findings in this report. We will publish a fuller analysis of the working experiences of SAS and LE doctors later in 2023.

Chapter 2: Breaking the cycle in the short term

The vicious cycle described in chapter 1 must be broken to improve doctors' working experiences, and ultimately improve patient care. The most commonly cited barriers to providing good patient care were inadequate staffing (33% of doctors) and pressure on workloads (24%). Resolving issues relating to these areas is a significant and long-term undertaking which will include additional healthcare staff, additional supporting roles and systems, and robust and transparent long-term workforce planning.

Our research indicated that positive feedback loops that improve workplace experiences would have significant benefits. Such virtuous cycles could act as an antidote to vicious cycles, with the positive effects likely to exceed the sum of their parts.

Feeling valued by their employers will help cultivate a sense of belonging amongst doctors. This sense of value can be developed by providing different levels and types of support for healthcare professionals, improving communication, and tackling bullying and discrimination, while providing facilities such as rest areas, making tea and coffee available, and developing a fairer approach to rota design. The effect of these changes could improve doctors' workplace experiences, thereby improving retention, decreasing workloads, and improving patient safety.

Learning environments should be developed, providing trainers and trainees with more protected learning time. This would allow better support to be given to trainees, whose competence and confidence will therefore improve, allowing them to work more independently.

Figure 3: Maintaining high satisfaction can help halt the vicious cycle

To protect patient safety, there is an urgent need to focus on doctors' wellbeing, which itself is anchored in having support from colleagues and leaders, satisfaction in their work, and a strong sense of belonging. 81% of doctors who reported that they had not experienced compromised patient safety or care said that they were part of a supportive team, while only 68% of those who had experienced compromised patient safety or care agreed that their team was supportive.

Team working and support are protective factors associated with increased doctors' satisfaction in their work. They also promote patient safety. Declining levels of support and effective team working may lead to further loss of satisfaction, with implications for the retention of doctors in the workforce, which could together jeopardise the delivery of effective and safe patient care.

Immediate action to improve working conditions is needed

It is crucial to act immediately to improve working conditions in workplaces across the UK health systems, so the workforce feels valued and supported. We believe changes that will deliver benefit quickly can be made in the following areas.

Ensure doctors feel valued by their employers and have a strong sense of belonging

A workforce that feels valued will have higher rates of retention, which will ultimately have a positive impact on patient safety. Employers can make clear to staff in many ways that they and their work are valued. As outlined in chapter 2, our commissioned report *Caring for doctors, Caring for patients*[5] outlines the 'ABC' that doctors need in order to feel valued and secure in their work: autonomy, belonging, and competence. Changes that relate to each of these important areas are discussed across chapters 2 and 3.

Enable effective and supportive team working to improve belonging

Effective teamwork and a sense of belonging can protect against the negative impacts of high and intense workloads, enhance doctor wellbeing, and contribute to improved patient safety and care. Working in a supportive team is a key component of belonging, so more effective teamwork and improved support for doctors who are struggling could be a way to start to alleviate the strain on them.

Doctors' sense of belonging and inclusion in teams needs to be improved, focusing first on groups who have worse experiences. As set out in chapter 1, different groups of doctors have widely varying working experiences. For example, doctors who gained their PMQ outside the UK are a group that needs particular attention and support, and their experiences and needs must be better understood. And disabled doctors are more likely than non-disabled doctors to report more negative experiences across a range of measures.

Evolving and developing what it means to be a leader

Ensuring leaders understand the needs of their colleagues, and have the resources and time to provide good, personalised support, can be extremely beneficial for the wellbeing of all healthcare professionals. Feedback should

be compassionate and constructive. Learning opportunities should be built into practice, particularly after mistakes have occurred, and workplaces should move away from blame cultures. Clinical leaders should respond quickly to requests for advice and support and be easy to contact. Hard work should be acknowledged and celebrated.

Building strong teams

Strong teams are vital for a doctor's sense of belonging. They can be built in a variety of ways, such as induction for new staff members (including introduction to colleagues and explanation of team structures), ice-breaking activities for new teams, staff events that create a sense of cohesion and belonging, formal support that makes clear the roles within teams, and rota design that ensures connections and relationships develop between colleagues.

Developing induction and onboarding

When a doctor joins a new workplace, it is important for there to be a thorough and ongoing induction into the new role. This should include introductions to both colleagues and systems, allowing new staff members to hit the ground running and feel confident in their role.

Developing flexible rota design

Rota design should be fair and flexible, and take into consideration life events and personal circumstances where feasible. Rotas should always handle individual preferences and circumstances fairly and be arranged in a timely manner. Rota design should consider the latest research about fatigue, to support the health and wellbeing of doctors. Effective rota design could also enhance the development of teams.

Providing workplace rest and refreshment facilities

Relatively straightforward changes could be made, including providing space for meaningful rest breaks, facilities for hot drinks and food (including during night shifts), facilities and information for parents and carers, and safe car parking facilities that are subsidised or free (especially for late shifts). Longer-term changes could include providing childcare facilities near workplaces, having rooms or dorms for naps during nightshifts, and making arrangements for safe transport home after late shifts.

Our research, including interviews with various senior stakeholders, highlights the value of these changes, which were not seen as especially expensive, particularly given their potential benefits. However, these changes should be developed alongside and simultaneously with longer-term changes that likely require more time and perhaps investment. These are described in chapter 3.

Chapter 3: Looking ahead – reflections for the health sector to consider when looking to the future

To maintain patient safety and the wellbeing of the workforce, there are several long-term strategic needs that the wider system should consider in view of our new evidence. This chapter sets out the areas which our evidence suggest would be beneficial to tackle, for consideration by leaders and policymakers.

Long-term strategic priorities

It is necessary to address difficult and interconnected challenges around work intensity, primary care, and training capacity. It is crucial to provide support and protected time to enable trainers to deliver training, trainees to build competencies and confidence, and all doctors to train and develop.

Making work intensity more sustainable

Much of the intensity of doctors' work is due to demand for care services outstripping the capacity to deliver it, particularly in primary care, but impacting all areas. There is a clear need to increase overall capacity to deliver patient care. But ways are needed to reduce the impact of high work intensities on staff wellbeing and patient safety. This should take into account that work intensity may have different drivers.

Working to increase training capacity

Doctors who take on the role of trainer report more negative workplace experiences, and describe challenges in finding time to dedicate to training and teaching. Training capacity needs to increase, given the intention to increase the number of UK training posts. Doctors need to be encouraged and motivated to take on training responsibilities. Trainers need to be supported, have protected time to train, and have flexibility in their service delivery and supervisory responsibilities.

Building trainees' confidence and autonomy

The future of the workforce depends on trainees, and it is critical that they are well prepared for their role to avoid medium-term capacity issues. How trainees are supported, and whether training experiences fully prepare them for practice, is a concern. Dedicated time for training may not be sufficiently valued, due to a drive to prioritise clinical time. Trainees need time set aside for them to develop their competencies and confidence, and need to be able to reflect on learning, receive and consider supervisor feedback, and prioritise time to implement their learnt skills. Trainees cannot be constantly relied on to plug gaps in a struggling workforce to the detriment of their development, and therefore to the detriment of future service capacity.

Enhance development opportunities for all doctors

Many doctors feel under pressure and unable to commit time to training and development, and use their own time to meet this requirement. All doctors and healthcare professionals need to be able to ring-fence training and development time. The existing pressures on doctors may mean that such ring-fencing takes time, but it needs to be worked towards.

Strengthen support for primary care

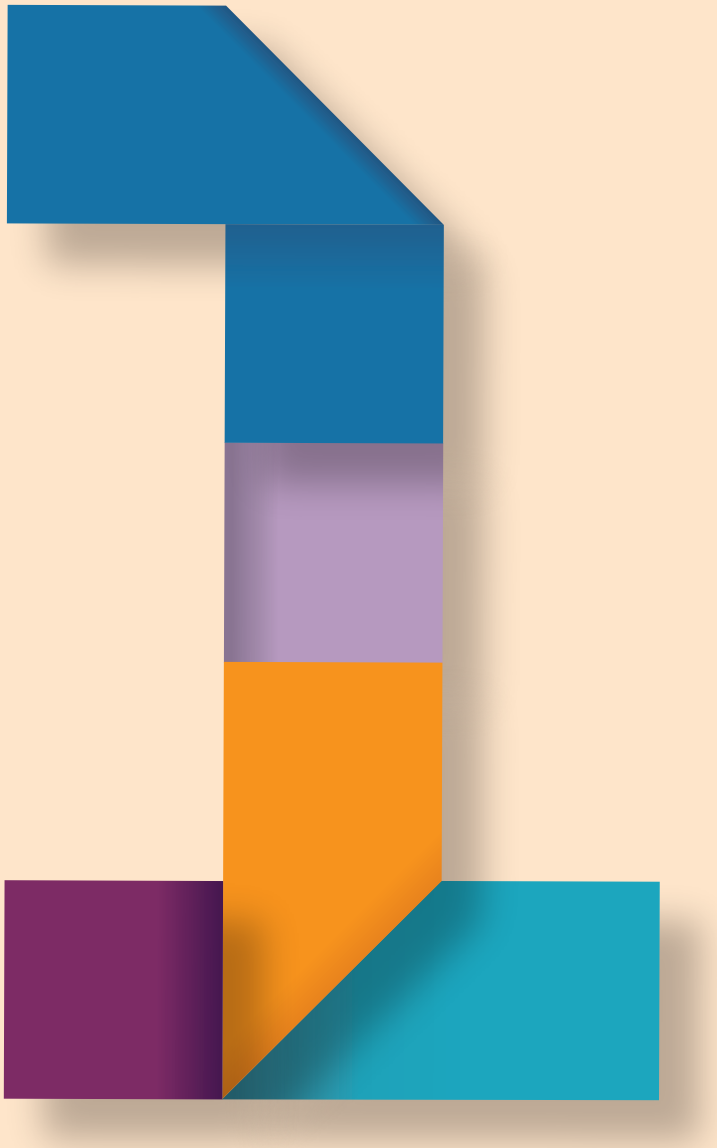
The particular pressures in general practice need to be addressed to protect patient safety and staff wellbeing. Consideration should be given to how links between primary and secondary care can be improved, how trainee doctors can be encouraged to choose primary care as a specialism, and how community and social care capacity can be increased to enhance care for patients before, during, and after their treatment. Greater use of other healthcare professionals, such as physician associates, anaesthesia associates, and advanced healthcare practitioners, should be considered to help improve productivity, increase capacity to provide care, and improve patient access to care.

Conclusion

Our research and analysis about the challenges facing the UK's medical profession paint a stark picture. What we have learnt from doctors and senior stakeholders across the UK health sectors should bolster resolve to tackle both the immediate and longer-term challenges the profession and health system face. We have outlined the challenges and suggested approaches to begin to address them in this report.

We will continue to work to better understand and accurately report on the state of medical education and practice in the UK by seeking ongoing input and dialogue from and with doctors, patients, and our partners.

Doctors' workplace experiences in 2022



Summary

- Our evidence shows the resurgence of a vicious cycle of workplace pressures, with increased workloads, lower levels of satisfaction, higher risk of burnout, and more doctors taking steps to leave the UK profession, ultimately putting patient safety in jeopardy:

	2021[1]		2022
Doctors working beyond their rostered hours at least weekly	59%	↑	70%
Doctors at high risk of burnout	17%	↑	25%
Doctors dissatisfied	22%	↑	43%
Doctors taking hard steps to leave	7%	↑	15%

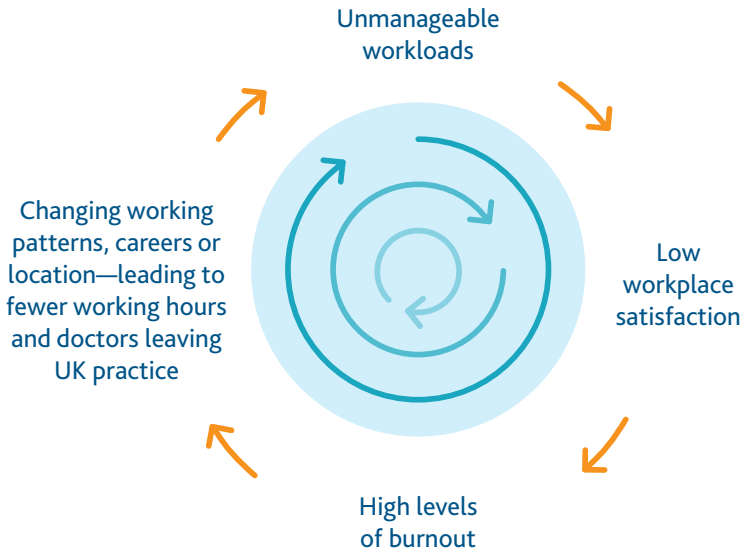
- This has a negative impact on patients. 44% of doctors reported finding it difficult to provide a sufficient level of patient care at least once a week in 2022, up from 25% in 2021. Perceived inability to provide adequate care and ensure patient safety puts doctors at risk of moral injury.
- Pressures experienced in certain parts of the workforce have the potential to jeopardise long-term workforce planning unless appropriate action is taken to support existing staff.
  - GPs reported worse workplace experiences in a range of areas and only 38% of GPs' were satisfied in their work, compared with 50% of all doctors.
  - Half (49%) of trainers described at least three-quarters of their days as high intensity, compared with 40% of non-trainers.
  - 47% of disabled doctors were categorised as struggling with their workload, compared with 37% of non-disabled doctors.
  - Fewer non-UK graduate doctors (65%) said they were part of a supportive team than UK graduates (78%).

Introduction

We have used *The state of medical education and practice in the UK* Barometer survey to track doctors' workplace experiences since 2019.[2] Over this period, we have reported significant changes in the ways doctors work and the environments they work in.

In 2019, our analysis of the Barometer survey findings highlighted a vicious cycle of unmanageable workloads, low satisfaction, burnout, and doctors leaving UK practice—putting more pressure on remaining doctors.

Figure 1: Vicious cycle affecting doctors

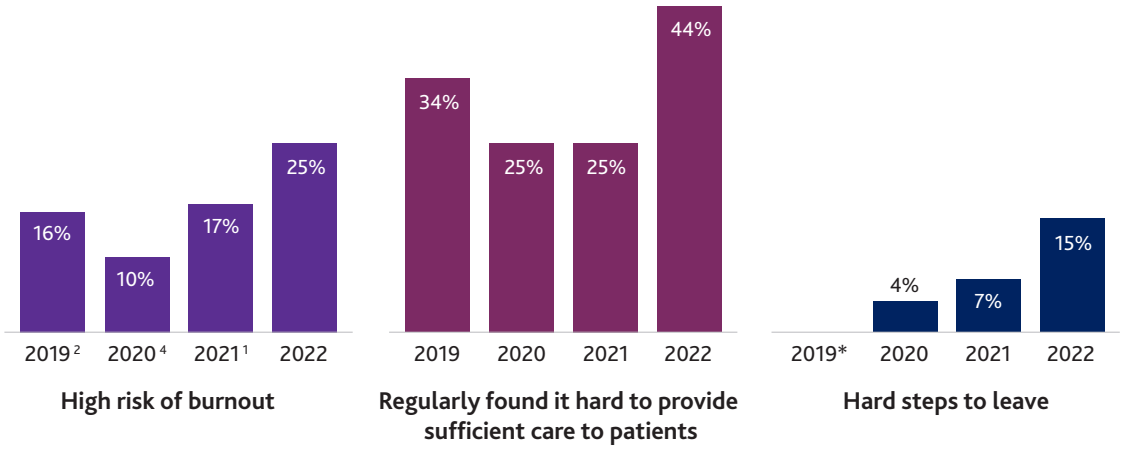


In 2020, the health system's focus shifted to dealing with the coronavirus pandemic. This had a significant effect on UK health systems, as they responded at pace to caring for patients in a new working environment.

However, doctors reported a range of surprisingly positive changes to how they worked during the pandemic. For example, in 2020[4] 54% of doctors reported that the response to the pandemic had improved knowledge sharing, while 38% said that the visibility of leaders had increased. Some doctors may also have had a temporary reduction in their workload because appointments and procedures were postponed.

But these positive perceptions were short-lived, as the UK's health systems began to deal with the considerable backlog of patients in the wake of the pandemic. Compared with 2020, the 2021 Barometer survey found higher risks of burnout among doctors, alongside declining levels of

Figure 2: Percentage of doctors at high risk of burnout, regularly finding it hard to provide sufficient care to patients, and taking hard steps to leave, 2019–2022



n = 3,876 (all doctors), the Barometer survey 2019 QD1/D2/D3-9/B3.
n = 3,693 (all doctors), the Barometer survey 2020 QD1/D2/D3-9/B3.
n = 3,386 (all doctors), the Barometer survey 2021 QD1/D2/D3-9/B3.
n = 4,269 (all doctors), the Barometer survey 2022 QD1/D2/D3-9/B3

* Comparable data for this metric not available in 2019

job satisfaction and growing workloads. At the same time, the longer-term effects of pressures that were building before the pandemic began to emerge. These included lengthy waiting times for treatment referrals in England [6] and significant challenges recruiting to vacancies in the growing workforce—driven to a large extent by increased demand for healthcare from an ageing population with more complex health needs.

Concerningly, in 2022, doctors' workplace experiences continued to deteriorate sharply. Figure 2 shows the general trend, which saw some improvement from 2019 to 2020, followed by a notable decline from 2020 to 2022.

The result of built-up pressures—caused by the coronavirus pandemic as well as longer-term challenges—was an increasingly fatigued and burnt-out profession in 2022.

Our analysis shows how multiple and complex pressures are manifesting in different ways. Senior clinical leaders often receive little support, early career medics are juggling work and catching up with assessments, while trainers are under increasing pressure from several directions.

The Barometer survey data suggest that unmanageable workloads lead to low job satisfaction and burnout, which ultimately change working patterns. Some doctors reduce their hours (in some cases due to stress or poor mental health) or leave UK practice entirely, either to practise abroad or change careers. The 'hard steps' shown in the figure above include actions such as contacting a recruiter, applying for a clinical job abroad, and applying for posts outside the medical profession. In 2021,[7] around 10,000 doctors left UK practice, while around 21,000 doctors entered it.

These issues are not confined to the UK's workforce of doctors. Leaving rates in other health professions have increased. Nurses are leaving in record numbers. More than 40,000 nurses left the NHS in England in the year to June 2022,[8] and almost 7,500 left in Scotland over a similar period. That is equivalent to one in nine nurses leaving.

Care often requires multidisciplinary teams, so this high rate of turnover, and related shortages, add to the pressure on doctors and other healthcare staff. Professor Jeremy Farrar, Chief Scientist of the World Health Organization, said in 2023 that healthcare workers around the world were 'absolutely shattered'.[9]

Summarising the challenges facing the healthcare system in England, in February 2023 the House of Commons Public Accounts Committee said that plans to reform healthcare in England will not succeed if major systemic problems in the NHS at a national level weren't tackled—namely, the record treatment backlogs, high vacancy rates, growing demand for care, a 'crumbling NHS estate', and a 'difficult financial outlook'.[10]

Against this worrying backdrop, the Barometer survey data trends suggest that doctors may be at heightened risk of moral injury. This is psychological distress caused by engaging in or witnessing behaviours that go against an individual's values and moral beliefs. In our 2021 report, we highlighted the traumatic effects of the pandemic on doctors. Despite the pandemic easing, we remain concerned that doctors who feel unable to meet the needs of their patients may experience detrimental psychological effects. This could play into the vicious cycle depicted in Figure 1 and is especially important given the close association between doctors' risk of burnout and perceived failures in patient care.

Examining each part of the vicious cycle in turn, in this chapter we look at how clinicians responded to very high patient demand in challenging circumstances. We analyse doctors' day-to-day satisfaction, workloads, stress levels, risk of burnout, and perceptions of patient care. Doctors' experiences of many of these issues have become increasingly negative—we explore what drove this in 2022. Where appropriate, we make comparisons across doctors of varying registration types, as well as how experiences varied by personal characteristics such as ethnicity and disability. Following this, in chapters 2 and 3, we set out some of the things our evidence suggests would help the situation, for the consideration of stakeholders.

Box 1: Evidence sources used in this chapter

The Barometer survey 2022 explored doctors' workplace experiences, with many questions kept consistent since 2019 to enable tracking. The survey asked about doctors' experiences, views on patient care and safety, career intentions, day-to-day satisfaction, workloads, and burnout indicators, perspectives on patient safety, and future career plans. A representative sample of 4,269 doctors was surveyed in September and October 2022.

This chapter also includes insights from commissioned, follow-up qualitative research exploring specific aspects of doctors' workplace experiences. This involved 20 in-depth interviews with a range of doctors, and ten further interviews with trainers. Participants were recruited from the sample of doctors who had completed the Barometer survey 2022, and had indicated that they would be willing to participate in further research.

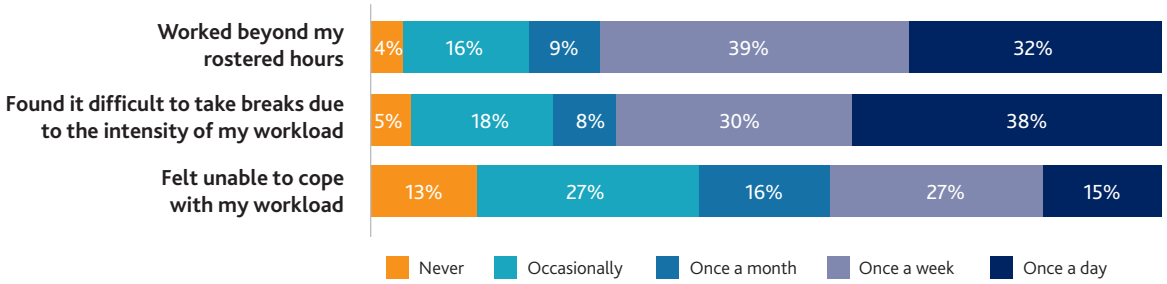
Further information on these evidence sources and the research methods applied is set out in the Note on research and data section.

Doctors' workloads are increasing

Findings from the Barometer survey 2022 show an increase in all elements of workload pressure since 2021. Figure 3 shows that more doctors worked beyond their rostered hours, found it difficult to take breaks due to workload intensity, and reported that they felt unable to cope with their workload. Looking at the percentage of doctors experiencing these pressures at least once a week, Figure 4 shows that all three of these metrics have worsened in the period from 2021 to 2022.

Figure 3: How frequently doctors experienced workload pressure in 2022

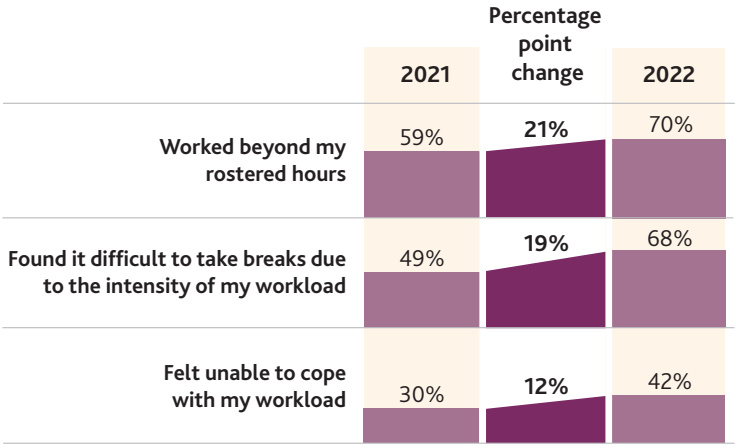
How frequently, if at all, over the last year have you experienced the following…?



n = 4,269 (all doctors), the Barometer survey 2022 QC1_1/C1_5/C1_2. Excluding don't know and prefer not to say.

Figure 4: Doctors' experiences of workload pressure at least once a week, 2021–2022

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



n = 3,386 (all doctors), the Barometer survey 2021 QC1_1/C1_5/C1_2. Excluding don't know and prefer not to say.
n = 4,269 (all doctors), the Barometer survey 2022 QC1_1/C1_5/C1_2. Excluding don't know and prefer not to say.

In 2022, on average doctors described their workload as highly intense on almost two-thirds of working days (63%). This was a slight increase from 60% in 2021. Doctors described just under a third of days (29%) as moderately intense in 2022—similar to 2021 when the figure was 30%. Doctors considered fewer than one out of ten (8%) days as low intensity, down from 10% in 2021. More than four out of ten doctors (45%) described the intensity of their workload as high on at least three-quarters of their working days, up from 35% in 2021.

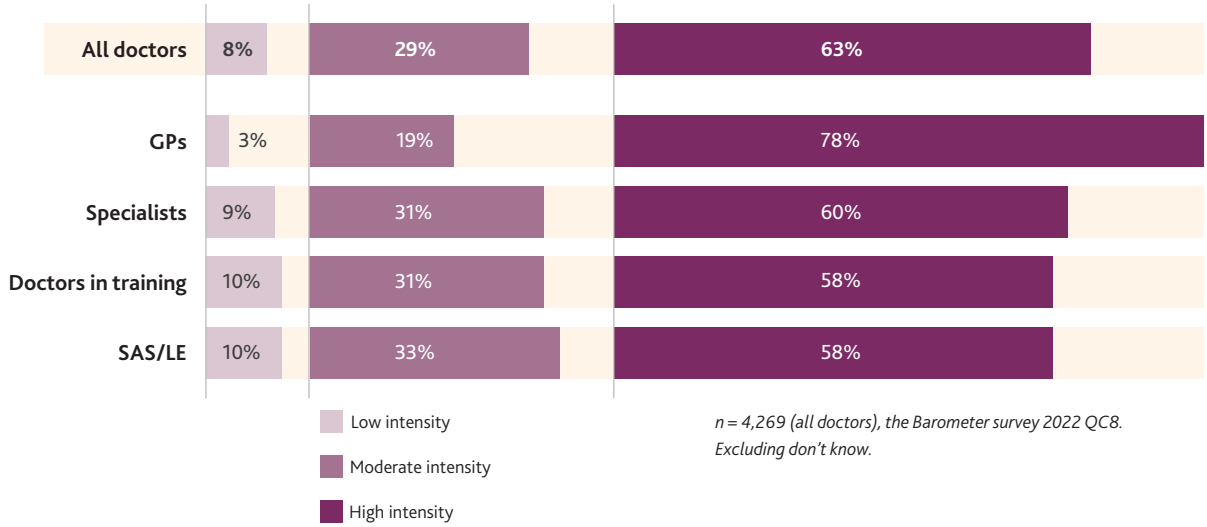
General practitioners (GPs) reported more high-intensity days (78%) than other doctors and fewer low-intensity days (3%).

Doctors who participated in the follow-up qualitative research said that they were expected to deliver more work than previously but were not given additional time. They said that they often felt pressured to work through their breaks to reduce the backlog of care. Several reasons were cited for this increased intensity, including the ongoing effects of the coronavirus pandemic, a lack of staff, and patients' ability to contact doctors through multiple channels. The return to in-person appointments and the tendency for patients to present with multiple problems at once also intensified the demand on clinicians.

In 2022, over half (53%) of doctors were asked to undertake tasks usually completed by doctors in a more junior role at least once a month, compared with 46% in 2021. These extra responsibilities added to doctors' overall workload intensity. This trend raises questions about efficiency and productivity in the workforce.

Figure 5: Intensity of workload by registrant type

Over the last year, on roughly what percentage of your working days would you describe the intensity of your workload as high, moderate and low?



n = 4,269 (all doctors), the Barometer survey 2022 QC8. Excluding don't know.

More doctors are struggling with their workload

Since 2019, we have used data from the Barometer survey to analyse the relationship between doctors' working hours and whether they feel able to cope with their workload. In the analysis, we split doctors into four groups.

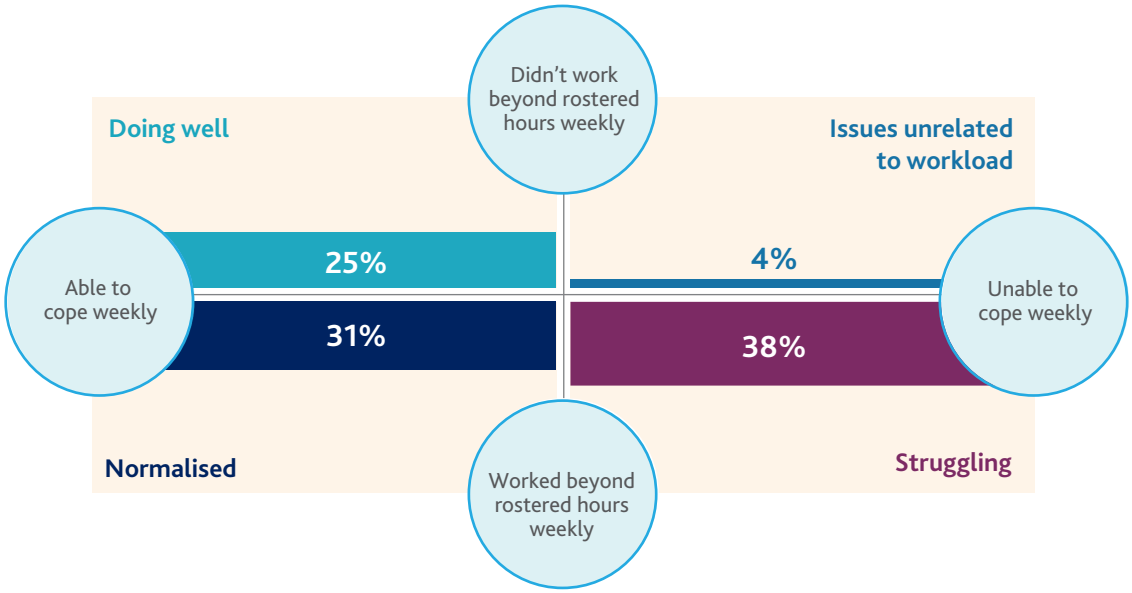
- 'Doing well': not regularly working beyond rostered hours and feel able to cope with workload.
- 'Normalised': regularly working beyond rostered hours, but not regularly feeling unable to cope with workload. In other words, long hours are a normal part of their working life, which they have learnt to cope with.
- 'Issues unrelated to working extra hours': not regularly working beyond rostered hours, but not feeling able to cope with workload because of other factors.
- 'Struggling': regularly working beyond rostered hours and not feeling able to cope with workload.

The decrease in the proportion of doctors doing well, from just over a third (35%) in 2021 to a quarter (25%) in 2022, is concerning.

There was an associated rise in the proportion of doctors who were struggling. Nearly four out of ten doctors (38%) were in this group, an increase from around a quarter (26%) in 2021.

Figure 6: Doctors working beyond rostered hours weekly and feeling unable to cope with workloads at least once a week

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



n = 4,269 (all doctors), the Barometer survey 2022 QC1.

In 2022, more GPs were categorised as struggling than doctors of other register types. Over half (55%) were in this category, compared with 38% of all doctors. Only one out of ten GPs (10%) were doing well, compared with a quarter (25%) of all doctors.

Fewer of both doctors on the specialist register (32%) and specialty and associate specialist (SAS) and locally employed (LE) doctors (27%) were struggling than all doctors (38%). And more SAS and LE doctors were doing well—37% were in this category, compared with 25% of all doctors.

In this section, and throughout most of this chapter, SAS and LE doctors are considered together as this allows time series comparisons, but changes in the Barometer survey in 2022 mean that we can use those results to look at SAS and LE doctors separately. We will publish a fuller analysis using this approach later in 2023. The section on SAS and LE doctors at the end of this chapter contains more details on this, including our initial analysis of SAS doctors and LE doctors as separate groups.

Looking in greater detail at those doctors who were struggling reveals some notable differences by ethnicity. 38% of all doctors surveyed were categorised as struggling. 42% of White doctors were struggling, compared with 34% of Asian / Asian British doctors and 27% of Black / Black British doctors. Overall, 34% of ethnic minority doctors were struggling. This pattern—a higher proportion of White doctors struggling than their ethnic minority peers—was evident among GPs and SAS and LE doctors, but the differences were not notable among specialists and trainees.

47% of disabled doctors were struggling, compared with 37% of non-disabled doctors. This pattern was seen in all registration types except GPs, in which no notable difference was found.

There were also differences by speciality area. The proportions of doctors who were struggling in the following specialty areas were below the average for all doctors (38%):

- Psychiatry: 29%
- Paediatrics: 28%
- Radiology: 23%
- Anaesthetics: 13%

Doctors working in these four speciality areas also tended to report higher levels of satisfaction and were less likely than the average (42% of all doctors) to have felt unable to cope with their workload. However, GPs (58%), those working in acute medicine (50%), and doctors working in emergency medicine (48%) were more likely than the average to have felt unable to cope with their workload.

Doctors under 30 years of age were more likely than older doctors to be struggling. 44% of doctors in this age group were struggling, compared with 38% of those aged 30 to 49 years and 34% of those aged 50 years and over.

Risk of burnout is increasing

In 2022, over half of doctors (57%) found their work emotionally exhausting to a high degree. Close to half (45%) found it frustrating, and four out of ten (40%) reported that they felt burnt out because of their work.

Doctors interviewed as part of the Barometer survey follow-up research spoke of the major negative impact of stress on their personal and professional lives.

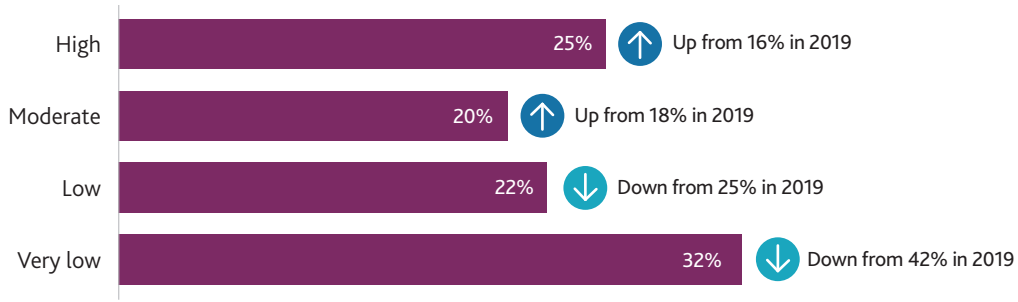
> "Twelve months ago I was in a hospital job where the idea of going to work—I had to physically drag myself there… I remember working a full day and then getting called back in for the evening shift on my fiancée's birthday because someone didn't turn up."
>
> *Doctor in training, Barometer survey 2022 follow-up interviews*

Seven out of ten doctors (70%) and more than eight out of ten GPs (82%) always or often felt worn out at the end of the day. Half (50%) of GPs said that they always felt worn out at the end of the day, compared with 33% of all doctors.

Doctors' burnout risk was categorised based on their responses to the burnout indicator questions. In 2020, one out of ten doctors (10%) were at high risk of burnout. In 2021, this went up to 17%, and by 2022, a quarter of all doctors (25%) were at high risk of burnout. At the same time, the percentage of doctors at very low risk of burnout has dropped from 60% in 2020 to 32% in 2022. This is a cause for concern.

In 2022, more than one out of five doctors (22%) took a leave of absence due to stress in the last year—a higher percentage than in 2021 (17%). Nearly three out of ten doctors in training (29%) and SAS and LE doctors (28%) took time off due to stress in 2022. Notably, a smaller proportion of GPs (17%) did so, despite reporting more negative experiences in response to other questions in the survey.

Figure 7: Proportion of doctors at risk of burnout, from 2019–2022



n = 3,876 (all doctors), the Barometer survey 2019 QD1/D2. n = 4,269 (all doctors), the Barometer survey 2022 QD1/D2.

Trainers face added pressures

Trainers play an essential role in supporting and developing the next generation of doctors. But in 2022 they had more negative workplace experiences than non-trainers in several areas.

Doctors who were trainers were more likely to work beyond their rostered hours once a week (78%, compared with 67% of non-trainers) and were more likely to describe three-quarters or more of their days as high intensity (49%, compared with 40% of non-trainers).

Across all doctors, a lower proportion of trainers (19%) were doing well than non-trainers (27%). However, there was no notable difference in the proportion of trainers and non-trainers who were struggling (40% and 37% respectively).

Within both GPs and specialists, trainers were more likely than non-trainers to be struggling. 63% of GPs with a training role were struggling compared with 53% of GPs who did not hold such a role, while 35% of specialists who were trainers were struggling compared with 26% of specialists who were not trainers. This pattern was not evident for SAS and LE doctors, though relatively few doctors in this group have a training role (11%, compared with 65% of doctors on the specialist register and 28% of GPs).

Trainers were also more likely to have seen patient safety compromised in the year leading up to the Barometer survey 2022 (51%, compared with 39% of non-trainers), and they were more likely to find it difficult to provide sufficient care to patients at least once a week (49%, compared with 43% of non-trainers).

Across all registration types, trainers were more likely to carry out tasks usually completed by a more junior doctor at least once a month (64% of trainers, compared with 49% of non-trainers).

Out of all doctors surveyed, those who were trainers were more likely to disagree that they were supported by their senior medical staff (18%) than non-trainers (10%). Doctors on the specialist register who were trainers were more likely to disagree that they were supported by their senior medical staff (22%, compared with 15% of non-trainers). Specialists who were trainers were also more likely than specialists who were not trainers to disagree that they were supported by non-clinical management (43% compared with 35%).

This could indicate that, across the board, there is a lack of support in place for doctors with training responsibilities. A future increase in the number of trainees, which appears likely given current plans to increase medical school places, could add to the pressure on trainers. Our data suggest that these greater workloads will be detrimental to trainers' wellbeing, patient safety and care, and the quality of training that trainees receive.

Spotlight on trainers: developing and supporting the workforce

What does the national training survey (NTS) tell us?

The NTS is an annual survey of all trainees and trainers on the medical register. It forms a core part of our work to monitor and report on the quality of postgraduate medical education and training in the UK. The findings from the 2022 edition[11] shine a light on some of the challenges trainers face.

Most trainers (90%) enjoyed their role, but those with higher numbers of trainees struggled to use the time allocated to them only for training purposes. Only 38% of those with more than five trainees said they could do this, compared with 50% of those with just one trainee.

Similarly, and perhaps unsurprisingly, the more trainees a trainer was assigned to supervise, the less positive the trainer was about being able to meet with their trainees as frequently as needed.

Experiences of delivering training varied by specialty. 61% of trainers in anaesthetics felt they were able to use their allocated training time specifically to deliver training, compared to only 34% of trainers in medicine and 32% in radiology.

A quarter of trainers (25%) who had a PMQ from overseas said that incidents of rudeness and incivility among doctors or healthcare staff were negatively affecting their experience in their role. This was higher than the proportion of trainers with a UK PMQ (18%).

When asked if their employer or practice provided a supportive environment for everyone regardless of background, beliefs, or identity, 79% of ethnic minority trainers agreed with this, compared with 84% of White trainers.

Qualitative interviews with trainers [12]

We commissioned follow-up qualitative research with a small number of trainers that took part in the Barometer survey 2022 and opted into further research. Ten one-to-one interviews were held in March 2023 with doctors working across the UK.
The purpose was to understand the positive and challenging aspects of the role, including the support available to trainers.

Trainers typically enjoyed the role and cited benefits such as career development and enhanced professional variety. They were often motivated by a desire to give back to the system that they had benefited from and to improve the quality of the workforce and therefore patient care.

Types of supervision, and the exact focus of training, varied from trainer to trainer. Some focussed more on clinical skills and addressing knowledge gaps, whereas others took a more

informal, 'whole-person' approach that emphasised personal wellbeing and work-life balance, as well as professional competence. Participants spoke of the need to boost trainees' confidence in applying the skills they had acquired, through years of training, in real-world situations.

> "To get this far, most of them are pretty competent … and I am not going to start teaching them basic stuff. What I'm teaching them is 'you have the knowledge, you have the skills, you have the aptitude'—this is how you use it.'"
>
> *GP, Barometer survey 2022 survey follow-up interviews*

Participants' views varied about whether they had sufficient time to fully meet their training responsibilities. They tried to plan and protect their time where possible, collaborated with colleagues to manage the training workload and worked flexibly—including outside regular hours—during busy periods.

There was a general sense that training had become less valued over time. System pressures, such as the coronavirus pandemic and high patient demand, had led to training being deprioritised. The result was dissatisfaction and a weakening of trainees' skills.

> "There is always pressure to provide more and more, and that will chip away at training time, and the only way to continue to provide quality training is to recognise that we need to train professionals, or they will leave."
>
> *GP, Barometer survey 2022 follow-up interviews*

Trainees were perceived as having a different perspective on the profession than their predecessors. They were seen as more motivated to achieve a good work-life balance and put clear boundaries around their job. These changes were not necessarily seen as negative, especially if they prevented burnout among trainees, but participants felt they had put more pressure on a health system already under strain.

Views on the effect of the pandemic on trainees varied. According to participants, many trainees had experienced trauma in the workplace, weakening their confidence and morale. In some cases, this led them to take a break from practice entirely. However, the system-wide response to the pandemic also meant that there had been fewer opportunities for some trainees to gain clinical experience, including contact time with patients. This meant that they were less prepared and experienced than they ordinarily would have been.

Trainers generally felt supported by their peers and colleagues, though views were mixed on support from management. Participants valued the opportunity to collaborate with peers in similar roles and thrived in environments in which training was valued, and time for it was protected. But they were sometimes held back by a lack of capacity to meet their trainees' needs as well as to engage in their own learning and development. Working cultures that generally deprioritised training exacerbated this issue. We examine these issues in more detail in chapters 2 and 3.

Implications of workload pressure for doctors and their patients

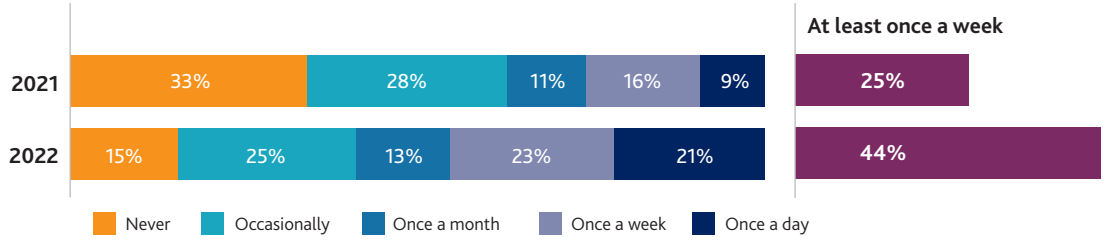
Doctors' wellbeing has been negatively affected by a marked increase in workloads. This heightens the risk of burnout among doctors, causing some to reduce their hours or even leave the UK profession completely. In this section, we analyse our data about the effects of these trends on patient safety and care.

Doctors' ability to provide good patient care is at risk

In 2022, most doctors (88%) reported having positive relationships with their patients. However, more than two-fifths of doctors (44%) found it difficult to give their patients the care needed at least once a week—and 21% struggled daily. This was a considerable increase since 2021, when 25% faced this challenge at least once a week, and 9% daily.

Figure 8: Doctors who found it difficult to provide a patient with the sufficient level of care they need in 2021 and 2022

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



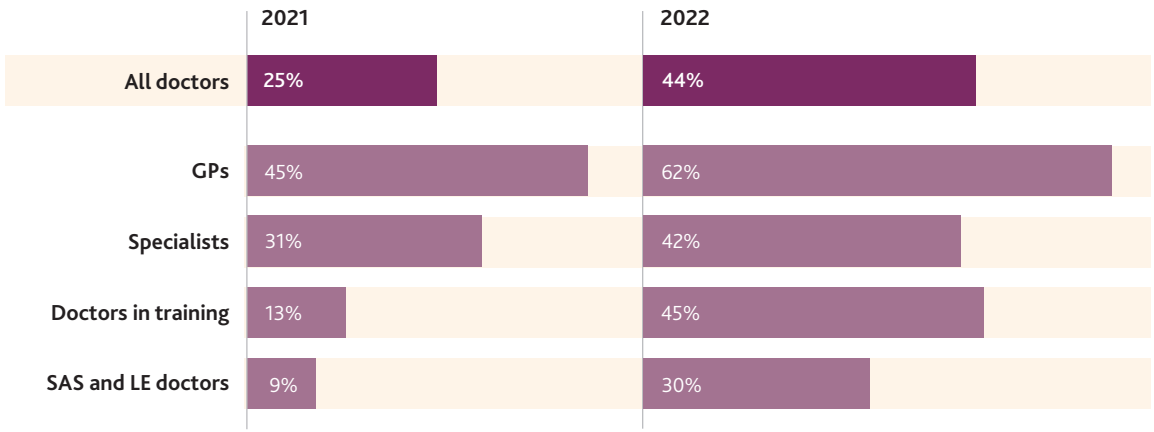
n = 3,386 (all doctors), the Barometer survey 2021 QC1_4. Excluding don't know and prefer not to say.
n = 4,269 (all doctors), the Barometer survey 2022 QC1_4. Excluding don't know and prefer not to say.

In 2022, the proportion of doctors who frequently found it difficult to provide patients with sufficient levels of care rose in all registration types. GPs had the most difficulty providing patients with sufficient care, with 62% finding this difficult at least once a week, up from 45% in 2021. There were notably large increases among trainees and SAS and LE doctors. 45% of doctors in training experienced this at least once a week in 2022, compared with 13% in 2021. 30% of SAS and LE doctors experienced this at least once a week in 2022, compared with 9% in 2021. These trends suggest doctors may be at heightened risk of moral injury, the psychological distress caused by engaging in or witnessing behaviours that go against an individual's values and moral beliefs.

In the 2022 survey, we used an open question to ask doctors what the main barriers were that prevented them from providing good patient care. Doctors most commonly identified inadequate staffing (33%), pressure on workloads (24%), and delays in providing care or treatment (16%) as the main barriers to providing good patient care.

Figure 9: Percentage of doctors who found it difficult to provide a patient with the sufficient level of care they need at least once a week by registration type in 2021 and 2022

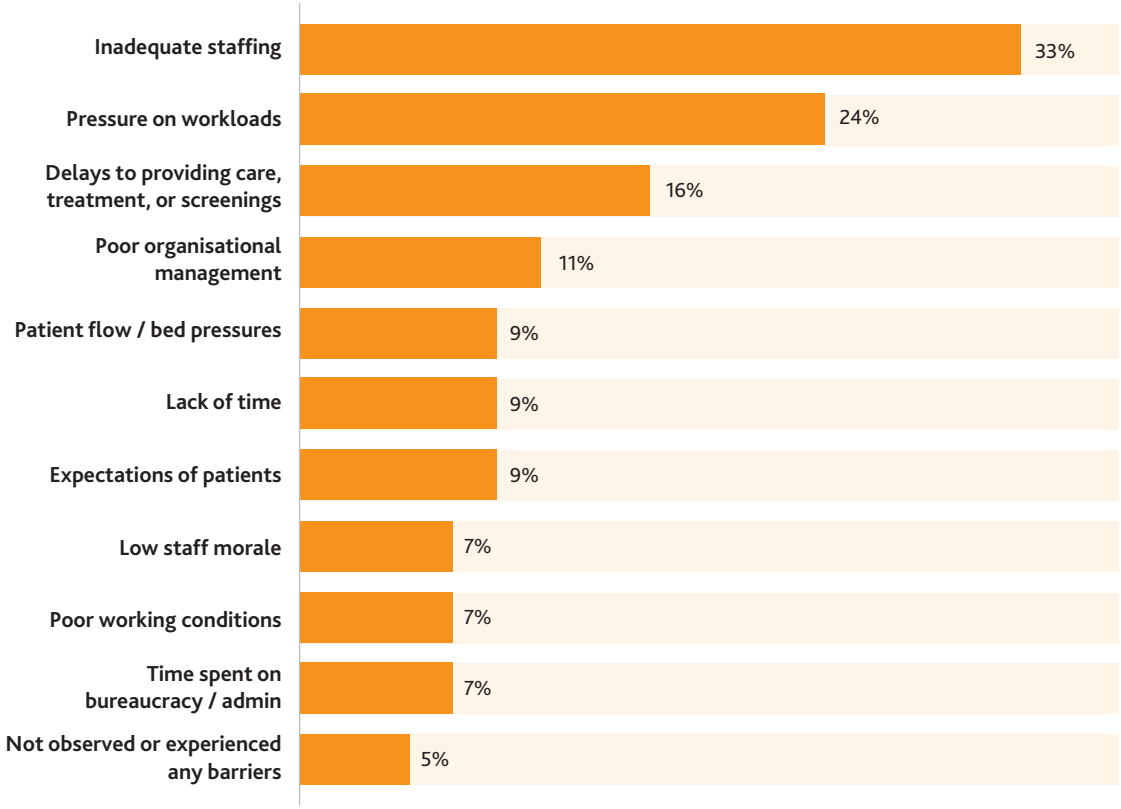
How frequently, if at all, over the last year have you experienced the following? Found it difficult to provide a patient with the sufficient level of care they need



n = 3,386 (all doctors), the Barometer survey 2021 QC1_4.
n = 4,269 (all doctors), the Barometer survey 2022 QC1_4.

Figure 10: Barriers to providing good patient care

What would you consider to be the main barriers, if any, to providing good patient care that you have observed or experienced over the last year?



n = 4,269 (all doctors), the Barometer survey 2022 QC9.

There was some variation in the barriers observed by registration type. Doctors in training were more likely to cite inadequate staffing (44%) than GPs (19%).

GPs were much more likely than all doctors to cite the following barriers:

- pressure on workloads (41%, compared with 24%)
- delays in care (32%, compared with 16%)
- lack of time (20%, compared with 9%)
- patient expectations (22%, compared with 9%).

Risks to the provision of safe patient care are growing

Over four out of ten doctors (42%) experienced a situation in which they believed patient safety or care was compromised in the year leading up to the Barometer survey 2022. This was a much higher proportion than in 2021 (29%), 2020 (26%), and 2019 (32%). Specialists (47%) and GPs (45%) were most likely to see patient care compromised, while SAS and LE doctors were least likely (34%).

Compromises in patient care were generally attributed to resource pressures. Four-fifths of doctors (80%) who had observed compromises in patient care blamed them on heavy workloads. Nearly two-thirds (64%) cited delays in treatment and over half (56%) highlighted rota gaps. Roughly half (52%) cited a lack of appropriately qualified staff.

> "A man had a blood pressure check at work and he came to me and had a tremor in his hand, he burst into tears and was suicidal—because he told me that [he was suicidal] I could make a plan with the mental health team. If I had been running late with other people in the waiting room I would not have asked about the tremor."
>
> *GP in training, Barometer survey 2022 follow-up interviews*

While more than six out of ten doctors (62%) felt confident raising concerns about patient care, almost one out of five did not (18%). Specialists were particularly likely to not feel confident in raising concerns (23%). This further adds to the risk of moral injury. A substantial minority of doctors may feel not only that they are unable to provide sufficient care to patients, but are also hesitant about voicing concerns.

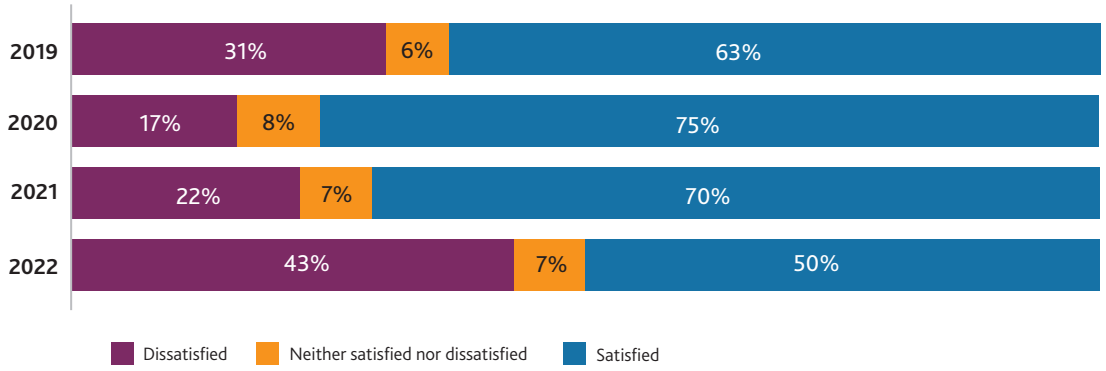
Rising pressures lead to lower satisfaction in day-to-day work

There has been a downward trend in satisfaction since 2020, when three-quarters (75%) of doctors were satisfied. By 2021, this had dropped to 70% and, in 2022, only half of doctors said they were satisfied (50%).

In 2022, around two-fifths of doctors were dissatisfied (43%), nearly double the proportion in 2021 (22%). More than one out of ten (11%) doctors described themselves as 'very dissatisfied'. This was an increase from less than one out of 20 (4%) in 2021.

Figure 11: Proportion of doctors satisfied with their day-to-day work, 2019–2022

To what extent are you satisfied or dissatisfied with your day to day work as a doctor?



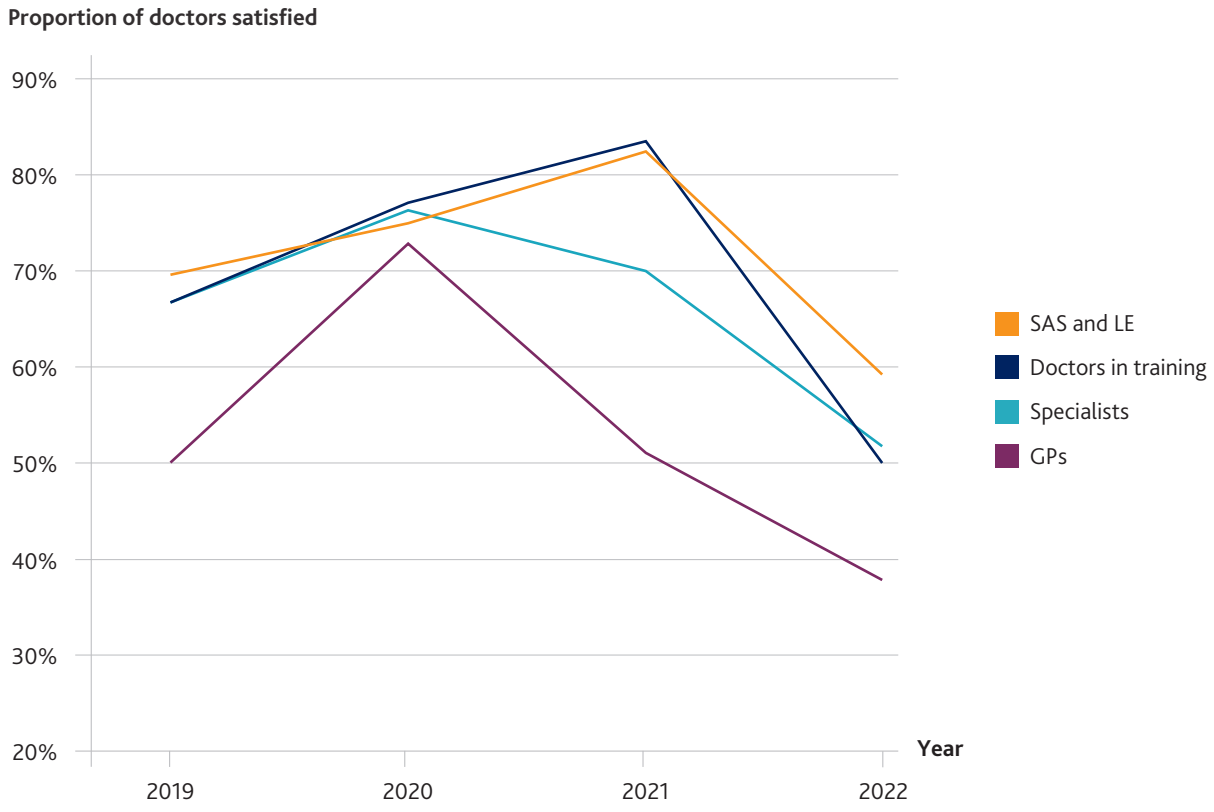
n = 3,876 (all doctors), the Barometer survey 2019 QA1.
n = 3,693 (all doctors), the Barometer survey 2020 QA1.
n = 3,386 (all doctors), the Barometer survey 2021 QA1.
n = 4,269 (all doctors), the Barometer survey 2022 QA1.

Satisfaction decreased across all registrant types from 2021 to 2022. GPs continued to be less satisfied than other doctors, with fewer than four out of ten (38%) stating they were satisfied in 2022, down from 51% in 2021. SAS and LE doctors reported the highest levels of satisfaction in 2022 (59%). Around half of doctors in training (50%) and specialists (52%) said they were satisfied in their work.

Doctors in training and SAS and LE doctors were notably more satisfied than GPs and specialists in 2021. However, experiences in 2022 were more uniform across all doctors, which was largely due to steep drops in satisfaction among SAS and LE doctors and doctors in training from 2021 to 2022. Doctors in training saw a very large drop of 33 percentage points in this period, from 83% expressing satisfaction in 2021 to exactly half (50%) in 2022. The decrease for SAS and LE doctors was 23 percentage points, from 82% in 2021 to 59% in 2022.

Figure 12: Overall satisfaction by registration type, 2019–2022

To what extent are you satisfied or dissatisfied with your day to day work as a doctor?



n = GPs (1,079), specialists (2,188), doctors in training (269), SAS/LE doctors (325), the Barometer survey 2019 QA1.

n = GPs (1,001), specialists (1,917), doctors in training (493), SAS/LE doctors (278), the Barometer survey 2020 QA1.

n = GPs (895), specialists (1,759), doctors in training (337), SAS/LE doctors (366), the Barometer survey 2021 QA1.

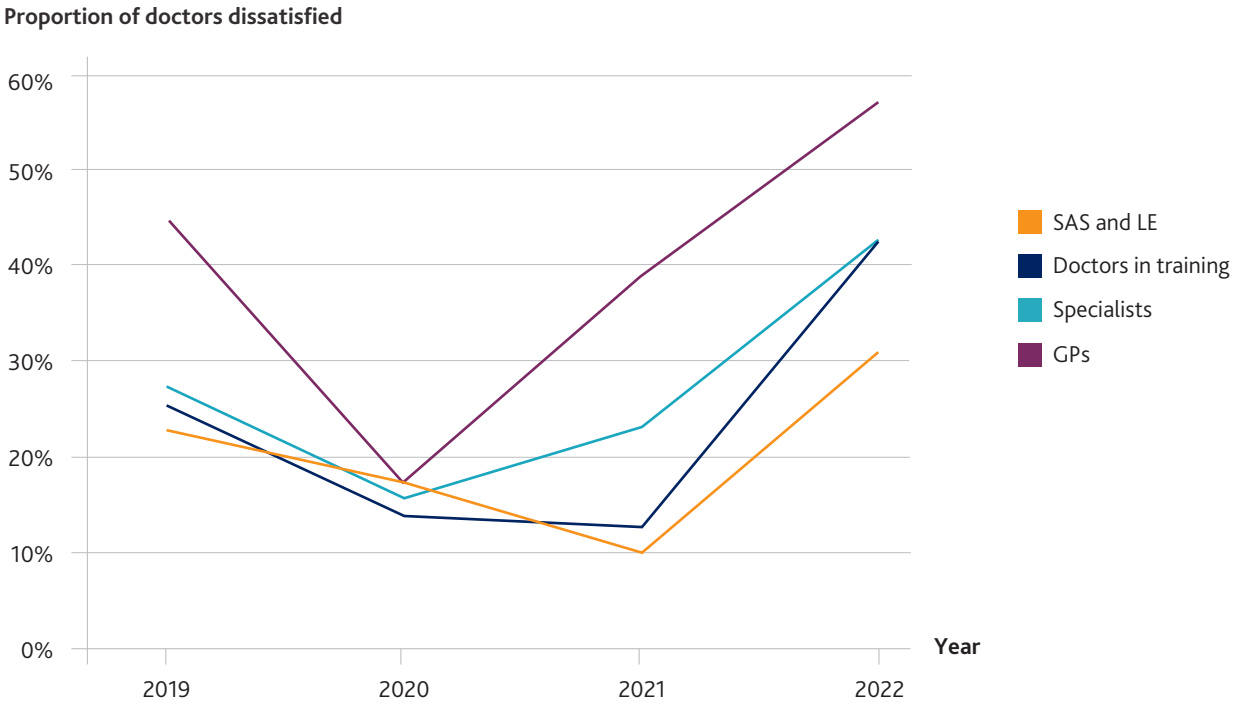
n = GPs (995), specialists (1,270), doctors in training (1,055), SAS/LE doctors (869), the Barometer survey 2022 QA1.

While satisfaction has decreased, unsurprisingly, dissatisfaction has grown across all registrant types. GPs were the most dissatisfied (57% in 2022, up from 39% in 2021). Just over one out of four specialists (42%) were dissatisfied, up from 23% in 2021. Doctors in training were equally dissatisfied (42%), a major increase from 2021 (13%). SAS and LE doctors were the least dissatisfied (31%), though their dissatisfaction had also increased by a large degree, from 10% in 2021.

The ability to provide patients with sufficient levels of care is associated with doctors' satisfaction. A higher percentage of dissatisfied doctors (64%) struggled to provide adequate patient care once a week or more compared with satisfied doctors (27%).

Figure 13: Overall dissatisfaction by registration type, 2019–2022

To what extent are you satisfied or dissatisfied day-to-day in your work as a doctor?



n = GPs (1,079), specialists (2,188), doctors in training (269), SAS/LE doctors (325), the Barometer survey 2019 QA1.
n = GPs (1,001), specialists (1,917), doctors in training (493), SAS/LE doctors (278), the Barometer survey 2020 QA1.
n = GPs (895), specialists (1,759), doctors in training (337), SAS/LE doctors (366), the Barometer survey 2021 QA1.
n = GPs (995), specialists (1,270), doctors in training (1,055), SAS/LE doctors (869), the Barometer survey 2022 QA1.

High proportions of doctors who found it difficult to provide patients with sufficient care were also at high risk of burnout (70%) and felt unable to cope with their workload at least once a week (also 70%).

Providing care mostly or all face-to-face is associated with higher levels of satisfaction. Just under three-quarters (73%) of doctors who were satisfied provided care mostly or all face-to-face, compared with just two-thirds (66%) of doctors who were dissatisfied.

Drivers of doctors' day-to-day satisfaction

In 2022, 50% of doctors reported being satisfied in their day-to-day work as a doctor, while 43% were dissatisfied.

As part of the Barometer survey, doctors are given the opportunity to state in their own words the reasons that they are satisfied or dissatisfied, with responses being coded as part of the survey analysis. These are open questions, and the responses are therefore top-of-mind thoughts from the doctors, providing a unique insight into drivers of satisfaction.

Interestingly, the main reasons doctors state for being satisfied all relate to the feeling that being a doctor is a vocation which requires strong professional values. Therefore, it is very concerning that the overall proportion of satisfied doctors has decreased, and that the proportion of doctors giving these 'vocation-driven' reasons for satisfaction has dropped since 2021.

The most common reason doctors stated for their day-to-day satisfaction in 2022 was that they found their work enjoyable, fulfilling, and rewarding. A quarter of all doctors (25%) who said they were satisfied gave this as a reason—down from 37% in 2021.

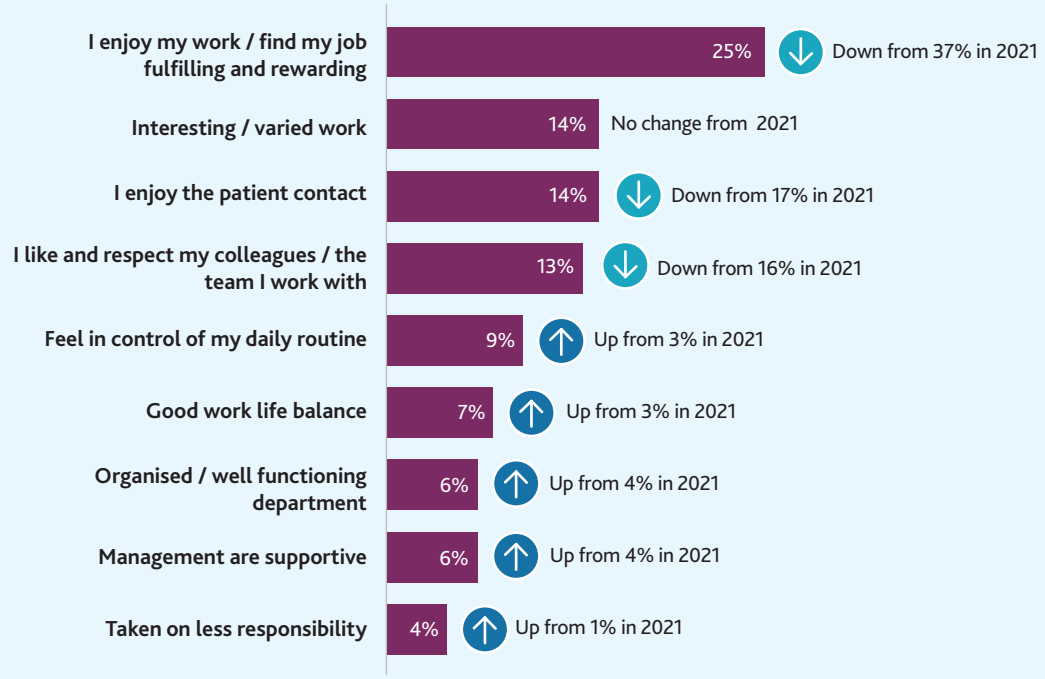
The next most cited reasons for satisfaction were that doctors did interesting or varied work (14%), and they enjoyed patient contact (14%).

The proportion of doctors who cited feeling in control of their daily routine as a reason for satisfaction (9%) increased by six percentage points, from 3% in 2021. A smaller percentage (7%) said it was because they had a good work-life balance, which was also an increase from 3% in 2021. There were also small increases in the proportions of doctors citing an organised / well–functioning department (from 4% in 2021 to 6% in 2022, supportive management (from 4% to 6%), and having taken on less responsibility (from 1% to 4%).

On the other hand, in 2022, increasingly high workloads or long hours remained the most common reason given for dissatisfaction, with around four out of ten (39%) dissatisfied doctors highlighting these issues. Around a quarter (26%) cited problems with the recruitment and retention of doctors and a similar proportion (25%) said they were unhappy with their remuneration.

Figure 14: Reasons for satisfaction

Why do you say that you are satisfied?



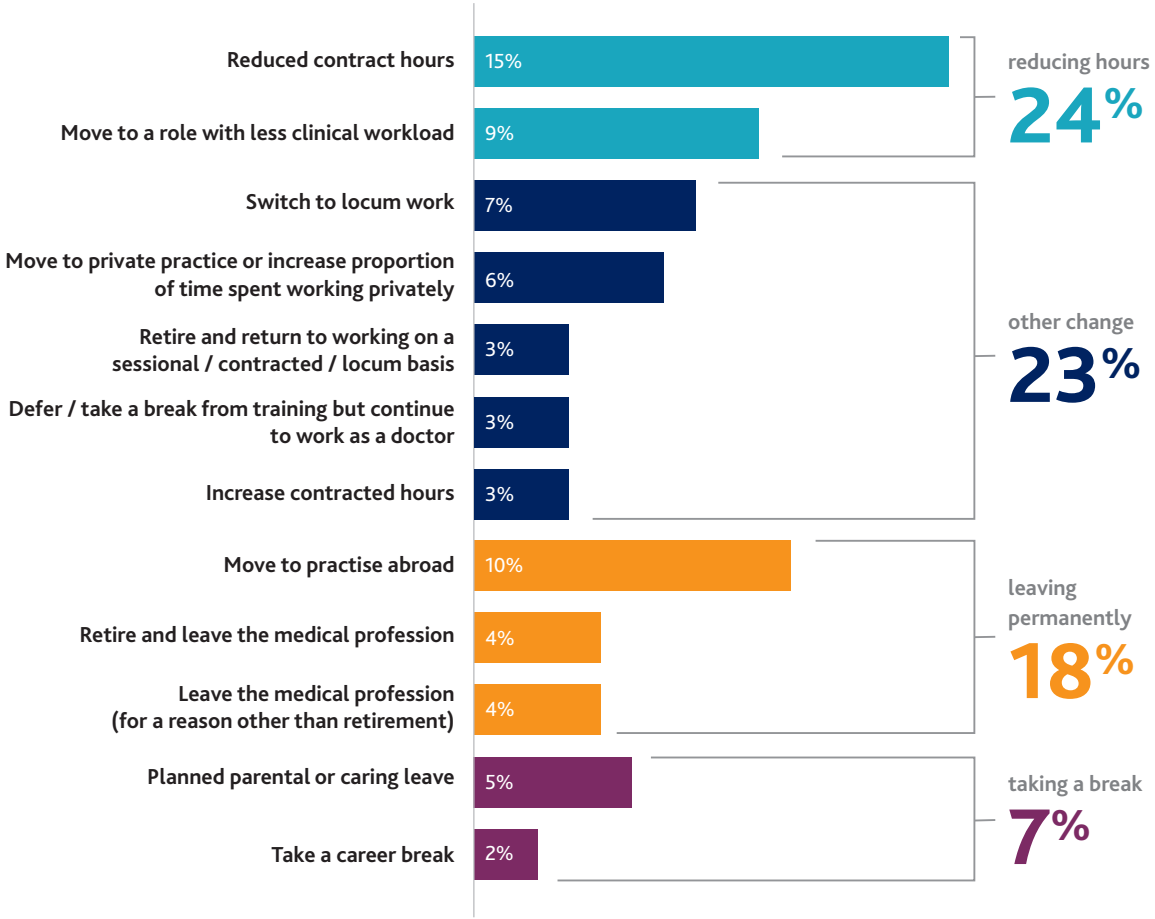
n = 2,131 (all satisfied doctors), the Barometer survey 2022, QA2. Open response.
n = 2382 (all satisfied doctors), the Barometer survey 2021, QA2. Open response.

More doctors plan to leave UK practice and have taken hard steps towards leaving

From 2021 to 2022, the proportion of doctors who said they were likely to make a career change[1] in the next year grew significantly—from 58% of doctors to more than three-quarters (77%). This included a large increase in those likely to leave the UK profession permanently. In 2021, only around one out of ten (11%) said they intended to do this. By 2022, this rose to nearly one out of five (18%).

1 'Career change' is broadly defined in this report as changes to working practices, including reducing hours and taking a career break. Doctors may have intended to make career changes but then not carried them out. Similarly, some doctors may have made career changes that were unplanned. No attempt is made in the analysis to compare doctors' subjective views with documented changes in the medical workforce.

Figure 15: Career change doctors are most likely to make



n = 4,269 (all doctors), the Barometer survey 2022 QB1a.

There is variation in the most likely career changes by type of registration, with doctors in training more likely than others to be considering taking a break from the profession. This is in line with previous years.

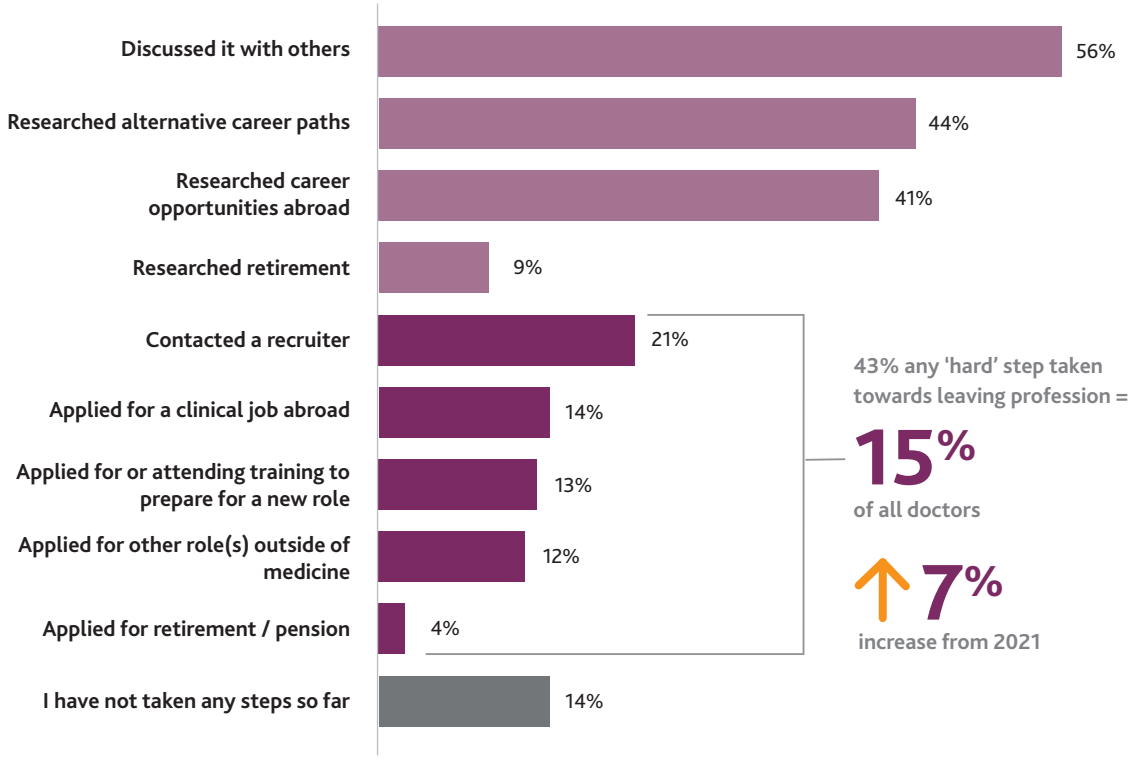
Among doctors who said they were likely to leave the UK profession, but who were not at retirement age, over half (56%) had discussed their plans with others, and over four in ten had researched either alternative career paths (44%) or career opportunities abroad (41%). Just over four in ten (43%) had taken hard steps towards leaving the UK profession. The most common hard step taken was contacting a recruiter (21%).

Around one in ten had applied for a new role abroad (14%) or outside medicine (12%). A similar proportion (13%) had applied for or attended training to prepare for a new role.

15% of all doctors reported having taken a hard step towards leaving, a notable increase from 7% in 2021. New response options that are considered 'hard steps' were included in the 2022 survey. However, analysis shows that there has still been an increase, even excluding the steps introduced in the 2022 survey.

Figure 16: Steps doctors have taken towards leaving the medical profession

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



n = 1,497 (those likely to leave the UK medical profession, excluding retirement age retirees), the Barometer survey 2022 QB3.

Among those likely to leave the medical profession for reasons other than retirement, the adverse effects on wellbeing of the demands of the job influenced three-quarters (75%) of doctors. Reasons for wanting to move to practise abroad were most frequently related to the perceived better treatment of doctors outside of the UK (80%), as well as a desire for higher pay (66%).

The risk of burnout may continue to push doctors away from full-time practice, or out of the UK profession completely. Doctors who were at higher risk of burnout were more likely to be planning to reduce their hours or to undertake any other career change, including leaving the UK medical profession.

Table 1: Likelihood of doctors making a career change and their risk of burnout

	Very low risk of burnout	Low risk of burnout	Moderate risk of burnout	High risk of burnout
Doctors likely to make any reduction in hours working in UK practice	49%	68%	81%	90%
Doctors likely to make any career change	60%	75%	85%	93%

n = 4,269 (all doctors), the Barometer survey 2022 QB1/D1/D2

In 2021, around 10,000 doctors left UK practice, while around 21,000 doctors entered it.[7] The exact relationship between doctors' intentions to leave the profession and then doing so is unclear. But we are concerned the data suggest a heightened risk of doctors leaving. Our 2023 Workforce report will examine this in more detail.

In 2022, we published research[13] into doctors' decisions to migrate from the UK. This identified a range of 'push and pull' factors. Negative experiences, burnout, and frustrations with UK health systems were cited, as well as the prospect of adventure, better treatment, and higher salaries abroad.

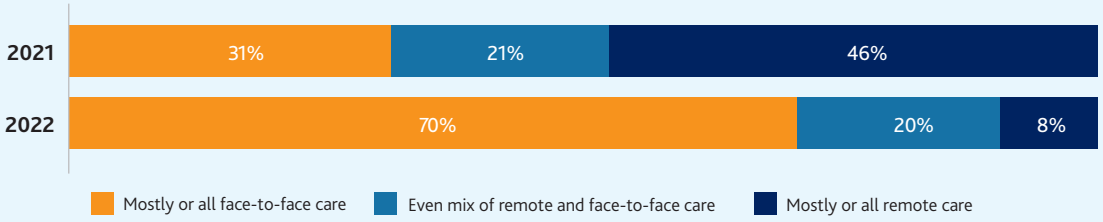
The provision of remote care is declining

From 2021 to 2022, there was a major shift back to pre-pandemic medical working practices. In 2021, 46% of doctors provided mostly remote care. By 2022, this had reduced to 8%.

At the same time, face-to-face care increased significantly. In 2021, only around a third of doctors (31%) said the care they delivered was mostly face-to-face. By 2022, this had increased to 70%.

Figure 17: Amount of doctors' care that was provided remotely in 2021–2022

Roughly, how much of your patient care has been provided remotely and how much face-to-face during the last year?

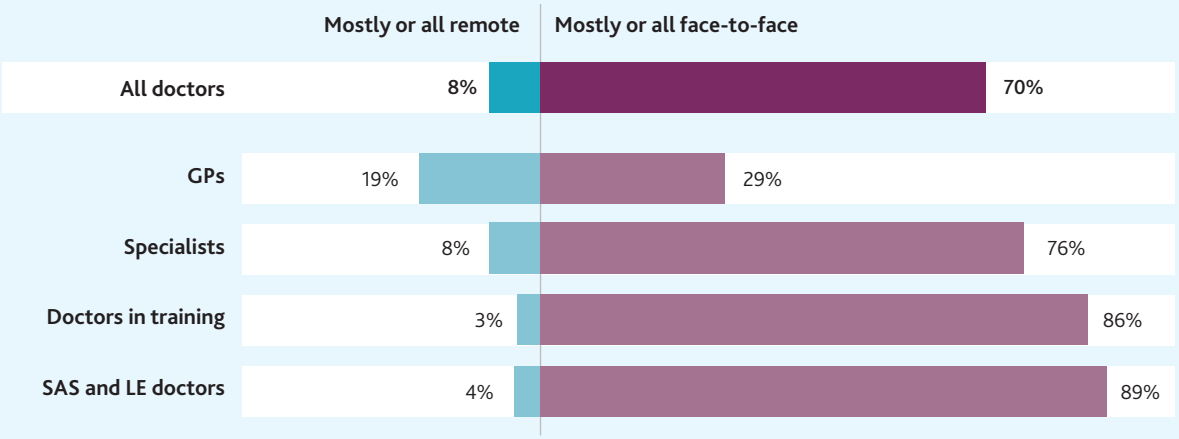


n = 3,386 (all doctors), the Barometer survey 2021 QI6.

n = 4,269 (all doctors), the Barometer survey 2022 QI6.

Figure 18: Proportion of doctors who provided care remotely and face-to-face in the year leading up to autumn 2022

Roughly, how much of your patient care has been provided remotely and how much face-to-face during the last year?



n = 4,269 (all doctors), the Barometer survey 2022 QI6.

The percentage of doctors who delivered all, or nearly all, of care face-to-face also markedly increased, from 16% to 45%.

GPs were much more likely to deliver remote care than other registrant types. 19% of GPs delivered mostly or all remote patient care, compared with 8% of specialists and 3% of doctors in training.

Around half of GPs (51%) provided an even mix of remote and face-to-face patient care, a much greater proportion than other registrant types.

Variation of experiences across the workforce

This section explores differences in perceptions and experiences across the UK medical workforce. There is a focus on areas where outcomes and experiences diverge. This includes the specific issues faced by GPs, variations by disability status and ethnicity, and how the experiences of non-UK medical graduates compare with UK graduates. Finally, we briefly explore the experiences of SAS and LE doctors as separate groups.

For each of these groups—GPs, ethnic minority doctors, doctors with disabilities, and doctors with a non-UK PMQ—their workplace experiences are important for several reasons. In some cases, these patterns may indicate direct or indirect discrimination and so require addressing in line with the 2010 Equality Act. In addition, where doctors have less support from peers or management or have worse workload issues, these issues happen alongside worse patient safety and care and may be amenable to intervention. Over time, doctors may gradually struggle to maintain their continuous professional development, or through lack of appropriate feedback and support, may increase their risk of being complained about or referred to the GMC.[14]

GPs are struggling with high workloads, but feel well supported

GPs had the highest risk of burnout (31% were at high risk of burnout compared with the average of 25%) and were the register type with the highest proportion of doctors who were struggling (55% of GPs were struggling, compared with an average of 38%).

However, GPs reported better-than-average experiences of feeling supported by non-clinical management, with 67% of GPs feeling supported by their non-clinical management compared with 42% of all doctors. A slightly larger-than-average proportion of GPs also reported that they felt supported by their immediate colleagues (85%, compared with an average of 82% for all doctors) and part of a supportive team (80% compared with an average of 73%).

This shows that although we generally see correlations between good levels of support and wellbeing, this is not always the case for all groups of doctors. The Barometer survey 2022 results show that, as in previous years, GPs experienced the highest intensity of work. 68% of GPs reported that three-quarters or more of their days were high-intensity, compared to an average of 43% of all doctors.

This extreme intensity is likely to be the driver of the high risk of burnout and the high number of GPs who were struggling. It is likely that if GPs had worse experiences of support, their risk of burnout would be even higher. The high levels of support reported by GPs may help them manage their high workloads—and if so, there may be useful insights for others to take away from examining how GPs build strong teams.

Disabled doctors have a less positive experience across multiple measures

As in previous years, disabled doctors were less likely to be satisfied in their work (44%) than non-disabled doctors (51%). In 2021, 54% of disabled doctors were satisfied, compared with 72% of non-disabled doctors. While the difference in satisfaction between the two groups has narrowed, this is largely due to the large decrease in the satisfaction of non-disabled doctors.

Disabled doctors were more likely to be struggling with their workload (47%) than non-disabled doctors (37%). They also felt less supported than non-disabled doctors. While 74% of non-disabled doctors felt they were part of a supportive team, 69% of disabled doctors felt this way. This is the third year in a row we have seen this trend.

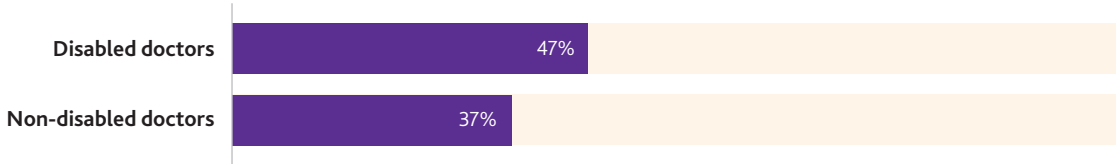
The disparity based on disability was found in all registrant types except GPs, where there was no statistically significant difference between the proportion of disabled and non-disabled doctors that were struggling.

Non-UK medical graduates mostly reported more positive experiences than UK graduates

In line with 2021, the 2022 survey data show that graduates with a PMQ from outside the UK (non-UK graduates) were more positive than UK graduates about certain aspects of their work experiences.

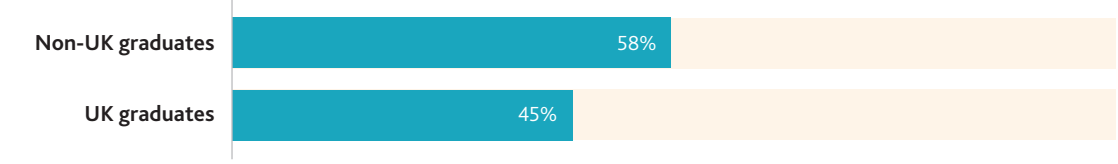
58% of non-UK graduates were satisfied with their work, compared with 45% of UK graduate doctors. UK graduates were more likely to be at high risk of burnout (27%) and more likely to be classed as struggling (44%) compared with non-UK graduates (22% at high risk of burnout and 29% struggling).

Figure 19: Doctors struggling with their workload, by disability status



n = 4,269 (all doctors), the Barometer survey 2022 QC1

Figure 20: Satisfaction in day-to-day work, by country of PMQ



n = 4,269 (all doctors), the Barometer survey 2022 QA1

The data show that PMQ was typically a strong driver of participants' responses, and that the pattern of non-UK graduates generally reporting more positive experiences than UK graduates was found across the sample, irrespective of ethnicity:

- Both White non-UK graduates (55%) and ethnic minority non-UK graduates (60%) were more likely to be satisfied than UK graduates of all ethnicities (45%).
- Both White UK graduates (43%) and ethnic minority UK graduates (44%) were more likely to be struggling than non-UK graduates of all ethnicities (29%).
- More than half of UK graduates (54%) found it difficult to provide a patient with sufficient care at least once a week, compared with fewer than a third of non-UK graduates (29%).
- However, while 87% of UK graduates felt supported by immediate colleagues, only 75% of non-UK graduates felt this way. Similarly, fewer non-UK graduate doctors (65%) said they were part of a supportive team than UK graduates (78%).

Ethnic minority doctors report higher satisfaction but less support

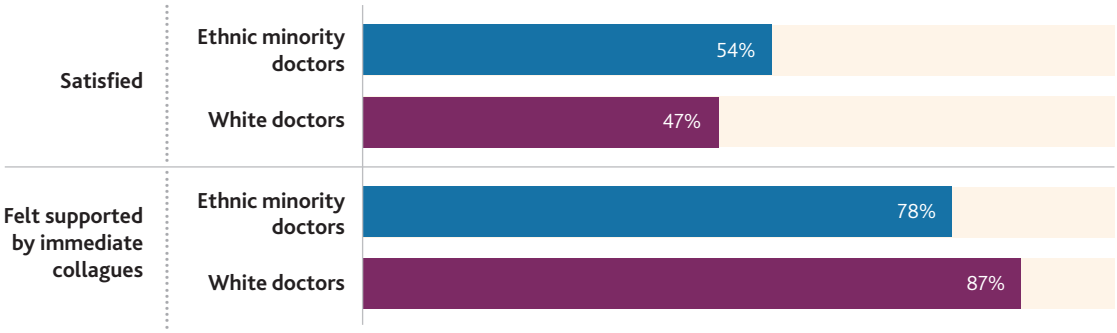
As highlighted above, it is important to bear in mind the close relationship between ethnicity and place of PMQ when exploring differences in ethnicities. In 2022, across the entire sample, more than half of ethnic minority doctors (54%) were satisfied in their work, compared with less than half (47%) of White doctors. Looking at specific groups, 62% of Black / Black British doctors were satisfied in their work while 52% of Asian / Asian British doctors were satisfied. Doctors from Mixed or multiple ethnic groups did not have a notable difference in their level of satisfaction (49%) when compared with the White group (47%).

Around a third of ethnic minority doctors (34%) reported that they were struggling with their workload compared with 42% of White doctors. A similar proportion of ethnic minority doctors (36%) said that three-quarters or more of their working days had been high intensity compared with almost half of White doctors (48%).

Ethnic minority doctors (35%) were much less likely than White doctors (52%) to have found it difficult to provide their patients with the care needed at least once a week. Ethnic minority doctors were also less likely than White doctors to have witnessed a situation in which they believed patient care was compromised. Roughly a third of ethnic minority doctors (35%) had witnessed this, compared with around half of White doctors (49%).

Despite this, ethnic minority doctors (78%) felt less supported by immediate colleagues than White doctors (87%). The lack of support from immediate colleagues was felt particularly acutely by Asian/Asian British doctors (77% felt supported). Black/ Black British doctors and those from Mixed or multiple ethnic groups had no notable difference from the proportion of all doctors that felt supported (82%). It is encouraging that, despite some differences by ethnicity, a clear majority of doctors in all ethnic groups felt supported by immediate colleagues.

Figure 21: Satisfaction in day-to-day work and support from immediate colleagues, by ethnicity



n = 4,269 (all doctors), the Barometer survey 2022 QA1/D3-1

SAS doctors and LE doctors

SAS doctors* and LE doctors† are two distinct groups of doctors, with differing experiences and challenges. Limitations in available data sometimes mean that SAS and LE doctors are analysed as a single group. Changes to the approach in the Barometer survey 2022 have enabled us to report on SAS and LE doctors separately for the first time, though it should be noted that comparison with past findings is not possible because previous Barometer surveys grouped SAS and LE doctors together.

This section provides a summary of our main findings relating to SAS and LE doctors based on the Barometer survey 2022. As well as looking at SAS and LE doctors as separate groups, both SAS and LE doctors have been analysed based on where they gained their PMQ. We will publish a fuller analysis of the working experiences of SAS and LE doctors later in 2023.

SAS doctors and LE doctors are together the fastest-growing part of the UK medical workforce. The SAS and LE doctor group grew by 40%[7] from 2017 to 2021, just under four times the rate of growth of doctors on the specialist register in this period (11%), and about six times that of GPs (7%). This is one of the most rapid shifts in the composition of the workforce since analysis was enabled by the digitisation of the

* Before 2008 SAS doctors were those appointed to staff grade or associate specialist posts. Since 2008 these appointments are specialty doctor posts or, since 2021, specialist grade. SAS doctors generally require four years postgraduate training and are a diverse group, spanning many skills and specialties.

† LE doctors are employed with locally defined terms and conditions, often in non-permanent posts. Unlike SAS doctors there is no nationally recognised career, contract, or pay structure.

medical register. The growth is mainly driven by doctors from overseas joining the UK workforce.

Doctors from overseas who are unable to join the specialist register directly may work as a SAS or LE doctor and apply to join the specialist register via the Certificate of Eligibility for Specialist Registration (CESR) or the GP register via the Certificate of Eligibility for General Practice Registration (CEGPR). A SAS or LE role can be a positive career choice for a doctor, but if a doctor is unable to successfully apply for a CESR or CEGPR—particularly SAS doctors with substantial overseas experience as specialists which they could not use to demonstrate CCT equivalence—they may remain in a SAS or LE role in which they feel unrecognised and underutilised.

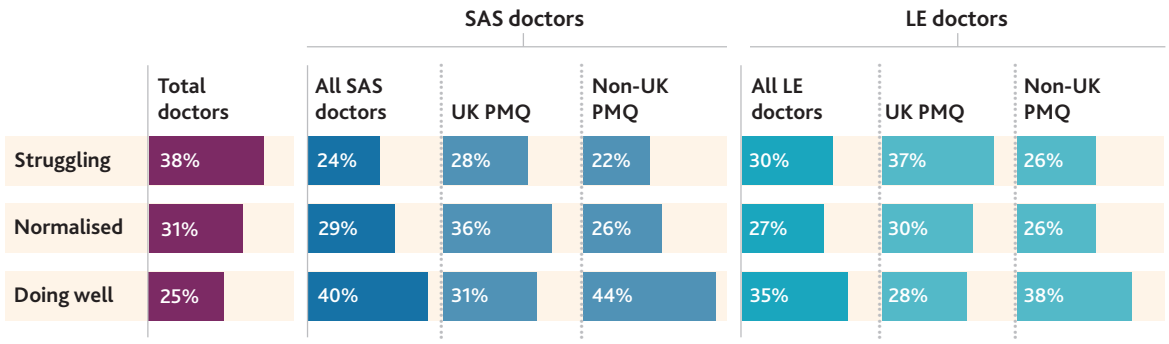
Analysis of our 2019 survey[15] of SAS and LE doctors corroborated this difficulty.[16] It revealed a group of experienced, international medical graduate (IMG) SAS and LE doctors having a very negative experience of UK practice. The survey found many SAS and LE doctors had negative experiences of their working environments, including bullying and lack of support. Qualitative research on doctors' decisions to migrate from the UK[13] in 2022 found that SAS and LE doctors appeared in groups with negative experiences of UK practice, and whose reasons for leaving included lack of promotion and unpleasant work interactions, including bullying.

Diversity of SAS and LE doctors and their experiences

SAS and LE doctors are not a homogeneous group in terms of their background and experiences. Exploring SAS doctors and LE doctors as separate groups, and further splitting by where doctors gained their PMQ, groups emerge with distinct characteristics and experiences that should be understood separately.

The categorisation of different groups of SAS and LE doctors by whether they worked beyond rostered hours weekly and felt unable to cope with workloads weekly is set out in Figure 22. The results for all doctors surveyed, SAS doctors, and LE doctors, are included for comparison. The characteristics of the groups of SAS and LE doctors analysed, and findings relating to them, are summarised in Figure 23.

Figure 22: Analysis of doctors working beyond rostered hours weekly and feeling unable to cope with workloads weekly



n = 4269 (all doctors), the Barometer survey 2022, QC1_1/2

SAS doctors

43% of SAS doctors were categorised as having a very low burnout risk, compared with 32% of all doctors surveyed. More SAS doctors carried out both work usually done by more senior doctors (14%, compared with 5% of all doctors) and work usually done by more junior doctors (27%, compared with 21% of all doctors) every day.

Many SAS doctors said that they were satisfied in their work. 36% of SAS doctors were in the 'most satisfied' category, compared with 23% of all doctors surveyed. 37% of SAS doctors with a non-UK PMQ and 36% of SAS doctors with a UK PMQ were in the 'most satisfied' category.

Many SAS doctors with a non-UK PMQ are doing well, but often carry out work usually done by more junior doctors and feel less supported by senior doctors

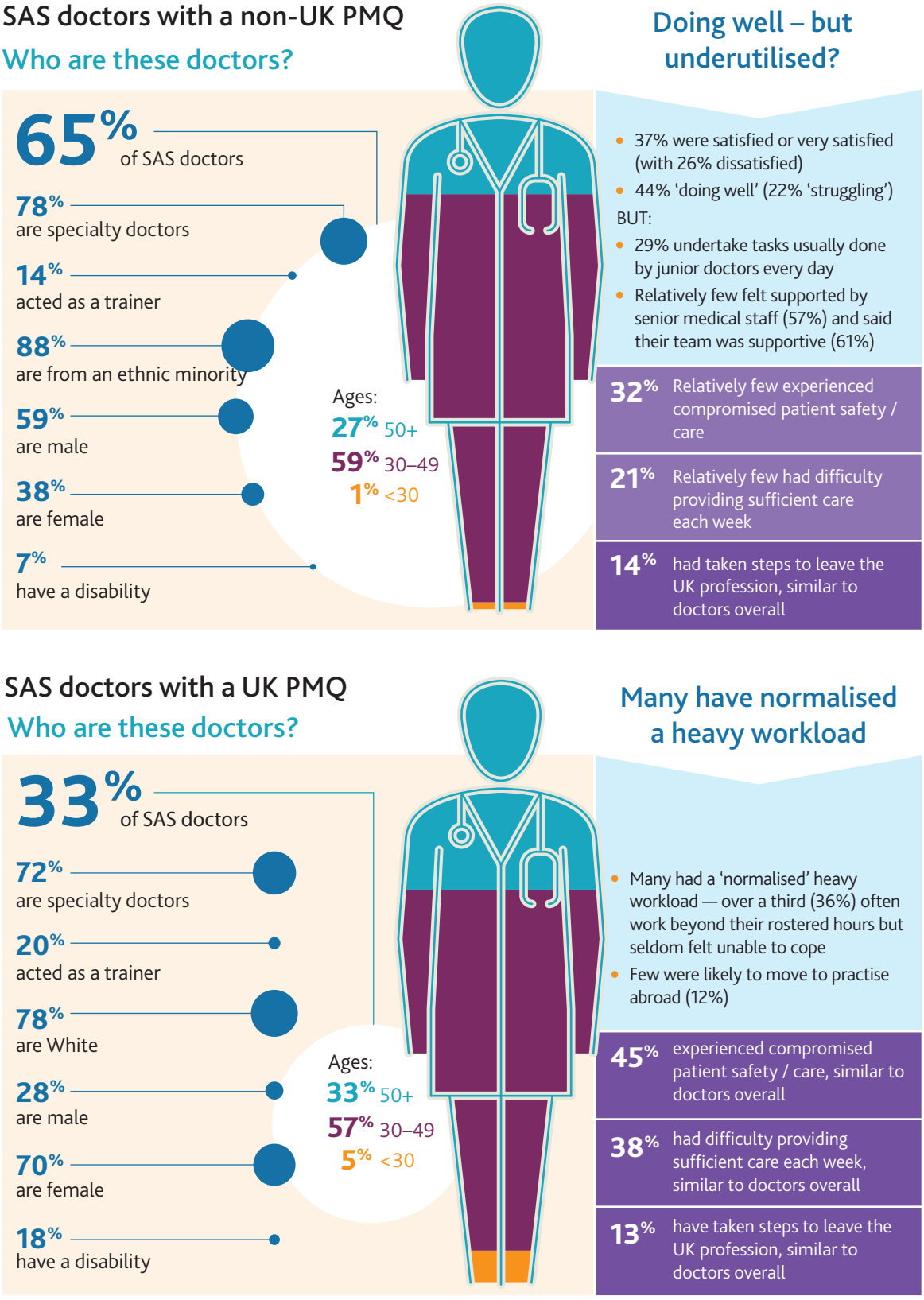
40% of SAS doctors were doing well in terms of workload, compared with 25% of all doctors surveyed (Figure 22). SAS doctors with a non-UK PMQ were more likely to be doing well than UK PMQ (44% compared with 31% respectively).

27% of SAS doctors reported undertaking tasks usually carried out by a more junior doctor every day, compared with 21% of all doctors surveyed. Three out of ten (29%) SAS doctors with a non-UK PMQ reported this, compared with 23% of SAS doctors with a UK PMQ.

62% of SAS doctors said they felt supported by senior medical staff, compared with 63% of all doctors surveyed. 57% of SAS doctors with a non-UK PMQ felt supported by senior medical staff, compared with 73% of SAS doctors with a UK PMQ.

These findings could indicate that the skills and experience of SAS doctors with a non-UK PMQ are not being recognised and fully utilised by senior medical staff. The growth in IMG joiners means it is particularly important to allow this group to function at the top of their skillsets, enable them to progress and develop, and encourage them to stay in the workforce.

Figure 23: Diversity of SAS and LE doctors and their experiences



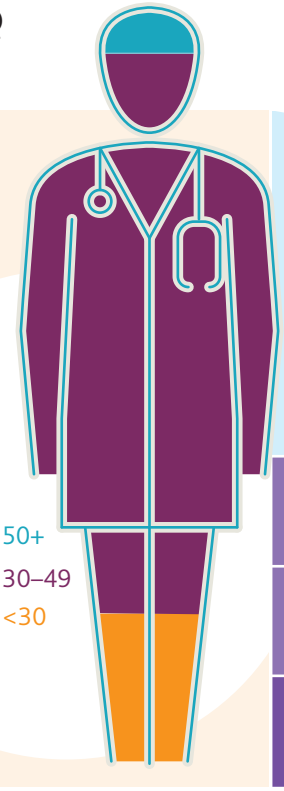
LE doctors with a non-UK PMQ

Who are these doctors?

71% of LE doctors

- **42%** Clinical fellows
- **25%** Trust doctors
- **8%** acted as a trainer
- **88%** are from an ethnic minority
- **55%** are male
- **42%** are female
- **4%** have a disability

Ages:
- **6%** 50+
- **68%** 30–49
- **18%** <30



More prone to taking leave due to stress

- 32% had taken a leave of absence due to stress
- 11% had taken stress related leave each month

24% Relatively few experienced compromised patient safety/care

23% Relatively few had difficulty providing sufficient care each week

13% have taken steps to leave the UK profession, similar to doctors overall

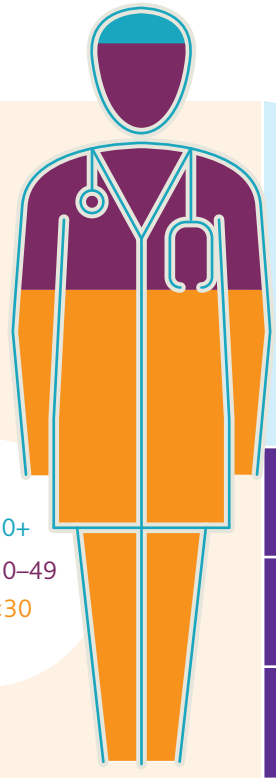
LE doctors with a UK PMQ

Who are these doctors?

28% of LE doctors

- **37%** Clinical fellows
- **23%** Locums
- **7%** acted as a trainer
- **65%** are White
- **53%** are male
- **45%** are female
- **14%** have a disability

Ages:
- **4%** 50+
- **29%** 30–49
- **59%** <30



Multiple areas of concern

- 45% dissatisfied and 37% 'struggling' with their workload
- 19% felt supported by management
- 45% said not enough development / learning

58% Many experienced compromised patient safety / care

60% Many had difficulty providing sufficient care each week

25% A quarter have taken steps to leave the UK profession

Many SAS doctors with a UK PMQ have a normalised heavy workload

SAS doctors with a UK PMQ appear to be a relatively settled part of the workforce, with few saying they are likely to move to practise abroad (12%, compared with 25% of all doctors surveyed and 32% of SAS doctors with a non-UK PMQ). But over a third (36%) have a 'normalised' workload, meaning they often work beyond their rostered hours but rarely feel unable to cope, compared with 31% of all doctors surveyed and 26% of SAS doctors with a non-UK PMQ. Though this group is managing their day-to-day work, normalising a heavy workload may have negative effects on their wellbeing and patient safety and care.

LE doctors

39% of LE doctors said they were likely to move abroad, compared with 25% of all doctors. One out of ten (9%) LE doctors reported that they had taken leave due to stress at least once a month, compared with 4% of all doctors.

More LE doctors with a non-UK PMQ take frequent stress-related leave

11% of LE doctors with a non-UK PMQ reported that they took a leave of absence due to stress each month, compared with 4% of all doctors surveyed and 4% of LE doctors with a UK PMQ.

By other measures LE doctors with a non-UK PMQ do not appear to have had particularly negative experiences, so this might be the result of their roles having flexibility that enables them to take stress-related leave—while the roles of other types of doctors do not—which may be a protective factor.

Many LE doctors with a UK PMQ have difficulty providing patient care, have taken steps to leave, and feel less supported, alongside other concerns

In the 2022 Barometer survey, 4% of all doctors were LE doctors with a UK PMQ. This group of doctors is relatively young, with three-fifths (59%) under 30 years old and includes doctors who have completed their foundation training but stepped away from the training pathway while continuing to work in UK practice. Such breaks in training are increasingly prevalent and are now perceived as standard by many. This means it is particularly important to recognise and urgently address the poor experiences of LE doctors with a UK PMQ set out here given the plans to increase UK training places.

LE doctors with a UK PMQ reported negative experiences in multiple areas. Many were dissatisfied (45%) and struggling with their workload (37%), and relatively few had a very low risk of burnout (29%), though these levels are in line with those of doctors in training. More strikingly, LE doctors with a UK PMQ fare worse than other SAS and LE doctors, and doctors in training, in the following areas.

- Most had experienced compromised patient safety or care (58%, compared with 43% of doctors in training) and most had regularly had difficulty providing patient care (60%, compared with 45% of doctors in training).
- A quarter had taken hard steps to leave the UK profession (25%, compared with 18% of doctors in training).
- Few felt supported by non-clinical management (19%, compared with 29% of

doctors in training), and many did not agree they had enough development and learning opportunities (45%, compared with 33% of doctors in training).

Summary of findings relating to SAS doctors and LE doctors

SAS and LE doctors are the fastest-growing part of the UK medical workforce. They face particular challenges and are not a homogeneous group in terms of background, skills, and experiences. The Barometer survey 2022 enabled us to explore SAS doctors and LE doctors as separate groups, but we cannot make comparisons with survey results from previous years.

Compared with all doctors surveyed, more SAS doctors had a very low burnout risk, and more were satisfied in their work. However, more SAS doctors said they carried out both work usually done by more senior doctors and work usually done by more junior doctors every day. Compared with all doctors surveyed, more LE doctors said they were likely to move abroad, and more reported that they had taken leave due to stress on a monthly basis.

We also looked at SAS and LE doctors based on where they gained their PMQ and found that these four groups had distinct characteristics and experiences.

- SAS doctors with a non-UK PMQ: many were doing well, but reported often carrying out work usually done by more junior doctors and feeling less supported by senior doctors.
- SAS doctors with a UK PMQ: many had a normalised heavy workload—while they rarely felt unable to cope, they often worked beyond their rostered hours.
- LE doctors with a non-UK PMQ: more of these doctors took frequent stress-related leave, though by other measures they do not appear to have had particularly negative experiences.
- LE doctors with a UK PMQ: many had difficulty providing patient care, have taken steps to leave the UK profession, and feel less supported, alongside a range of other concerns. This group includes doctors who have completed foundation training and are working in UK practice while not currently training. Some concerns stand out even in comparison with doctors in training, a group with similar characteristics.

Chapter conclusion

The UK health system has been under sustained pressure for a considerable period, and the Barometer survey 2022 findings make for uncomfortable reading. Healthcare staff workloads have expanded in the wake of the coronavirus pandemic, and doctors have made huge efforts to deal with the backlog of care. But many doctors are now struggling to cope and are at greater risk of burnout than previously. A growing number of doctors also feel concerned that they have been unable to provide sufficient patient care, risking increased moral injury. This context creates the vicious cycle described earlier in this chapter. Dissatisfied, overworked doctors are more likely to seek opportunities elsewhere, putting further pressure on existing staff, and ultimately jeopardising patient care and safety.

While doctors across the register are feeling the strain, GPs have been particularly badly hit. More than half (55%) were struggling, compared with an average of 38% of all doctors. There are major disparities between GPs and groups in other areas too, notably workload intensity. Solutions must be found to address the unsustainable pressures on the whole system, and especially on general practice. In the following chapters, we explore some of these potential solutions.

The survey results also give cause for concern about doctors facing barriers due to their protected characteristics, particularly disability. These issues may exacerbate the vicious cycle if doctors feel their workplace is not welcoming or inclusive.

The next chapters introduce the concept of a virtuous cycle that could help counteract this vicious cycle, and explore changes that our evidence suggests will help put this concept into practice. This virtuous cycle involves ensuring a greater sense of belonging in the workplace, mitigating stress and burnout, boosting satisfaction and the feeling of being valued, and increasing retention of doctors.

Breaking the cycle in the short term

Summary

- This chapter considers how the vicious cycle of pressure can be broken, and the practical steps this might involve.
- The first part of the chapter looks at how vicious cycles can be challenged through creating positively reinforcing 'virtuous cycles', such as by helping doctors feel better supported and more valued, and have a strong sense of belonging within their workplaces.
    - The development of virtuous cycles could result in higher satisfaction, lower risk of burnout, improved retention of doctors, and ultimately better patient safety and care.
- The second part looks at practical short-term steps that could help implement the virtuous cycles and potentially improve staff wellbeing, retention, and patient safety and care. These steps include:
    - Evolving and developing what it means to be a leader and enabling compassionate leadership, to ensure that leaders can support and encourage teams, building a stronger sense of belonging.
    - Building strong teams that work effectively together and have a strong sense of belonging and cohesion, for example by ensuring effective inductions.
    - Focussing on groups that currently have worse experiences in specific areas regarding support, including in particular disabled doctors and non-UK graduates.
    - Improving working conditions, including by developing fair and flexible rotas and making sure that there are sufficient facilities in place for all staff.

Introduction

Chapter 1 set out the poor workplace experiences of many doctors. It described them in terms of a vicious cycle of pressure that ultimately leads to poor patient care. This chapter sets out a number of actions that may help reduce, or even break, this vicious cycle. It is clear from our evidence that the core underlying issues are complex and will be slow and difficult to change. It is necessary to start tackling these long-term issues now, and chapter 3 shares what our research and data suggest would help.

This chapter discusses the more immediate changes that employers can make to working conditions while longer-term improvements are made. The exact priorities will vary from place to place, but it is vital that boards and leaders reflect on the evidence we present here and consider the implementation of the changes that are most applicable to them.

In the first part of the chapter, we describe some general approaches to breaking the vicious cycle by building virtuous cycles of workplace improvement. In the second part of the chapter, we outline the specific steps that doing this might involve.

Part 1: Breaking the vicious cycle by building virtuous cycles that improve workplace conditions

Vicious cycles must be directly challenged to improve doctors' experiences and retention

The vicious cycle of pressure discussed in chapter 1 is contributing to the rapid increase in the proportion of doctors who are struggling with their workload. We need to see more doctors doing well, and fewer doctors struggling, as quickly as possible if patient safety is to be maintained.

Data from our Barometer surveys from 2019 to 2022 show that satisfaction in day-to-day work correlates with a sense of belonging among doctors, better retention and, ultimately, safer patient care. Improving satisfaction could help to disrupt the vicious cycle described in chapter 1 of unmanageable workloads, mounting pressures, and staff absences (Figure 1).

Figure 1: Maintaining high satisfaction can help halt the vicious cycle

Enable virtuous cycles by ensuring staff feel valued, developing more positive learning environments, and improving teamworking

To break the vicious cycle, systems and employers need to ensure that there are practices in place that help improve workplace experiences.

Creating positively reinforcing virtuous cycles could act as an antidote to the vicious cycle. Our evidence shows several areas where changes can support the development of virtuous cycles. Furthermore, the overall positive effect of achieving a virtuous cycle could be greater than the sum of the individual impact of each change.

Here we explore some examples of positively reinforcing factors in virtuous cycles that we developed using evidence from the Barometer survey 2022, the follow-up Barometer interviews, and interviews with senior stakeholders (Box 1).

Box 1: Evidence gathering through senior stakeholder interviews

As part of the research underpinning this report, we conducted a series of interviews with senior stakeholders in healthcare from across the four countries of the UK. The interviews explored senior stakeholders' views and perceptions about doctors' workplace experiences and considered how workplace pressures may be addressed now and in the future.

We asked senior stakeholders about their views on the main challenges to providing patient care, and what factors contributed to these challenges. We also explored any solutions or examples of recent approaches that could address these challenges in both the short term and long term, and the main priorities for future planning.

Topics explored were largely guided by what interviewees placed importance on. Therefore, we gained a rich insight into the views of senior stakeholders in various positions across the UK healthcare sector.

Because of the unique position of each stakeholder, they brought different perspectives and broad expertise, which we have drawn on throughout this chapter and the next to give examples of what they saw as workable and helpful solutions.

Ensure doctors feel valued by their employers and have a strong sense of belonging

Senior stakeholders felt that offering more visible, tangible support to doctors and other healthcare professionals, and ensuring that they feel valued, could be done at team level with support from employers.

> "It is usually a multidisciplinary team effort to make the workplace environment more rewarding, and then people will be more productive and then there will be better patient outcomes."
>
> *Senior stakeholder interview*

Overall, an increased sense of value could have a positive impact on doctors' working experiences and ultimately on retention. Senior stakeholders felt that the impact of taking steps in this area is likely to be significant: they could help to improve retention and attract doctors to work in these environments, further incentivising other employers to introduce the sorts of changes that increase the sense of being valued. Examples include:

- within teams, encouraging positive everyday behaviours, such as improving communication between colleagues and taking proactive steps to tackle bullying and discrimination head on
- at an organisational level, providing staff with facilities such as parking spaces, lockers, tea and coffee, and rest spaces
- Improving rota design to be fairer and allowing teams to work together regularly enough over time so that they can form meaningful bonds.

In many workplaces outside of healthcare, these provisions are often seen as a minimum standard—and they add up to make staff feel valued.

Our 2019 commissioned research *Caring for doctors, Caring for patients*[5] found that doctors are best supported by having three core needs met, referred to as 'ABC':

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

The consequences of not meeting these needs are set out in *Caring for doctors, Caring for patients*[5] and include doctors showing cognitive and emotional symptoms of stress, such as mood disturbance, depression, anxiety, and poorer workplace performance. Doctors are also at higher risk of developing chronic fatigue, and other issues.

Having a strong sense of belonging is important to doctors' experiences of working and wellbeing, and their ability to give good, safe patient care. It overall contributes to a strong sense of being valued, while previous commissioned research, including the Barometer surveys in 2020[4] and 2021,[1] show that patient experience and safety are associated with doctor wellbeing. Research outlined in *Caring for doctors, Caring for patients*[5] showed that doctors with higher levels

of burnout are more likely to make medical errors than those with lower levels of burnout.

A sense of belonging is enhanced if the leadership teams of health and social care organisations are able to nurture cultures that are high quality, continually improving, and able to provide compassionate care. They need to ensure the wellbeing and intrinsic motivation of all the diverse staff they lead, including doctors. This must be a clear and explicit focus of attention for those involved in managing and commissioning healthcare services.

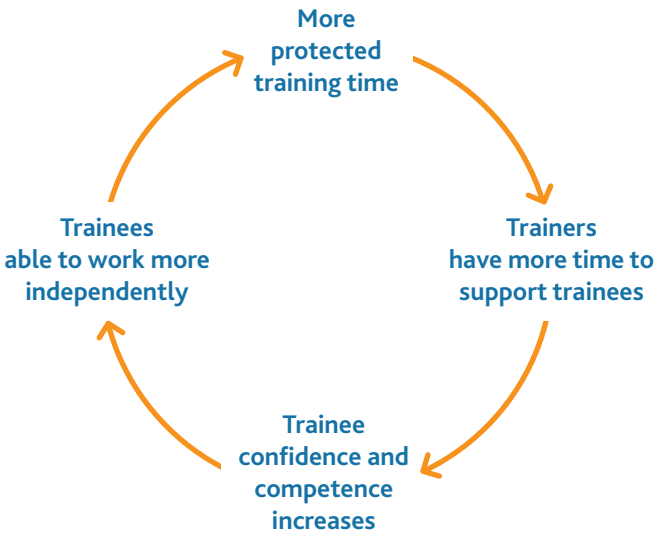
Enhance learning environments

As part of the research for this report, IFF Research conducted a series of interviews with trainers.[12] A substantial theme that emerged was that overall workload pressures meant that many trainers had limited capacity to train people in the way they would have liked. Training responsibilities can be difficult to balance alongside workload pressures.

Protecting training time could enable trainers to have more time to support trainees and ensure high-quality training. This allows trainee confidence and competence to develop, allowing trainees to work autonomously with appropriate oversight, which could help to improve the flow of patients. The ability for trainees to work autonomously could contribute to reducing backlogs, ultimately leading to a reduction in workload intensity (Figure 2).

These changes could have a multiplier effect on the training of doctors: improved trainer experiences may encourage more doctors to choose to become trainers. This would build further capacity into supporting trainees and healthcare workers with their learning and development in the future, helping them in turn to become more confident and autonomous. As this is a crucial and long-term challenge, ways of supporting trainees and trainers are explored in more detail in chapter 3.

Figure 2: A virtuous cycle: the benefits of protecting training time



Enable effective and supportive team working to improve belonging

As we discussed earlier in this chapter, an essential part of the ABC that doctors need in order to have positive working experiences is a sense of belonging. Belonging can be built through working with supportive colleagues and within effective teams.

Patient safety is protected when doctors have supportive colleagues

In the Barometer survey 2022, 42% of all doctors surveyed had seen a patient's safety compromised in the year leading up to the survey.

The data we reported in chapter 1 show a clear association between having supportive colleagues and maintaining patient safety. Only 52% of those who had seen patient safety compromised said their organisation encouraged a culture of teamwork, compared with 75% who had not seen patient safety compromised.

Overall, the evidence is clear: good, strong teams in clinical environments contribute to doctor satisfaction, protect against high risk of burnout, and therefore also help to maintain patient safety.

Supportive workplaces are critical to doctor wellbeing and patient safety

Compassionate working cultures, supportive teams and colleagues, and visible leadership all play an important role in ensuring the wellbeing and safety of the patient. Doctors' overall satisfaction and manageable workloads are crucial in underpinning good, safe patient care.

Support, teamworking, and belonging are all associated with each other. Each enhances the others and together they create good working environments. Doctors who feel supported work more effectively with their colleagues in and across teams, and therefore provide better patient care. Having a sense of belonging ultimately reinforces the support systems in place and further strengthens teamworking.

The support that doctors receive from their colleagues and their teams is therefore a vital component of positive working experiences. Doctors who are generally satisfied in their work—and who have manageable workloads that are fairly shared between teammates—form the basis of good patient care.

> "I feel supported by my colleagues a lot. We all recognise the fact that our workload is great and although we are allocated different tasks in the day … we each dip in and support each other."
>
> *GP, Barometer survey follow-up interviews 2022*

> "If you give consultants appropriate autonomy, belonging, and working within their competence, then they are happier, are more likely to stay, the patient experience is better, patient outcomes are better—so why would you not do that?"
>
> *Senior stakeholder interview*

Belonging to a supportive team is associated with doctors having better workplace experiences.

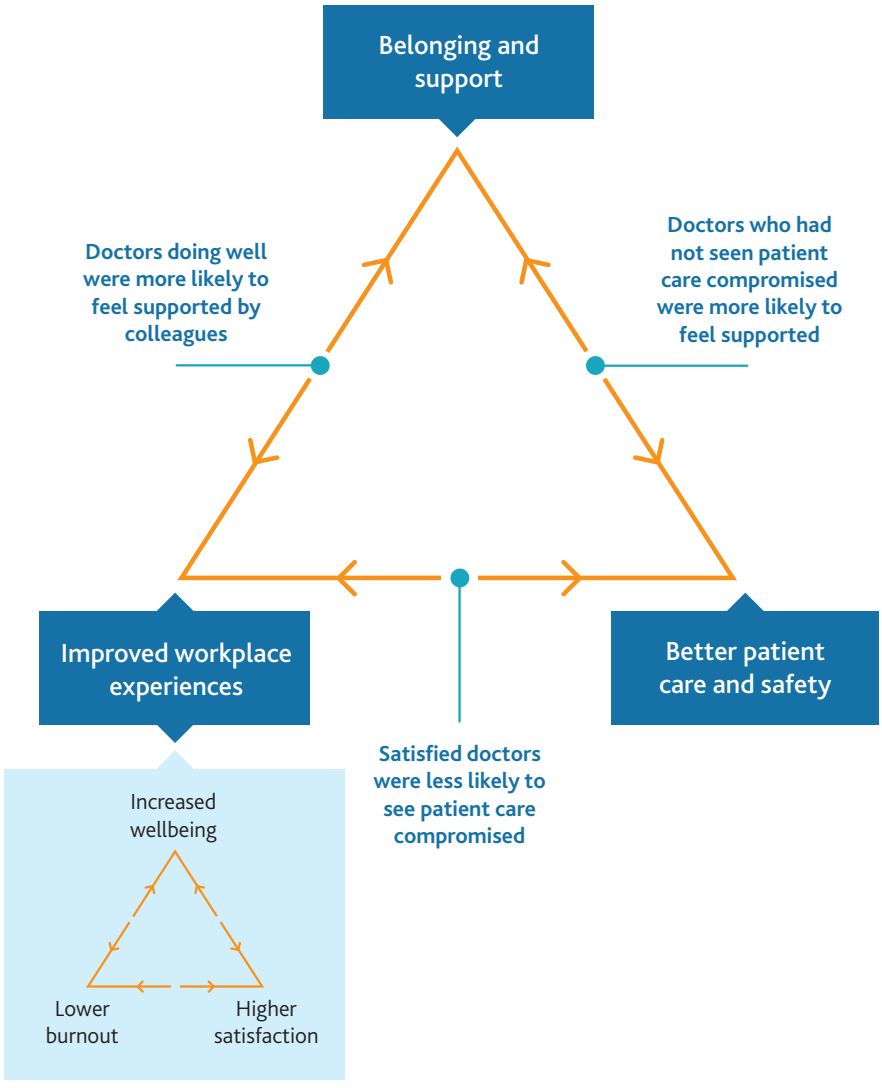
80% of doctors who were doing well agreed they were part of a supportive team, compared with 66% of doctors who were struggling.

83% of doctors who were at very low risk of burnout agreed they were part of a supportive team, compared with 57% who were at high risk of burnout. And 85% of doctors who were satisfied agreed they were part of a supportive team, compared with 60% who were not satisfied.

Better experiences of support and belonging, and improved workplace experiences, are associated with better patient safety and care (Figure 3). For example, 81% of doctors who had not seen patient care compromised in the year leading up to the Barometer survey 2022 agreed they were part of a supportive team, compared with 68% of those who had seen patient safety compromised.

You can find further data on these associations in the Barometer survey 2022 reference tables.[17]

Figure 3: The relationship between supportive teams, positive workplace experiences, and patient care and safety

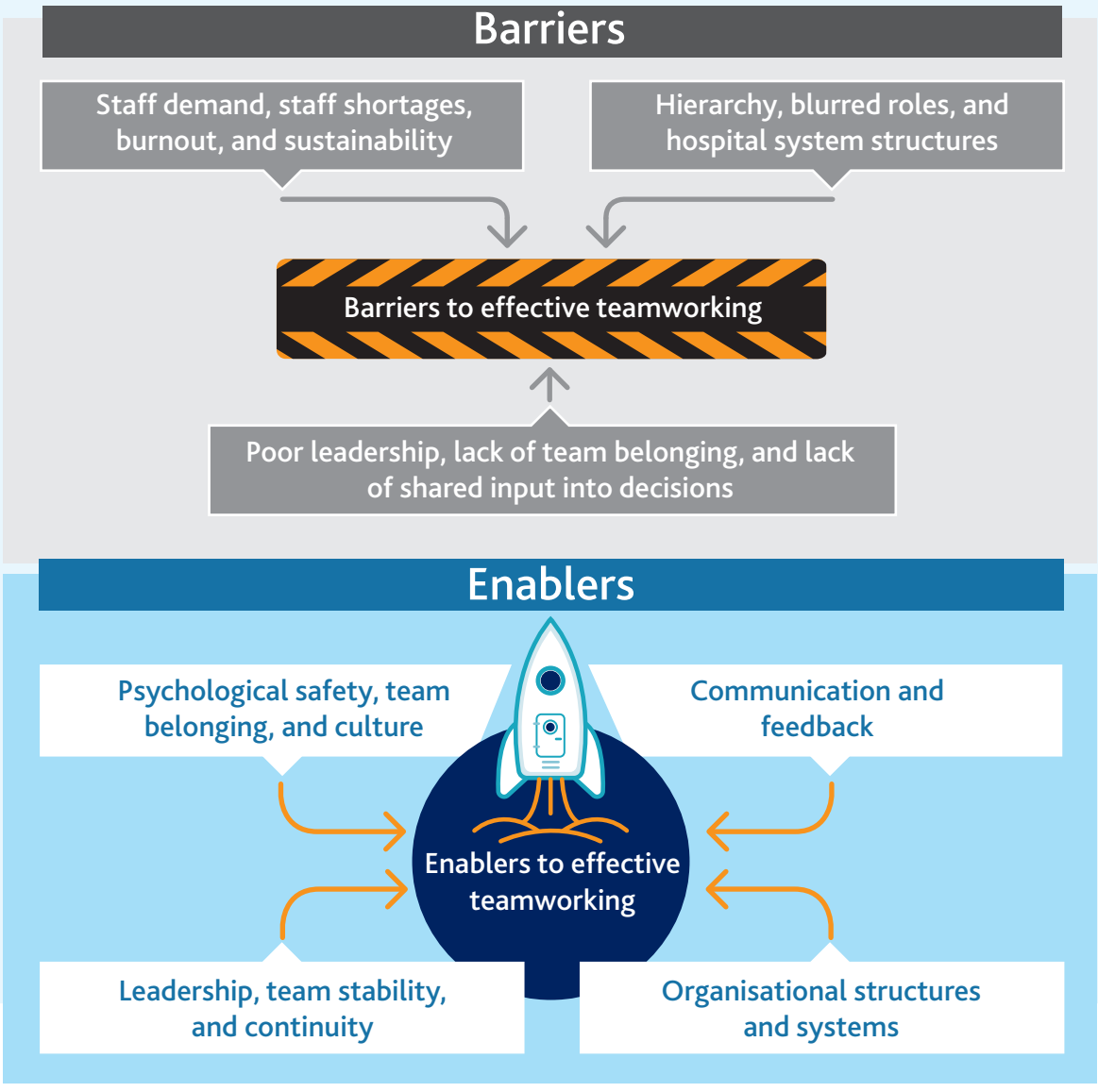


Box 2: Understanding risks to teamworking will help identify opportunities to improve it

Chapter 1 suggested that some aspects of teamworking have deteriorated over the last couple of years. The findings in this edition of the *State of medical education and practice in the UK: Workplace experiences* report allow us to glean some insight into the drivers of these worsening experiences. This understanding has been enhanced through commissioned research by Hull York Medical School. A full report[18] outlining the barriers to and enablers of teamworking will be published on our website in 2023.

Figure 4 summarises the main barriers and enablers to effective teamworking that the first portion of the research found and highlights the importance of the practical steps to improve workplace conditions that we discuss in the rest of this chapter.

Figure 4: Summary of the barriers and enablers to effective teamworking



Part 2: Practical steps organisations can take to improve satisfaction and wellbeing

The Barometer survey 2022 results and the interviews with senior stakeholders gave rise to many examples of how satisfaction and wellbeing of doctors can be supported to help build virtuous cycles. These examples included the importance of support from senior staff members, good teamworking, and the provision of good facilities.

Doctors who took part in the Barometer survey 2022 follow-up research had some suggestions for how to improve support from senior members of staff, including calls for mentoring programs or shadowing opportunities, ringfenced training and development time, and building team cohesion by ensuring that everyone knows each other.

We recognise that there are challenges around available resources at present. Many of the changes to working conditions mentioned could make a huge difference to satisfaction and wellbeing of staff, and many would not cost a huge amount in this resource-constrained period. These steps could be critical to improving retention as quickly as possible so that doctors and the UK health systems can better meet their aspirations.

The elements highlighted in this part of the chapter might be a useful checklist of areas for organisations to consider as priorities.

Improving working conditions

Healthcare environments are places that care for people. However, senior stakeholders working in healthcare described how workplaces can be very uncaring towards their staff. Inflexible and non-consulted rotas, and a lack of or outdated and worse-for-wear facilities and physical environments, can leave doctors feeling undervalued and fatigued. These feelings can be further compounded by an inability to influence positive change.

These poor workplace environments are acting as a push factor away from UK practice. As we saw in chapter 1, the proportion of doctors who were planning to permanently leave UK practice increased from 11% in 2021[1] to 18% in 2022. The proportion who had already taken hard steps towards leaving had roughly doubled from 7% to 15% of all doctors and is the highest proportion we have seen since we started monitoring this in 2019. Employers must consider all reasonable ways of retaining healthcare staff in UK practice, including ensuring that the value of doctors is shown through supportive and rewarding working environments.

In this part of chapter 2, we outline the recommendations we have heard from doctors, trainers, and senior stakeholders. The focus is to explore ways in which employers and others can show doctors that they are valued and appreciated. As well as impacting the day-to-day wellbeing of doctors, these steps will also play a role in improving retention and, ultimately, patient safety.

> "Most hospitals, general practices, healthcare facilities, they won't have break rooms, won't have toilets—or they will have a toilet, but it won't be proportionate to the number of staff. They'll have areas that junior doctors are not allowed to use. They won't have food overnight. They have to pay for rubbish coffee… There aren't nice rest facilities, there isn't somewhere where you can easily go outside and walk in most healthcare facilities… public transport links are often expensive, never subsidised for healthcare workers, parking—some doctors are charged to park at work… there's all these little things that build up to being told 'you're not worth it'."
>
> *Senior stakeholder interview*

Evolving and developing what it means to be a leader

Our research shows value in good support from colleagues, as indicated in the first part of this chapter, but also from leaders and managers. Ensuring that leaders understand the needs of their colleagues and teams, and have the resources and time to provide good, personalised support, can be extremely beneficial for the wellbeing of all health workers.

Support from senior colleagues should be provided to staff members who need it, and Schwartz[19] rounds—forums that give staff from all disciplines an opportunity to reflect on the emotional and social aspects of working in healthcare—could be introduced where they are suitable but not already in place. Feedback should be compassionate and constructive, build learning opportunities into practice particularly after there have been mistakes, and move away from blame cultures.

Clinical leaders should be quick to respond to requests for advice and support, and they should take concerns and feedback seriously. They should be easily contactable. Hard work should be acknowledged and celebrated. This will show doctors that they are valued, listened to, and that their work is not taken for granted. Acknowledgement and appreciation of good work can be in the form of supportive, positive, or constructive feedback from leaders, or in the form of staff awards schemes, such as the Whittington Staff Awards[20] described in this chapter (Box 3).

Some of these actions were implemented over the course of the coronavirus (COVID-19) pandemic, however, many of the positive changes have since been lost, often due to extreme service pressures. Recapturing these examples of good leadership should have a positive effect on staff wellbeing as well as patient safety.

> "There are some organisations within the NHS that do quite a good job at making people feel secure in their environment, [and have] an open and learning culture where blame is not a big part of it, so clinicians are still accountable, but they don't feel that when something goes wrong that they're going to be hung, drawn, and quartered. We do know that there are organisations that do that well. Equally, we do know organisations that are really, really bad at it."
>
> *Senior stakeholder interview*

Box 3: The Whittington Staff Awards [20]

Whittington Health NHS Trust holds annual staff awards, in which people (including patients) can nominate staff, either individuals or teams, to win one of a number of awards. Categories include awards for clinical and non-clinical roles, teams who have delivered improvement to services, a patient safety award, and awards for leadership.

Nominees attend an evening event and winners receive a pin badge showing their achievement. These awards are an effective way in which the Trust demonstrates how it values its staff members—by rewarding people who have gone above and beyond in their role, or who have demonstrated a commitment to excellence.

Building strong teams

As we have discussed extensively in this chapter, strong teams are vital. Senior stakeholders have told us that the following might be useful to consider within the concerted effort organisations make to ensure that all individuals they employ feel part of a team:

- planning ice-breaking activities when new teams form
- creating a sense of cohesion and belonging by organising staff events (such as having a team Christmas party)
- providing formal support, such as mentoring programs or shadowing opportunities, to help colleagues understand different roles within teams
- Designing rotas that take into account timings regarding who works with whom, ensuring that people have the chance to build connections and relationships with their colleagues over a period of time, rather than always working with different people.

Developing induction and onboarding

A thoughtful induction into a new role can be vital to settle people into teams and help them feel supported by their colleagues. An effective induction scheme ensures that new staff members hit the ground running in their roles, quickly understanding how systems and procedures work. Good inductions are also valuable because they enhance a doctor's sense of belonging in the workplace.

All doctors need some level of induction when starting a new role. But organisations should consider whether their inductions are sufficiently tailored to the individual, as doctors with different experiences will need distinct types and levels of support.

Next steps should consider focusing on groups who currently have worse workplace experiences regarding support

In the Barometer survey 2022, we tracked different groups of doctors' experiences of working within teams. Overall, teamworking

metrics were worse than in 2021, and some groups reported more negative experiences of working with colleagues than others.

As we set out in chapter 1, fewer non-UK graduate doctors said they were part of a supportive team than UK graduates. Furthermore, fewer disabled doctors felt part of a supportive team than non-disabled doctors. They were also less likely to feel supported by senior medical staff than non-disabled doctors.

The reasons why these groups feel less well supported must be better understood and addressed. For some, this might mean receiving a structured and ongoing induction when joining new working environments, for others, it might be making reasonable adjustments to working practices. It will also be necessary to tackle discrimination and bullying robustly and through compassionate leadership. Referring to our previous publications, including *Fair to refer?* [14] (2019) and *Caring for doctors, Caring for patients* [5] (2019), can help to understand and address these issues.

Employers of doctors who have a disability must consider our evidence here in their own discussions and prioritisation work, and ensure that they create safe and inclusive environments where doctors feel able to declare their disabilities. Employers are collectively obligated by equalities laws to make reasonable adjustments for staff where they are identified. However, there is more that can be done. We, along with others in the wider system, must work to share best practice in ensuring that doctors and other staff with disabilities are appropriately supported. Doctor membership bodies should build their awareness of disabilities, and work with doctors to run campaigns or set up disability networks, ensuring that there is a broad support network for disabled doctors. Employers can support disability networks and should keep up-to-date staff survey data and act on the findings.

Overall, we have ample data that reveal the range of different working experiences in the UK medical workforce. Employers need to consider the degree to which this applies to their own workforces and there may also be implications for national approaches. This is to ensure that targeted support is used so that the working experiences of doctors improve across the board and that we retain doctors from all groups within the UK workforce.

Developing flexible rota design

Many senior stakeholders who were interviewed mentioned that current rota design practices are not fit for purpose. Rota design is often seen as an inflexible process that does not consider the existence of the personal lives of doctors.

Rota design should be developed to be fair and flexible, considering life events and the personal circumstances of doctors. Planners should always handle individual preferences and circumstances fairly.

However, there needs to be flexibility from both sides: the ability to request time off, but also an understanding of the constraints of rota design, particularly in large organisations, are required. It is important for employers and doctors to find a middle ground in which rotas have a level of flexibility built in for doctors, but that also ensures that all shifts are fully covered. In some places, rotas are seen as inflexible beyond what is necessary to cover shifts. Failure to address this can be significant in doctors feeling

under-valued or unable to stay in the job because of unacceptable work-life balance issues.

Importantly, rota design could also be used to enhance the development of strong teams, by considering which staff work together, and when, allowing for connections and relationships to form over time.

Senior stakeholders also discussed the importance of how to address factors that contribute to fatigue. They advised that rota design should consider the latest research and knowledge about fatigue and sleep cycles, ensuring that rota design supports the health and wellbeing of doctors.

The development of technology that could support longer-term rota planning is an area that could be explored by employers to help address fairness, building teams, and mitigating against fatigue.

For an example of how rota design could make doctors feel more valued, we suggest that employers look at the Royal College of Physicians' *Working flexibly toolkit*,[21] which puts forwards ways in which flexible working can be promoted as an alternative to doctors leaving the medical profession. Employers may find it helpful to consider how advice such as this could be applied.

Providing workplace rest and refreshment facilities

Over the course of our research discussions for this report, we heard time and time again how the facilities and infrastructure in workplaces could be improved to better meet the needs of staff and make them feel valued. Ultimately, this could ensure that the whole heath sector, not only doctors, feels valued and supported.

Senior stakeholders made several suggestions for improved facilities.

- There should be space for rest breaks that are away from patients and visitors, allowing doctors and others to take meaningful breaks and have space to regroup after dealing with stressful cases.
- Facilities for hot drinks and food should be readily available, including during night shifts.
- For healthcare professionals who are parents or carers, information about and access to creche facilities and childcare options, which are close to or on sites and which match service provision to rota patterns, should be readily available.
- Safe and subsidised or free car parking for healthcare workers should be provided, especially for those working late shifts, or arrangements should be made for safe transport home after late shifts to avoid fatigue-related accidents and to increase doctors' sense of safety and security.

Most of these suggestions were widely made and discussed. They were not seen as especially expensive, particularly given the dividend that will result, not only in terms of staff retention, but also in terms of better teamworking and effectiveness. So, boards and leaders need to ask seriously 'why not?' in relation to these. Are there genuinely insurmountable reasons why some, at least, cannot be introduced?

Box 4: Milton Keynes University Hospital NHS Trust improved staff retention

Milton Keynes University Hospital NHS Trust is a notable exemplar for positive employee support interventions,[22] and was mentioned by a number of senior stakeholders interviewed. This Trust has made several meaningful steps to create a supportive and flexible environment. They have kept car parking free for staff members and provide good rest facilities. The Trust also subsidises meals for the staff, trusting that this will have a positive impact on the Trust in the long term due to improved staff satisfaction and retention.

These interventions reduced staff turnover, with more staff members choosing to stay at Milton Keynes, thereby reducing spending on agency staff and increasing the number of people in the staff bank who wanted to take advantage of the new benefits.

> "Milton Keynes is doing a lot of [interventions] pretty well. I think they use their agency. They do what they can within their own resources, they take meaningful steps towards creating a supportive and pretty flexible environment. I think they've trialled a lot of the flexible working stuff. They're absolutely clear on free car parking, no matter what, even if the government stops subsidising it, they'll continue doing it. Proper rest facilities, etc,. etc. There are places doing it, and a lot of that is within the gift of Trusts themselves."
>
> *Senior stakeholder interview*

Chapter conclusion

Vicious cycles of pressure in healthcare harm doctors and ultimately impact patient care and safety. However, these vicious cycles can be challenged, and positively reinforcing virtuous cycles can be developed in their place to create more positive working environments.

Strengthening supportive teams for doctors and other healthcare workers is one element that our evidence suggests has many positive effects on doctor wellbeing, retention, and patient care.

This needs to be anchored in enabling support from both colleagues and leaders, a strong sense of belonging to a team, and, ultimately, higher satisfaction in their daily work. The results of the Barometer survey 2022 show just how much effective teamworking and support are associated with higher levels of satisfaction among doctors and safer patient care.

While the specifics of what works best can vary from place to place, there is a range of practical steps that organisations and policymakers can examine. We have also shared our data about which groups may benefit the most from greater support, such as trainers and disabled doctors.

We call for greater support for systems and local leaders to scale up good practices. This needs to start now and we have commissioned a research project about the enablers of, and barriers to, teamworking in different settings, that will be published[18] in 2023, to contribute to this continuing endeavour.

Looking ahead – reflections for the health sector to consider when looking to the future

Summary

- To maintain patient safety and the wellbeing of the workforce, there are several long-term strategic needs which the wider system may wish to consider in view of our new evidence.
- Long-term strategic plans must include developments that will fundamentally reduce the degree to which high—and still increasing—work intensities are impacting the wellbeing of health workers and patient safety.
- Improving trainers' experiences will better support future growth in the UK training of healthcare staff.
- Trainees must be better supported to develop their competencies and confidence, otherwise healthcare capacity in the long term will be negatively affected.
- Primary care needs better support given general practitioners (GPs) reported the highest levels of work intensity and burnout. This could include encouraging more doctors to choose GP training routes and developing more multiprofessional roles that support GPs.

Introduction

In chapter 2, we described changes, including many improvements to working conditions, which might be possible to implement in the short term to break the vicious cycle of pressure set out in chapter 1. In particular, we focused on those changes that could enhance doctors' feelings of belonging and being supported, which our research shows is highly important.

In this chapter, we set out a range of practical, meaningful steps that leaders, employers, and policymakers should consider in the longer term that our research and data suggest can help alleviate the pressure on the profession and therefore contribute to both retention and patient safety.

Action to address both short-term and long-term concerns is a necessity. Making only the easiest of short-term changes will almost certainly not be adequate in response to the scale of challenges our data are showing. Both short-term and long-term approaches will be vital in reducing the pressures on the profession. This will be a team effort, with all parts of the UK health systems working together and sharing progress in developing effective approaches to the challenges we face.

Many of the changes to working conditions that our research and data suggest could make a huge difference to the satisfaction and wellbeing of staff would not cost a huge amount in this resource-constrained period. They are critical to improving retention as quickly as possible so that doctors and the UK health systems can better meet the needs of their populations. Some of the investments to meet longer-term strategic needs, such as improving training capacity, may have significant financial costs in the medium term, but it is vital not to completely sacrifice the medium-term future of the NHS just to meet short-term goals and targets more quickly.

Long-term strategic priorities

Our data highlight many competing priorities for the UK health systems, but at the heart of the evidence in this report is a need to fundamentally make levels of work intensity sustainable. In this chapter, we will summarise the variety of approaches stakeholders have suggested that may begin to address the underlying conditions that are impacting doctors' working experiences so negatively. We go on to discuss the importance of training capacity and of ensuring trainees are able to develop appropriately in this challenging time—and we note the particular underlying pressures on primary care.

Making work intensity more sustainable

The data presented in chapter 1 are clear: doctors are finding it more difficult to cope with workloads, their experiences are worsening, and they are increasingly struggling to provide patients with sufficient care.

This level of work intensity is affecting patients: of those doctors who reported that three-quarters or more of their days were 'high intensity', 50% had seen patient safety compromised. Doctors who reported that less than half of their days were 'high intensity' were much less likely to have seen patient safety compromised (32%).

Long-term strategic plans must include developments that will fundamentally reduce the degree to which high—and still increasing—work intensities are impacting on health worker wellbeing and patient safety. There may be different drivers of increasing work intensities in various parts of the UK health systems.

For example, in some areas the main driver might be how work is organised, rather than due to resource levels. Therefore, some of the measures to quickly improve work conditions discussed in chapter 2 may help to decrease work intensities.

However, a large part of unsustainable work intensity is because demand for care services outstrips the capacity to deliver it. This is an issue that impacts all parts of care, but particularly primary care.

> "In primary care […] the number of patients per doctor has gone up, the complexity has gone up as people have aged […] Also, I think some of the demands of how practices work have changed very significantly."
>
> *Senior stakeholder interview*

Various factors compound this issue, including the recent backlog of care from the pandemic, which, though reducing, is still presenting challenges for many, alongside longer-term issues such as an ageing population with more complex comorbidities.

However, heavy demand on service is not a new issue. As one of the senior stakeholders we spoke to said, 'We've got the [cyclical] trend over time between the imbalance from an ageing population and the medical workforce. And that mismatch has really been going on for decades.'

There are many views on the best way to ensure that supply addresses demand in a way that does not create unsustainable work intensity. Improved population health and wellness, improved productivity, increased supply of general practice staff, and better integration of health, social, and community care were all commonly cited.

Box 1: Improving provision by increasing retention

NHS England is currently running a pilot study, titled the People Promise Exemplar Programme. This pilot is working with 25 trusts to examine what effective workforce retention strategies look like, in particular, when encouraging doctors in their early 50s to stay in the medical profession.

This work is in its early stages, but we look forward to the findings when they are available. As we described in our 2022 Workforce report,[7] the rate of doctors leaving the UK medical profession observed between 2020 and 2021 showed a concerning increase after the relatively low numbers of leavers over the pandemic. In the Barometer survey 2022, we saw that 15% of doctors said they had taken hard steps to leave the UK medical profession. Therefore, retention schemes are extremely valuable in keeping experienced doctors working within the UK healthcare settings in a medical role.

> “Huge investment [is] needed not [just] in social care, but in community and social care. We need to get people cared for differently, so they don’t have to come to the front doors of a hospital, and I think that’s a massive challenge.”
>
> *Senior stakeholder interview*

> “The frail elderly with multi-morbidities who are just not quite surviving at home… once they get into hospital, a doctor who has never met them before makes the decision that they’re not safe to go home. Then, as they don’t want to go into a nursing home or a care home, they’re stuck in hospital, and they get these horrible titles like ‘bed blockers’ or ‘delayed discharge’ when actually we just don’t have a way of diverting the resource.”
>
> *Senior stakeholder interview*

> “If we can’t discharge patients in a timely fashion then this causes a significant number of flow issues throughout hospitals and other services, particularly prevalent in mental health as well, where the lack of social care provision is causing significant issues.”
>
> *Senior stakeholder interview*

> “If you invest in communities, in social care, in primary care, then you get legion-fold improvement in health outcomes and you get reductions in health inequalities.”
>
> *Senior stakeholder interview*

What is clear is that there are no simple solutions, and almost certainly no quick solutions. While it is imperative that we act now to protect the wellbeing of staff and patient safety, we must not lose sight of the need for longer-term solutions. We must also acknowledge that short-term pressures need to be handled in a way that does not cause problems in the medium and long term.

Box 2: Getting It Right First Time

Several of the senior stakeholders we spoke to brought up Getting It Right First Time (GIRFT) as a positive and successful example of an innovative national programme designed to improve medical care within health services in England.

GIRFT is an evidence-based approach that uses data to inform actions and recommendations, with the aim of improving care and patient outcomes. GIRFT also helps support workflows, workloads, and the meeting of standards. It aims to synchronise delivery across different services and to encourage trusts to share examples of what works well.

Learning from data, GIRFT has allowed services to increase their efficiencies, reduce unnecessary procedures, and has boosted cost savings.

An example shared by a senior stakeholder was the rollout of elective surgical hubs that are separated from emergency care units. These were developed to support recovery efforts on the post-coronavirus (COVID-19) elective backlog. Supported by guidance from GIRFT's High Volume Low Complexity programme[23] and NHS England's Targeted Investment Fund, systems and trusts were supported to individually plan, design, and implement their elective surgical hubs.[24] This approach allowed clinical and non-clinical staff to work efficiently and effectively and has supported both staff morale and positive patient experiences.

Senior stakeholders also referenced the success of a similar 'GIRFT-style' approach that was adopted in NHS Scotland's out-of-hours services.[25] Using GIRFT approaches, flow navigation centres developed the use of senior-level triage alongside input from health and social care organisations to determine the best place for patients.

There were recommendations by some senior stakeholders that looked at improving productivity and tackling workloads, such as by making greater use of new AI capabilities and remote working, or by redesigning care pathways systems and service delivery models. To some, this would be to bridge the gap until the longer-term workforce supply grew, while others believed that these actions paired with reducing demand would be effective enough to address the current challenges themselves.

The move away from expensive institution-based mental health services, and towards supported and community care was held up as one positive example of how a redesign can benefit patients and be cost-effective.

Box 3: Improving care for the frail: connected services leading to reduced pressures on A&E

South Warwickshire University NHS Foundation Trust has developed services specifically targeted at frail and elderly people, which has resulted in reducing the number of people having to attend hospital after a fall.[26, 27] This service is provided thanks to a multidisciplinary and interdisciplinary team effort, with input from doctors, nurses, advanced nurse practitioners, the fire service, and more.

Paramedics can contact the frailty service for advice when responding to somebody who has had a fall and can speak directly to experts on frailty.

After being discharged from care, elderly and frail people are protected from having to return to hospital by a range of services, including a call from a nurse, the delivery of food packages, and a risk assessment of their home. Overall, this has reduced admissions into hospitals, therefore reducing demand on accident and emergency services, and has allowed many more people to receive the care they need at home.

Another necessary step that was mentioned was for the improved integration of health and social care and healthcare. The approach taken in Scotland[28] of uniting the two services was given as a clear example of how the systems can work together for mutual benefit.

> "One thing I usually cite in conversations around these issues is how do we make day-to-day work easier? What's the environment we can create that makes things easier?... If we're going to make working life more attractive – keep more people, attract more people in – removing the obstacles and making work more productive is absolutely critical."
>
> *Senior stakeholder interview*

Working to increase training capacity

Trainers are vitally important for the future of the medical profession. If the number of UK training posts is to increase, and we are to protect the pipeline that produces our future workforce capacity, then more healthcare professionals must feel motivated to take on the extra responsibilities of training. This, alongside the pressures on current trainers' time, carries a risk to the future quality of the whole healthcare workforce and future patient safety.

As described in chapter 1, doctors who take on the role of trainer report more negative workplace experiences. They describe challenges in finding the time to dedicate to training and teaching, resulting in more pressurised working experiences and working beyond their rostered hours.

There is evidence that at least some training is being deprioritised due to service pressures.

In the short term, employers can do more to show they value trainers and ensure that training roles are seen as positive and appealing career choices. This will increase the number of trainers who stay in role and will make the choice to become a trainer more appealing.

Trainers have various motivations that drive their choice to commit time as a trainer. They cite the importance of 'giving back', of improving the quality of the workforce, of improving patient care, and of building the trainers of the next generation. Doctors who choose to train also highlight the benefits of the role, including career development, increased variety in their day-to-day work, and the value and privilege of passing on their expertise. Employers should be aware of these motivations when encouraging people to become trainers and ensure that trainers do not feel as if their goodwill and good intentions are being taken advantage of.

Trainers must be able to protect their time to train. They must have the ability and freedom to seek support from others when their workloads become overwhelming and have some level of flexibility in their service delivery or supervisory responsibilities. This will help to allow them to manage and balance variations in workloads for each side of their roles.

We see that doctors, perhaps more apparently early career doctors, increasingly find value in a healthy work-life balance, and therefore set more boundaries to achieve this: for example, they are more willing to say no to additional hours than trainee doctors have been in previous decades.

It is important that this new reality is recognised and that trainers and training systems, as well as employers, are able to adapt to accommodate this appropriately.

> "There [are] different expectations in the current workforce than in perhaps past workforces [attitudes] around work-life balance."
>
> *Senior stakeholder interview*

Overall, retaining the high-quality trainers currently in role and encouraging more doctors to become trainers will improve workforce flow, improve support for trainees, and will have knock-on positive effects on all healthcare professionals, as trainers do not exclusively train doctors, but train and support the development of many multiprofessional colleagues.

> "On trainers, the system has become a lot more bureaucratic over time, and a lot of people, therefore, are not training who previously would've done because they just can't be bothered to go through the process. The aim has been to standardise people's ability to do training, but it has achieved that at the expense of driving a lot of people who would've done training previously out of the system. Therefore, those who remain 'in' tend to be more hurried and do it more quickly because they don't have as much time, it's a narrower base. I think that's one of the areas we as a profession need to take another look [at]."
>
> *Senior stakeholder interview*

Box 4: What does support look like to trainers?

We commissioned IFF Research to conduct a series of in-depth interviews with trainers from across the UK.[12] They identified the ways in which trainers and supervisors feel supported and unsupported by their leaders and colleagues.

Table 1: How trainers feel supported and unsupported

	Educational bodies / membership organisations	Senior Leadership Team / Management	Colleagues / administrative staff	Peers / other trainers
Supported	• Clear learning outcomes • Good collaboration between the Trust / practice, Colleges and supervisor	• Ability to ring-fence supervision time • Culture of passing on knowledge	• Good inductions • Effective processes that drive efficiency	• Collaborative approach to supervision • Ability to seek help from peers
Unsupported	• Lack of integrity in selection and assessment process leading to trainees who do not meet the required skill level • Unbalanced power dynamic between trainer and trainees	• Training is deprioritised • Supervisors are not encouraged to pursue their own learning and development	• Difficulties balancing competing priorities due to inefficiencies	• Lack of capacity to meet all supervision requirements

Building trainees' confidence and autonomy

Trainees fulfil a vital role in service delivery while they train, and the future of the workforce depends on them. Within the ranks of current trainees are future clinical leaders, trainers, and providers of clinical expertise. Given this, it is critically important that they are well prepared for practice and able to practise safely, autonomously, and confidently. Our conversations with senior stakeholders, and the commissioned research[12] which interviewed a range of trainers, revealed some concerns within the sector about how the trainee workforce is being supported and whether their training experiences are preparing them fully and robustly for practice. As trainees are critical for service delivery and make up a large part of the future workforce, the capacity of the system to deliver care is negatively affected if trainees are not fully prepared for their future roles.

There was a general sense among trainers and senior stakeholders that dedicated time for training is becoming less valued, with a drive to prioritise clinical time to meet patient needs (or, in some cases, to increase revenue for GP practices), thereby reducing the time set aside for learning and development.

Trainers described that, due to the pandemic response, there were reduced opportunities for trainees to gain valuable and varied clinical experience, and that currently there are multiple challenges around protecting time for training as a result of waiting lists and the patient backlog. Some new approaches introduced during the pandemic, such as remote training and consultation, can be viewed as constructive developments.

For example, over 70% of trainees in the 2022 national training surveys (NTS)[11] responded positively when asked if virtual learning environments were being used effectively to support their training, highlighting an area which can be built upon when considering the experiences of trainees.

However, pressures on workloads are forcing doctors to focus on short-term positive results for patients in the use of trainees rather than the long-term focus on ensuring that trainees have the right experiences and space for development, ensuring patient outcomes in the future. Overall, these challenges are impacting the quality of trainees' learning experiences.

In particular, the pandemic and the subsequent drive to prioritise tackling waiting lists has resulted in fewer opportunities to fulfil training requirements, develop relevant experience, and learn necessary skills. This has impacted trainees' learning so much that many feel increasingly under-confident in their abilities. Trainees in particular specialties have told us they do not think they are on course to gain enough experience in the operative or practical procedures needed for their stage of training. For example, in the 2022 NTS,[11] four out of ten (39%) trainees on obstetrics and gynaecology programmes and three out of ten (31%) trainees in surgery and ophthalmology programmes said this was the case. A lack of opportunity to learn skills equals a lack of opportunity to gain confidence using those skills.

Over a third of trainees (34%) disagreed that educational or training opportunities were rarely lost due to gaps in the rota and 30% of trainees said these gaps are not dealt with appropriately to ensure their education and training aren't adversely affected.

The response from trainers was similar. 35% of trainers in secondary care disagreed that gaps in the rota are always dealt with appropriately to ensure their trainees' education and training are not adversely affected. This rose to 45% of trainers in obstetrics and gynaecology and 44% of those in medicine. Considering the best approach to rotas is not only necessary in order to improve workplace experiences and staff's sense of value, but also vitally important to ensuring that both trainers and trainees have adequate protected time for training activities.

Therefore, more time must be set aside for trainees to develop their competencies and their confidence. Trainees must have the time and space to reflect on their learning, take and think on feedback from their supervisors, develop their autonomy, and be able to prioritise time to put into practice their learnt skills, rather than constantly being relied on to plug general service provision gaps. Due to the levels of service pressures seen in 2023, this goal may not be met quickly in the short term but should be worked towards over the medium and long term to ensure capacity within the UK health systems.

> "What have we seen that works? Being much more directed in terms of [what] the needs of the individual trainee are and moving [the trainee] around to [meet] those needs… that takes communication between the trainees and the trainers and the rota coordinators. Sometimes you need to put training first to get better service, but the current model says we're going to do the service and blow the training."
>
> *Senior stakeholder interview*

Box 5: Training approach suggestions for trainers and supervisors in how to support trainees

We commissioned IFF Research to conduct a series of in-depth interviews with trainers from across the UK. A summary of their advice for their peers who train or supervise trainee doctors is as follows:

- Take a structured approach to meeting the learning outcomes of trainees: plan, deliver, review.
- Plan how trainee learning outcomes will be met during their time in placement.
- Listen to and engage with trainees—be attentive to their overall learning and development needs rather than 'only' meeting core competency requirements.
- Try different methods of training to find what suits the supervisor and their trainees.
- Be aware of potential teaching opportunities—have a training and development mindset at all times.
- Be friendly but firm with trainees—maintain a respectful distance while being present and supportive.

Good support, teamwork, and feedback help build trainee confidence

Some trainees have more positive experiences of support and teamwork

In the Barometer survey 2022, trainees reported slightly more positive experiences of working with their colleagues. For example, 86% said they felt supported by their immediate colleagues (compared with the average of 82%), while results for trainees on other support and teamworking metrics were not significantly different than the average.

However, the results of the 2022 NTS [11] reveal more insight into the experiences of trainees. The NTS results [11] show positive experiences for trainees in the UK, but it is collected via a different mechanism to the Barometer survey, so care should be taken when comparing the two different sources.

As in previous NTSs, trainees continued to report positive experiences of working with colleagues. In the 2022 NTS, 90% of all trainees agreed that their organisation encourages a culture of teamwork between multidisciplinary healthcare professionals. Of those who disagreed, over a third (34%) said they had a concern about patient safety, which underlines the importance of teamwork.

Some specialties recorded a larger proportion of positive responses—most notably general practice, psychiatry (both 93%), and public health (100%). While over three-quarters (77%) [11] of all trainees agreed that their organisation encourages a culture of teamwork between clinical departments, once again general practice (GP) trainees (90%) were particularly positive.

Supportive workplaces and effective feedback are crucial for trainees

We know that inclusive and supportive working environments are good for patients and for doctors' wellbeing. Indeed, in the NTS 2022,[11] of those doctors who agreed that their department, unit, or practice provides a supportive environment for everyone regardless of background, beliefs or identity, a smaller proportion (16%) were measured to be at high risk of burnout using the Copenhagen Burnout Inventory,[29] compared to over half (53%) of those who disagreed.

The NTS 2022 also showed that an overwhelming majority of GP trainees (93%) said that their practice provides a supportive environment everyone regardless of background, beliefs, or identity. Eight out of ten (82%) GP trainees said that there is a culture of listening to doctors in training about working practices. 90% said that staff, including doctors in training, always treat each other with respect and three-fifths (59%) said that they had not experienced any rudeness or incivility among doctors or healthcare staff.

Receiving regular and effective feedback also enhanced the overall training experience for GP trainees. A much larger proportion of GP trainees (82%) said they received either daily or weekly informal feedback from senior colleagues about their performance, compared with 58% of all trainees. A larger proportion of GP trainees also reported that they had received useful feedback in a formal meeting with their educational supervisor about their progress (75% compared with 58% of all trainees).

Overall, 92% of trainees rated the quality of experience in their GP post positively and over half (52%)[11] rated it as very good. These findings

emphasise the importance of effective feedback and inclusive, supportive environments. They are not only key to the quality of medical education and practice, but they are also vital to help develop and retain healthcare professionals in the UK.

Enhance development opportunities for all doctors

With the current high intensity of workloads, many doctors feel under pressure and unable to commit working time to compulsory training and development programmes, meaning that many work in their own time to meet this requirement of their employment.

For more informal training and development, bite-size learning opportunities should be incorporated into routine tasks, such as debriefs.

As well as supporting team development, shadowing opportunities and the provision of mentoring schemes will also help support doctors.

Royal Colleges should look at ways that they can encourage more of their members to support the development of future specialists and other health professions.

> “It would be good to have formal support systems in place in terms of mentorship or a mentoring programme which would be useful, but we are struggling to find manpower.”
>
> *Trainee, Barometer survey follow-up interviews 2022*

Strengthen support for primary care

As described in chapter 1, GPs report the highest work intensity of all doctors, and there are widely reported difficulties recruiting to GP posts. Any solution adequate to addressing the full scale of this challenge would almost certainly require some increase in the number of GPs. To do this, we must ensure that primary care is seen as a rewarding and fulfilling career choice and encourage the right trainee doctors to choose it as a specialty.

The UK health systems should work to encourage medical students and trainee doctors to choose the GP pathway and retain the GPs we already have by ensuring that general practice is a rewarding and supported area of medicine in which to work.

In primary care, clinical leads acknowledged that greater teamwork, and a flatter hierarchy which recognises multidisciplinary skills, allowed general practice to keep functioning through the coronavirus pandemic.[30]

Our data show that GPs have more positive experiences of support than other parts of the profession. Many GPs have working environments and experiences that allow them to achieve the ABC (autonomy, belonging, competence) that is so important to wellbeing and patient care.[5] There may be useful insights for others to take away from examining how GPs build and maintain strong teams.

However, this support is not protecting GPs against high levels of work intensity and GPs are still highly vulnerable to moral injury due to work intensities. High volumes of patients result in GPs not being able to give enough time to all patients, while long waiting lists mean GPs cannot refer a patient to be seen quickly in secondary care. GPs struggled the most to provide patients with sufficient care, with 62% finding this difficult at least once a week.

The introduction of more multidisciplinary roles has provided more support and expertise within multiprofessional teams by enhancing capacity to provide care for patients before, during, and after their treatments.

UK health systems need to develop more roles which will help support GPs. Newer types of team members have a positive effect on problematic work intensity in primary care. Newer roles 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[31] and so having better support for this aspect of work is key.

Chapter conclusion

We recognise that solving the issues outlined in this report is not an easy task. We know that the drivers of the increasingly pressurised and negative working environments experienced by doctors are varied and complex.

However, change is essential.

It is imperative that employers and the UK health systems at large consider the new evidence presented here as they continue their complex discussions on how to manage service delivery.

Changes are necessary at all levels: locally by team leaders and managers in individual employers; within trusts and systems; and at the national level, by policymakers, thought leaders, and organisations.

In Northern Ireland, Integrated Care Systems are being developed, onto which some responsibility will fall, while Welsh health boards together with the Welsh government and the NHS Executive in Wales should work together to drive forward change. In Scotland, integrated joint boards, and in England, Integrated Care Boards (ICBs), must push forward with developing solutions.

Integrated Care Systems (ICSs) and ICBs in England have more powers to ensure that trusts take the right steps to improve the workplace experiences of doctors. Many of these changes will also have the advantage of improving the workplace experiences of healthcare workers as a whole: there will be a multiplier effect across different professions and workers. In England, these changes might start in the hands of ICSs and ICBs.

We look to our partners in the sector who have also been investing time and careful thought into

how best to approach the challenges we all face. For example, the NHS Long Term Plan lays out a series of case studies[32] that show how different areas of NHS England have been making changes to develop their support for their patients. Another example is from the Royal College of Physicians' 2022 paper[33] which summarises short-term and medium-term solutions that can be taken into account to help address the workforce challenges facing the NHS. We also direct the reader to the ABC outlined in *Caring for doctors, caring for patients*.[5]

With increasing numbers of new professionals entering the medical workforce, the current unprecedented pressure on trainers will only get worse. It's clear that something needs to change. Over the next five years, we will work with others to improve recognition of, and support for, a wider range of educators.

We will establish a more inclusive definition of an educator, drawing from a multiprofessional workforce and acknowledging the value of recognising individuals and the role of the supervisor. We are exploring the development of new standards for those who employ educators, reinforced by our quality assurance processes, setting expectations around protected time, learning and development, and representation in local governance structures.

With the aim of removing the barriers to being an effective educator, we want to help make the role more attractive and fulfilling for healthcare professionals now and in the future.

We all have a role to play in improving the working conditions of doctors and other healthcare professionals, and therefore in patient safety. We, the UK health sector as a whole, need to make changes now, for the short term, to give us the space and time to tackle to core issues in the medium and long term.

Conclusion

Our research and analysis about the challenges facing the UK's medical profession paint a stark picture. What we have learnt from doctors and senior stakeholders across the UK health sectors should bolster resolve to tackle both the immediate and longer-term challenges the profession and health system face. We have outlined the challenges and suggested approaches to begin to address them in this report.

We are facing the highest levels of doctor burnout and dissatisfaction we have ever recorded since starting the Barometer survey in 2019. 15% of the workforce have indicated that they are taking hard steps to leave UK practice.

These are all consequences of the current working conditions that doctors are facing, including mounting workloads, increased work intensities, and backlogs from the pandemic.

As doctors consider leaving the UK workforce, or reducing their hours, these pressures will be compounded, fuelling the vicious cycle of increasing workloads affecting good, safe patient care. Chapter 1 maps out the scale and nature of some of the challenges inherent in this vicious cycle.

However, the evidence presented in this report also suggests ways in which employers, policy makers, and regulators can make changes that might help slow the vicious cycle that we have described.

Understanding the positive effect that feeling supported, valued, and having a sense of belonging can have on satisfaction, retention, and patient safety, highlights specific areas of workplace conditions that can be targeted for improvement. The vicious cycle can be replaced by building and reinforcing a virtuous cycle of increased support, better workplace conditions, increased retention, and improved patient safety. Some of the specific elements of such a virtuous cycle are covered in chapter 2.

In chapter 2, we also identify groups of doctors who need specific support, and this can help employers prioritise and target interventions.

Short-term solutions can be started on immediately—bolstering support and leadership, and improving working conditions and environments—which we discuss in detail in chapter 2. At the same time, it is vital that all parties in the UK health systems start planning and developing longer-term solutions, of which many can be started now. These solutions will include making training in the UK more sustainable. Training roles will need to become more attractive through protecting time to perform the role, and by giving trainees the space and time to develop their confidence and competence. We cover the ways that longer-term issues could be addressed in chapter 3.

We will continue to track and monitor the experiences of doctors in the UK health systems, as we all continue to work together towards developing and providing constructive solutions to the challenges the health systems are facing.

As part of this, we are working to eliminate disproportionality in doctors being referred to us, and to secure fairer training pathways. Our outreach teams will continue to work with employers and doctors to develop and encourage professional working behaviours and good teamworking, while *Good medical practice*[34] undergoes a thorough review to ensure that it is clear about the behaviours expected of all medical professionals in working with colleagues and in promoting fairness and inclusion.

We will continue to work to better understand and accurately report on the state of medical education and practice in the UK by seeking ongoing input and dialogue from and with doctors, patients, and our partners.

List of acronyms

ABC	Autonomy, belonging, and competence
BME	Black and minority ethnic
CEGPR	Certificate of Eligibility for General Practice Registration
CESR	Certificate of Eligibility for Specialist Registration
EEA	European Economic Area
GIRFT	Getting it Right First Time
GMC	General Medical Council
GP	General practitioner
ICB	Integrated Care Board
ICS	Integrated Care System
IMG	International medical graduate
LE	Locally employed
NTS	National training surveys
PMQ	Primary medical qualification
RCP	Royal College of Physicians
SAS	Specialty and associate specialist

A note on research and data

Much of the analyses and data in this report have been drawn from primary research undertaken for *The state of medical education and practice in the UK: Workplace experiences 2023* report, including the Barometer survey 2022, and interviews with doctors, trainers, and senior stakeholders.

Commissioned primary research

The Barometer survey 2022 was an independently delivered research project conducted by IFF Research. It explored the experiences of doctors in the UK, and was accompanied by qualitative interviews with survey respondents and trainers.

We conducted additional research to explore the views and perceptions of senior stakeholders from across the four UK countries about doctors' workplace experiences and how workplace pressures may be addressed now and in the near future. We commissioned further research to understand the barriers to and enablers of supportive teams in UK health systems.

The research methods of these projects are outlined in this section of the report.

The Barometer survey 2022

The Barometer survey 2022 research was carried out by IFF Research. The Barometer survey was first conducted in 2019 and was designed to provide a baseline for annual tracking of doctors' experiences in the workplace, the adaptations they make to cope with pressure, and their career intentions.

In the Barometer survey 2022, the survey sample was sourced directly from the medical register for the first time. From 2019 to 2021, doctors were recruited through a number of sources including a commercial sample provider, a panel of healthcare professionals, and a 'snowballing' exercise. Using the medical register helped to ensure a more representative sample of doctors completed the Barometer survey 2022, with larger base sizes for doctors in training and SAS / LE doctors. While this change should be taken into consideration when looking at historical trends, checks to compare the 2021 and 2022 survey samples showed only small differences in profile which do not give cause for concern in terms of comparing findings over time.

Changes to the content of the Barometer survey 2022 included:

- the removal of questions on experiences of practising during the the coronavirus (COVID) pandemic
- the addition of questions on the doctor-patient relationship, raising concerns about patient safety and workplace culture, and access to development and learning opportunities
- the addition of new response options on what steps have been taken by doctors who indicated in the survey that they are likely to leave the UK profession, including options which are considered 'hard steps' towards leaving
- a new question on the main contracted role of those who are neither on the specialist register nor in training has allowed us to report on the experiences of SAS and LE doctors separately for the first time.

The Barometer survey 2022 was also conducted at a different time of the year compared to previous Barometer surveys. From 2019 to 2021, the survey ran in spring / summer, while in 2022 it took place in early autumn.

Barometer sample and respondents

A random sample of 50,000 doctors was sourced directly from the UK medical register. The sample was reflective of the overall population of the UK medical workforce with oversampling of doctors in Northern Ireland and those of mixed ethnicity.

Following a month long opt-out period, the survey was distributed to 49,451 doctors.

Over September and October 2022, a total of 4,269 doctors currently working in the UK completed the online survey. To ensure the findings were representative of the licensed doctor population, the results were weighted against GMC population data on the basis of age, registration status, ethnicity, and place in which their primary medical qualification was gained.

4,269 doctors completing the survey provides high levels of statistical reliability. For every question, we can be at least 95% confident that the 'true' result (if a census had been conducted) lies within +/- 1.5 percentage points of the survey finding. While the margin of error is larger within sub-groups, such as registration status and demographics, the sample size still allows for robust analysis and statistical tests (using a 95% confidence interval) have generally been used where differences between groups are reported in the reference data provided to the GMC by IFF Research.

The tables below give a breakdown of the 4,269 respondents (i.e., actual unweighted numbers) by various characteristics. The totals for most tables are less than the overall number of respondents (4,269) because not all respondents provided information for the relevant question (including answering 'don't know' or 'prefer not to say'). The total for registration type is greater than the overall number of respondents (4,305 compared with 4,269) because some doctors are on more than one register.

Registration type

GP	Specialist	Training	SAS / Non-training	Other
995	1,270	1,055	869	116

Primary medical qualification

UK	EEA	Outside UK / EEA
2,714	348	1,133

Nation

England	Northern Ireland	Scotland	Wales
3,423	132	352	181

Ethnicity

White	BME (all)	Asian / Asian British	Black / Black British	Mixed or Multiple ethnic groups	Other ethnic group
2,428	1,524	953	223	144	204

Gender

Male	Female
2,065	2,008

Disability

Disabled	Non-disabled
400	3,703

Age

Under 30 years old	30–34	35–39	40–44	45–49	50–59	60 years and over
434	677	528	436	510	883	394

Indicators of burnout in the Barometer survey 2022

Burnout is a state of emotional, mental, and often physical exhaustion caused by prolonged or repeated work-related stress. Feeling depressed and lacking motivation are characteristics of burnout. The Barometer survey 2022 included seven questions from the Copenhagen Burnout Inventory,[29] an internationally recognised and validated tool for assessing the physical and psychological fatigue associated with burnout.

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

1 Is your work emotionally exhausting?

2 Do you feel burnt out because of your work?

3 Does your work frustrate you?

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

4 Do you feel worn out at the end of the day?

5 Are you exhausted in the morning at the thought of another day at work?

6 Do you feel that every working hour is tiring for you?

7 Do you have enough energy for family and friends during leisure time?

Differing risk levels for burnout were calculated based on the number of indicators to which participants gave a 'negative' score, where a negative score was:

- for questions 1-6, answering a question with experienced to a 'high' or 'very high' degree, or experienced 'often' or 'always'
- for question 7 (energy for family and friends), answering experienced 'seldom' or 'never'.

Participants were grouped into four categories based on their responses, though the categories are indicative only given the subjective nature of burnout and the burnout questions.

- **Very low burnout risk**—gave a negative response on 0–1 of the 7 indicators.
- **Low burnout risk**—gave a negative response on 2–3 of the 7 indicators.
- **Moderate burnout risk**—gave a negative response on 4–5 of the 7 indicators.
- **High burnout risk**—gave a negative response on 6–7 of the 7 indicators.

Categorisation of doctors as SAS or LE

As in previous years' surveys, the Barometer survey 2022 asked doctors about their registration status, and those that said they were 'licensed and in a non-training post' were categorised as SAS and LE doctors.

The Barometer survey 2022 asked an additional follow-up question to the SAS and LE doctor group about their main contracted role or post. Based on their response to this question, these doctors were then categorised as either:

- SAS doctors—if their main role or post was specialty doctor, associate specialist, or staff grade doctor.
- LE doctors—if their main role or post was clinical fellow, trust doctor, locum appointment for service (LAS), trust registrar, teaching fellow, senior clinical medical officer, clinical medical officer, hospital practitioner, or 'other'.

This has allowed us to report on the experiences of SAS and LE doctors separately for the first time. As the new question asking these doctors about their main contracted role or post was only introduced in the 2022 survey, comparison with previous years is not yet possible.

The initial findings from the SAS and LE data are shared within this report, with the intention to publish a fuller analysis of the working experiences of SAS and LE doctors later in 2023.

Steps towards leaving the UK profession

Doctors who indicated in the Barometer survey 2022 that they are likely to leave the UK profession (whether due to retirement, moving to practise abroad, or for another reason), were subsequently asked what steps they had

taken towards leaving. Several new response options were included in the 2022 survey, some of which are considered 'hard steps' towards leaving. The response options categorised as 'hard steps' within reporting are listed below, with new options introduced in the Barometer survey 2022 indicated with an asterisk.

- Contacted a recruiter
- Applied for or attended training for a new role
- Applied for other role(s) outside medicine
- Applied for a clinical job abroad*
- Applied for retirement / pension*

Open responses

The Barometer included questions which offered participants the opportunity to make a free text response.

For example:

A2. Why do you say that you are satisfied / dissatisfied day-to-day in your work as a doctor?		
WRITE IN		
Don't know	1	
Prefer not to say	2	

The free-text responses by all participants have been analysed and coded for key themes. Counting the occurrence of these themes forms the basis for the quantification presented in this report. As responses to these questions are open, they may not cover the same themes that would have been included in a closed-response question.

Barometer accompanying qualitative interviews

We commissioned IFF Research to conduct in-depth interviews with 20 doctors alongside the main Barometer survey. A range of doctors took part, including those with more and less positive workplace experiences, and a mix by demographics, registration type, and geography to ensure broad coverage.

These interviews aimed to build on the quantitative survey results and enhance our understanding of the emerging themes. In particular, the interviews focused on the impact of high workloads on doctors' wellbeing, including support and practices which can help to prevent or mitigate this.

Trainer interviews

We also commissioned IFF research to conduct ten in-depth interviews with trainers to understand more about their role and how they balance it with their other responsibilities as a doctor.

Doctors were invited to take part if they had indicated within the Barometer survey 2022 that they had acted as a named clinical or educational trainer for postgraduate trainees during the previous year. The ten interviews were conducted in March 2023 and included a mix of those working in primary and secondary care.

The interviews explored the responsibilities of trainers, the positive and challenging aspects of their role, and the support available to them.

Senior stakeholder interviews

As part of the research underpinning this report, we conducted a series of 30 interviews with senior stakeholders from across the four UK countries between January and April 2023. The interviews were conducted by GMC staff and a contracted health writer. They explored senior stakeholders' views and perceptions about doctors' workplace experiences and how workplace pressures may be addressed now and in the near future.

We asked the senior stakeholders what they thought were the main challenges to providing patient care, and what factors were contributing to these challenges; if there were any solutions or examples of recent approaches that could address these challenges in both the short and long-term; and what their main priorities would be in regard to future planning.

Although the conversations were guided by the interviewer, there was space and time for organic thought to develop. Topics explored were largely guided by what interviewees raised importance on. Therefore, we gained a rich insight into the views of senior stakeholders in various positions across the UK healthcare sector.

Because of the unique position of each stakeholder, they each brought a different perspective and broad expertise which we have drawn on to give examples of what they saw as workable and helpful solutions.

Understanding teamworking interviews

We have commissioned Hull York Medical School to conduct research into teamworking to understand the barriers to and enablers of supportive teams in UK health systems. The research seeks to explore how doctors work together and across wider teams; what factors contribute to effective team working and the elements that make it more challenging; and develop understandings to improve doctors' teamworking.

The research consists of a literature review and scoping interviews during the first phase, followed by a second phase of interviews to explore a range of teamworking experiences.

This research is ongoing and more detailed findings will be published at a later date.

GMC surveys

The GMC has undertaken research to help direct priorities and to keep up to date with the experiences of doctors and doctors in training. As in previous years, this research is used to inform *The state of medical education and practice in the UK* report series.

The national training surveys

Every year, we survey doctors in training to get their views on their training and the environments where they work. The survey also asks trainers to report their experience from their perspective as a clinical and / or educational supervisor. These findings have been included in previous editions of *The state of medical education and practice in the UK*. The survey questions are focused on our standards for medical education and training—Promoting excellence—which are organised around
five themes:

- Learning environment and culture
- Educational governance and leadership
- Supporting learners
- Supporting educators
- Developing and implementing curricula and assessments

This 2023 edition of *The state of medical education and practice in the UK: Workplace experiences* report uses data from the *national training survey 2022*, which ran from 22 March to 17 May 2022.

Over 67,000 doctors in training and trainers completed the 2022 survey. 76% of all trainees in the UK responded (over 48,000), and 34% of all trainers (over 18,000).

The survey results are published in an online reporting tool with filters to explore the data by region or country, specialty, programme, or trust / board—all benchmarked against the UK average.

Our data

Analysis of data on the medical register (known as the List of Registered Medical Practitioners) and data on fitness to practise activity will be published as part of the upcoming *The state of medical education and practice in the UK: Workforce report* later in 2023.

Previous data

Previous editions of the *The state of medical education and practice in the UK* Barometer survey are available at https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/the-state-of-medical-education-and-practice-in-the-uk/archived-the-state-of-medical-education-and-practice-in-the-uk-reports

The data tables for this year's *The state of medical education and practice in the UK* Barometer survey 2022 is available at https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/the-state-of-medical-education-and-practice-in-the-uk

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