

General
Medical
Council

The state of medical education and practice in the UK

2018



Working with doctors Working for patients

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and practice in the UK

2018

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Foreword

Medicine can be a fantastic career. It continues to attract talented applicants and many doctors remain highly motivated and satisfied. Most are able to provide good and often superb levels of care to patients despite the pressures that our health services are under, across the four countries of the UK.

And those pressures are considerable. No one can be in any doubt that steadily rising numbers of patients with more complex health conditions, coupled with the evident gaps in the medical workforce, are testing the ability of doctors to deliver the level of care that they want for patients – the care that we all wish to see for our loved ones.

The professionalism, commitment, and determination of the UK's medical workforce in providing that care is second to none. But it is clear that the costs for some doctors – to their own well-being and work-life balance – are significant, and not sustainable.

Research commissioned for this year's edition of *The state of medical education and practice in the UK* paints a clear picture of the effects that those pressures are having on the health system, and on those who work on the frontline. Our report also shines a light on the steps that some doctors feel they need to take to cope with growing demands, which in turn can lead to increasing pressure in other parts of the system.

Alongside this, our data indicates that many doctors are considering career changes to step away from the demands placed on them in primary and secondary care. Around a third of 2,600 doctors we surveyed said that they are considering reducing their hours in the next three years. A fifth plan to go part time and a further fifth intend to leave the UK to work abroad. Of

particular concern is that 21 per cent of 45-54 year old doctors, and two-thirds of 55-64 year olds, intend to take early retirement by 2021. These doctors are among the most experienced and have much to offer to both patients, and the next generation of medics.

Our findings come against a backdrop of uncertainty with a possible Brexit 'no deal' and uncertainty around how EEA qualified doctors will be able to join the UK medical register after we leave the European Union. That group makes up nine per cent of licensed doctors in the UK, and they are vital to our health services and patient care.

As the UK medical regulator, we are doing everything possible to prepare for the various scenarios possible in March 2019. The status of EEA qualified doctors already registered in the UK is guaranteed. But it is crucial that in whatever scenario we face after March 2019, we do not turn off the tap in enabling EEA doctors to come and work in the UK in future.

While there are different challenges in England, Northern Ireland, Scotland and Wales, it is clear that the NHS as a whole is at a critical juncture. What is badly needed now is long-term UK-wide planning to ensure that we have a workforce with the right skills, in the right places, and with the right support.

There already exists, across each of the four countries, the data and intelligence that identifies where support is needed in the workforce, now and in the future. That insight is held by a range of organisations responsible for training and employing doctors, but to date, it has never been brought together.

We can help with the solutions to this potential future workforce crisis. We have already submitted proposals to the English government's consultation on the NHS England long-term plan which set out how our data, insights and revised processes can help to build a sustainable medical workforce. We are exploring similar contributions in the other countries of the UK. The GMC's responsibilities in approving post-graduate education can make sure that the right skills in leadership, patient safety and preventative medicine are prioritised. We will address urgent staffing needs through support for doctors from overseas and assuring the safe use of remote technology. Our data can contribute to a joined-up picture of the skills and staff available to the UK's health service, and where more is needed.

Now is the time to act. That means being prepared to change long-established paradigms of what it means to educate and train doctors, and what it means to have a sustained career in the profession. Failure to turn wringing hands into helping hands risks undermining 70 years of work to create a world leading healthcare system.



Professor Sir Terence Stephenson
Chair



Charlie Massey
Chief Executive & Registrar

An information resource

This year we are again publishing online a large set of reference tables to accompany this report. These tables comprehensively cover GMC data relating to the register, medical education, and fitness to practise. They summarise the source data used to create many parts of this year's report. They are available at www.gmc-uk.org/somep2018.

We are publishing this resource in line with our wish to be as transparent as possible about the data we hold. We hope that it will be useful for a wide range of purposes and to many different people including general policymakers, patient groups, doctors interested in particular medical policy issues, educationalists and researchers. We would welcome feedback on the usefulness and use made of these online data tables at gmc@gmc-uk.org. The tables are grouped into five separate files, each including its own detailed table of contents and details of where the data is sourced and how it is summarised, to make finding specific data easier.

Each set of tables includes breakdowns showing the key views of data used in our analyses including showing it by age group, gender, ethnicity, place of qualification, region and country of the UK, register type, and specialty of the doctors.

1 Who is on the register of medical practitioners?

These are based on data from the List of Registered Medical Practitioners (LRMP), showing data for each of the years from 2012 to 2018.

2 How does the make-up of the register differ by country and region?

Also based on data from the LRMP which has been combined with employment and other data to locate doctors into particular countries and regions on the basis of where they were working.

3 Who are doctors in training and what are their training programmes?

These tables are based on LRMP data combined with national training surveys census records.

4 Who are medical students?

These tables are based upon the Medical School Annual Return (MSAR) provided to the GMC.

5 Fitness to practise

These tables show our data about complaints made to the GMC about doctors. They are based upon registration data combined with management information arising from the GMC's fitness to practise work.

GMC Data Explorer

Accessing our data through GMC Data Explorer

GMC Data Explorer is an interactive data sharing tool which allows external users to access our registration, revalidation, fitness to practise and education data directly, quickly and easily.

It provides access to data on:

- the makeup of the medical registers including ethnicity, specialty over time and doctor country location
- revalidation activity
- education
- doctors' training and fitness to practise, including:
 - the number of UK graduate doctors, which can be broken down by the body that awarded their primary medical qualification or by the doctor's register type e.g. specialist register, GP register
 - the current location of registered doctors, where they graduated from and their deanery/local education providers
 - the number of doctors with open cases and active sanctions at each designated body
 - what allegations are made about doctors over time.

Users can quickly and reliably find information they need, without needing to complete request forms and wait for a response.

Why have we developed this tool?

We are committed to sharing our data with others to improve patient care and aid workforce planning.

We already make information and insights widely available through the medical register and publications such as reference tables detailed above. GMC Data Explorer goes one step further to make our key data easily accessible on a self-service and interactive basis. The data is updated daily so it will always be up to date.

In GMC Data Explorer, adjustments have been made to protect doctors' personal information by suppressing any identifiable data that is not in the public domain via the LRMP.

How can users access GMC Data Explorer?

GMC Data Explorer can be accessed through:
<https://data.gmc-uk.org/gmcdata/home/#/>

Executive summary

In our eighth annual *The state of medical education and practice in the UK* report we set out the challenges in healthcare that continued throughout 2018.

We present important new primary data and analysis on the mindset and coping mechanisms of a medical profession working within a highly-pressured system. This will help our understanding of what is needed to support and retain the current workforce and supply of doctors for the future. The UK is running out of time to prevent a significant decline in workforce numbers, which risks patient safety.

A workforce strategy to make sure the progress of the past 70 years does not stall (chapter 1)

The profession is at a critical juncture

Demand for care is increasing in volume and complexity. Combined with severe shortages of staff in some areas of the UK and in some parts of health and care provision, this creates huge pressures on the medical workforce.

Doctors are still delivering good care in very trying circumstances. Many are still positive and managing, but the stress is causing many doctors to consider future options that would reduce or end their clinical practice.

The health system now faces a decline in what can be offered and how it is offered by doctors who are prioritising and compromising their work in an effort to maintain standards of care for their patients. It shows that doctors are reaching the limit of what can be done.

Our new evidence reveals the effect of these pressures and the steps doctors are taking to cope. We are concerned that some of these strategies are risky or unsustainable.

We are saying loud and clear: the medical profession is at the brink of a breaking point in trying to maintain standards and deliver good patient care.

New evidence shows how doctors on the frontline are experiencing current pressures

We have commissioned two pieces of independent research. The first, *Adapting, coping, compromising*,* looks at how doctors are having to adapt their practice, the coping mechanisms they are adopting, and the compromises they are forced to make – and what this means for patients as well as doctors.¹

* For further details of *Adapting, coping, compromising* and *What it means to be a doctor* see research and data note on page 139

Our second piece of research, *What it means to be a doctor*, attempts to understand the essence of being a doctor and how they experience their role in 2018.²

Our intelligence from frontline engagement with doctors has already been picking up the multiple signs of a profession under pressure. Doctors feel less supported and more vulnerable than ever, working in a system under such intense pressure. This is not sustainable and changes must be made.

What we are concerned about

Burnout and poor mental health

We are worried about the effect of pressures on doctors who suffer stress, ill health and particularly mental health issues exacerbated by the pressures they encounter. We are working on several aspects of this including commissioning an independent review of doctors' wellbeing.

Urgent steps are required to retain doctors

Our commissioned independent survey of 2,602 doctors shows that almost two thirds are working more hours than in the past, but often with less time to provide continuity of care for patients.²

We are at high risk of doctors leaving clinical practice in unprecedented numbers. Within the next three years, many are considering reducing their hours (around a third), going part time (a fifth) and/or planning to leave UK practice and work abroad (a fifth).²

Encouraging a new supply of doctors

There is a need to increase the supply of new doctors to cover these shortages. We welcome the addition of five new medical schools in England³ and additional medical school places in Scotland⁴ and Wales.⁵ Given the urgent need to increase supply, we are planning a rigorous programme of visits and scrutiny to help these new schools meet the same existing high standards as current ones.

Implication of Brexit on the workforce

Continued uncertainty over Brexit adds to the risk of us and others being unable to plan in a way that enables a sufficient future supply of doctors. It is essential that exiting the EU does not either deliberately or inadvertently deter the approximately 2,000 EEA qualified doctors who come here each year and contribute to the NHS.

Call to action

The pressures continue to mount and doctors' intentions to leave or reduce clinical practice threaten further decline in the supply of doctors.

The severe pressures are already affecting services, training environments and the ability of doctors to do their jobs. Significant numbers of doctors are reporting burnout in the face of these pressures. Many have already reduced their hours to cope with the stress of these pressures.⁶

We are adopting approaches to support doctors under pressure and to make the processes involved in joining the register as streamlined as possible to encourage the supply of new doctors. But we can't work alone – there are implications for everyone involved in the UK health system.

What is needed now?

- The UK health system needs long-term planning to make sure that the healthcare sector has a workforce with the right skills in the right places. Without the right support, doctors will come under even greater pressure and the situation may deteriorate.
- The healthcare sector needs action. Not just more money, but a commitment to new ways of thinking about how workforce supply can be achieved. And how that workforce can be enabled to achieve the professional standards and consequent quality of care that should be expected 70 years on from the founding of the NHS.
- There are particular opportunities to act now. We have particular opportunities to achieve this with new investment in the NHS in England, new workforce strategies in Scotland and England, and ongoing workforce planning across the UK. Strategies in all four countries of the UK need to set out a clear plan for making the UK a great place to work for doctors and a world-leading healthcare environment that attracts, develops and retains the best doctors and provides fantastic patient care. As well as setting a compelling vision for the next ten years, these strategies must also address clear and present dangers, such as the potential cliff edge of a no-deal Brexit and some of the workplace culture issues.

Supply – the medical workforce (chapter 2)

In this chapter we look at the make-up of the 242,433 licensed doctors and how trends have differed across primary and specialist care and between the countries of the UK.

We examine the pool of doctors available to the workforce – the net effect of those joining and those leaving. We highlight the specialisms and localities where there is the risk that the UK may not have the supply of doctors needed to meet growing demand.

There are positive signs that the shape of the workforce is improving. But much still needs to be done to make sure there are enough practising doctors to meet the UK's needs.

Doctors joining the profession

Licensed doctors

We are seeing an increasing pool of doctors potentially available for the workforce, with the number of licensed doctors on the medical register and students studying medicine rising. And we see signs that gaps in the workforce for GPs are being improved through the increase in doctors training in general practice.

The number of licensed doctors on the medical register is now increasing. As the effect of introducing revalidation has stabilised, we are seeing a rise in doctor numbers larger than the growth in the UK population, with a 2.0% growth in licensed doctors in 2016–17, and 2.4% in 2017–18.

Number of licensed EEA graduate doctors remains steady

From 2014–16, the number of EEA licensed doctors dropped by 9%. This was probably due to the introduction in June 2014 of a requirement to show proof of their English language capability before they gain a licence to practise. Since then, the number of licensed EEA doctors has increased slightly each year, rising by 0.3% in 2016–17, and by 0.8% in 2017–18.

We have no evidence of an overall decrease in EEA doctors since the outcome of the June 2016 referendum to leave the European Union.

Number of GPs continues to grow, but at a slower rate than specialists

The GP Register has grown by 4% in the period 2012–18, compared with the Specialist Register, which has grown by 11%. This is significant given the shortages of GPs generally and the fact that so many GPs intend to retire or go part time.

The growth in GPs is primarily driven by numbers in England, where the number of GPs by grew 6.8%. Northern Ireland and Scotland showed very small increases, while Wales showed a decrease.

Welcome increase in emergency medicine, but decline in psychiatry worrying

There is a considerable difference in growth in the pool of available doctors between specialties. There has been a very strong growth of a third in emergency medicine doctors since 2012, but reports suggest this has not been sufficient to alleviate pressures in emergency departments.^{7, 8, 9}

As last year, our most up-to-date figures re-emphasise that the number of psychiatry specialists on the medical register is decreasing.

Occupational medicine and public health are both reducing in terms of the number of specialists.

Supply of new doctors from outside the UK

Half of doctors new to the UK are non-UK graduates

Medical graduates from outside the UK continue to be a source of doctors coming into the UK workforce. In 2017–18, half of new joiners were non-UK graduates, up from 44% in 2012.

Increase in doctors joining from Central and Eastern Europe and the Baltic countries relative to the rest of the EEA

This year we see a continued slight increase in doctors from EEA central, eastern, and Baltic countries on the medical register. The numbers from other EEA regions has continued to decrease, with a notable 20% reduction since 2012 in the number coming from the northwest of Europe.

Declining number of doctors joining from North America and Australia

The number of doctors joining from North America has declined by a fifth since 2012. And those joining from Oceania – which includes Australia – has reduced by over a third (35.8%); the largest relative decline from any region.

Supply of new doctors from within the UK

In 2017 the number of medical students in the UK passed the 40,000 mark, rising to 40,997. The enduring popularity of medicine as a degree is encouraging and reassuring, particularly because it comes amid a dip in the general population of UK 18-year-olds, which provides a significant proportion of the new medical students each year.¹⁰

The number of doctors entering training in general practice is up by more than 10% since 2012, compared with a 1% increase in doctors in training overall, which is welcome given the shortages to the UK workforce. The number of doctors entering training in emergency medicine also increased, by 144% to 1,520 over the period from 2012–18.

However, psychiatry – a specialism reducing in number overall, but with growing demand – is down the most by almost 12% in the number of doctors in training choosing it. This highlights the need to source these doctors from outside the UK – in the short term at least.

Doctors leaving the UK profession for at least one year

Almost 4% of licensed doctors – 9,314 doctors – left the profession for at least one year in 2017.

Younger UK graduate and international medical graduate doctors are increasingly leaving the profession, primarily to go abroad

The number of doctors leaving the profession varies between those of different ages and between those whose primary medical

qualifications are from the UK, EEA and elsewhere. Among UK and international medical graduate doctors, the number and proportion of doctors leaving who are under 30 years old was considerably higher in 2017 than in 2012. Younger doctors are most likely to be moving overseas, potentially to work abroad, and so may return to UK practice.

Evidence of doctors changing their work patterns in response to pressures

Both of the primary research studies we commissioned for this year's report have shown that many doctors have made, or are considering making, changes to their working patterns including leaving or reducing their hours.

Out of 700 doctors surveyed, around one out of four reduced their hours over the past two years as a direct result of the pressure they were under.⁶

A third considering leaving clinical practice in the next three years

A third of doctors are considering as their main career change one or more courses of action in the next three years, which would result in them no longer working in clinical patient-facing roles.²

Urgent action is needed to make sure doctors are supported so they don't leave just because the pressures on the system make their role as a doctor feel untenable.

Supporting doctors working under pressure (chapter 3)

In this chapter, we look at the realities of doctors' experience of training and working in a system under pressure, some of the strategies and coping mechanisms they are adopting, the concerns we have at how sustainable some of these are, and the support doctors tell us they need.

Our new research from *What it means to be a doctor* and *Adapting, coping, compromising* demonstrates how the strategies that doctors are forced to adopt are unsustainable – not only because of the effect on them personally, but also because they are potentially increasing patient care demand in the future.^{1, 2, 6}

The evidence gathered shows that the pressure and heavy workloads doctors report experiencing are presenting risks to standards in patient safety and slips in the quality of care. The evidence is very concerning and demonstrates the urgent need to relieve the pressure our medical workforce is under.

Types and sources of pressure

There is evidence from a range of sources showing that pressures on doctors are continuing to build.

External pressures:¹ In interviews, doctors raised a range of external factors that cause them to feel pressured and to ask themselves whether they will be able to do their job with the limited time and resources available. These included:

- increasing number of patients, particularly those with co-morbidities

- specific time periods of high demand and/or shortage of experienced staff
- the overall system, including targets and administrative requirements.

Of these, a shortage of experienced staff is the most cited source of pressure by doctors, there being too few doctors with the right level of experience and skills.

Internal pressures:¹ Doctors are also subject to internal pressures – whether they believe they will be able to do their job well. Doctors' own feelings of responsibility lead them to take on more work than they can strictly manage; they know they will put themselves under pressure, but feel an obligation to patients and colleagues. Over two thirds reported that they are working beyond their rostered hours at least once a week.²

Longer hours but less continuity of care

Three out of five doctors (63%) said the time they spend working has increased over the past three years. And only 13% said they now spend less time working.²

This is in stark contrast with feelings around continuity of patient care: 44% of doctors said that opportunities to offer continuity of care have decreased, with just 15% saying they have increased.² Doctors are working longer, but are less able to provide continuity of care in the face of increased work and system pressure.

Deterioration of work-life balance

Doctors also found themselves catching up on work or training in their free time or on annual leave. Though these strategies were not adopted willingly, doctors felt that sometimes they were the only available options.

The majority of surveyed doctors* (60%) reported that their satisfaction with their work-life balance has deteriorated (either somewhat or significantly) in the past two years. Over a fifth of these doctors (22%) reported that it has deteriorated significantly.⁶

This deterioration is most pronounced for GPs, and is worst among younger GPs. Around three quarters of younger GPs surveyed (72%) said their work-life balance has deteriorated.⁶

Impacts of the pressure

Pressures are making it difficult for doctors to support each other

- Three out of ten felt unsupported by management or senior colleagues at least once a week, and one out of eight felt unsupported by immediate colleagues at least once a week.²
- Three out of ten said mentoring provided to them has decreased and nearly half said the time available to reflect on their practice has decreased.²
- Just under a quarter of doctors (23%) felt unsupported by immediate colleagues at least once a month.²

Taking leave of absence and considering leaving the profession

- One out of four doctors said they have considered leaving the medical profession at least every month.²
- Two out of every 100 doctors said they had to take a leave of absence due to stress at least once a month over the last year. This rises to four out of every 100 doctors on neither the GP nor the Specialist Register and not in training.²

Strategies to deal with pressures

The research findings suggest that there are four ways that doctors are dealing with these pressures. We have a number of concerns about the limitations and impacts of these strategies.

- 1 **Using smarter ways of working to manage workloads**, such as telephone consultations, and accessing test results and imaging online. While many developments in this area are seen as positive, there is a sense for many that the limits of smarter working have been reached.^{1, 6}
- 2 **Prioritising certain aspects of clinical service and patient care at the expense of other activities**. Often this means withdrawal from continuing professional development (CPD), less time spent reflecting and a drop in attendance at activities that are important for the overall health system to operate efficiently and safely in the longer term.^{1, 6}

* 700 doctors were surveyed in the *Adapting, coping, compromising* research project (reference 6 only). See the data note on page 139 for more information.

3 Changing the type of work doctors do such as working outside their grade or level, with doctors 'acting up' or 'acting down' becoming normalised and changing how they work with colleagues and patients.^{1, 6}

4 Adopting strategies that prioritise immediate patient care and safety, including making unnecessary referrals.

These appear to be applied when previous coping mechanisms have been exhausted. Doctors have to move patients on to reduce their own workloads, so they are not spending sufficient time with them and are bypassing the use of clinical checklists and protocols.^{1, 6}

Personal coping mechanisms

Many doctors discussed reducing their hours and taking retirement earlier. But there were other less-dramatic solutions. These include pushing back when they felt the demands being made on them were unreasonable.^{1, 6} Nearly two fifths of surveyed doctors said they had refused to do additional work over the past two years as a result of pressure on workload and capacity.⁶

Pressures are felt differently among the profession

The extent of the pressures, the way they are felt by individuals and the degree to which the various strategies and coping mechanisms are adopted vary from place to place and doctor to doctor.¹

Despite most doctors being exposed to at least some of the pressures and negative effects of some of the coping strategies they are forced to adopt, two thirds remain at least somewhat satisfied.²

- There needs to be more learning about some of the factors that may contribute to this satisfaction in some places despite the pressures.
- Even so, one out of four doctors said they are at least somewhat dissatisfied.²

Support

Resources are required to reduce doctors' need for strategies that compromise patient care and safety, that prevent doctors from supporting each other and developing professionally, and store up problems for the health system in the long term.

Our response must also involve creative ways to directly address the areas doctors have told us would support them.

Some of the areas doctors have said they would like more support around include:^{1, 2, 6}

- support and mentoring from colleagues and senior management
- prioritisation of mental and physical health
- implementation of work-based support systems
- promotion and protection of continuing professional development (CPD) and other non-clinical activities.

A quality workforce: ensuring standards, applying fairness (chapter 4)

The provision of a quality workforce needs to be a collective action by all in the health system. In this chapter we examine the measures we are taking to make sure high standards are maintained, and to relieve the burdens doctors are facing in modern clinical medicine. It looks at how we support all groups of doctors to achieve high standards throughout all stages of their career, and particularly how they can realise their potential during training.

This chapter also provides our latest data on fitness to practise, and gives an update on the reforms we are making to make these procedures fair.

Ensuring standards

Enhanced monitoring

When postgraduate bodies are concerned about the training of doctors, they work directly with trusts and health boards to make improvements.

If the situation doesn't improve, they tell us. We also receive reports from the medical royal colleges, faculties, and others if they have concerns, so we can see evidence of pressures building from different sources.

We then work with all the organisations involved to address the concern, improve the quality of training, and develop a sustainable solution through our enhanced monitoring process.

Feedback from those we work with tells us that enhanced monitoring is effective. We know

that direct GMC involvement raises the profile of education issues. It also means that local education providers will dedicate resources to education and training. This is important for influencing longer-term cultural change at struggling organisations. It also makes sure education is given appropriate weight.

Enabling all groups to reach their potential

Our standards require training pathways to be fair for all. We have worked to support groups of doctors who have different achievement levels from others, known as differential attainment.

- We hold organisations to account through capacity building and building the evidence base on differential attainment. We have strengthened our regulatory monitoring of how organisations responsible for the design and delivery of medical education are responding to the differentials as required by our standards. We have asked each local office for Health Education England, NHS Education for Scotland (NES), Health Education and Innovation Wales and Northern Ireland Medical and Dental Training Agency, and the medical royal colleges to describe how they are responding to the attainment gap.
- We have published a toolkit, which gives practical ideas on how organisations can evaluate the impact of their activities. And we run a national forum, through which they can share their learning with others across regional and specialty boundaries.

A common threshold for safe practice

We are developing plans to establish a Medical Licensing Assessment (MLA), which builds on our existing assurance work by setting a common threshold for safe practice for UK medical graduates and international medical graduate doctors.

New guidance on reflective practice

We co-produced and published new guidance on reflective practice in September this year – *The reflective practitioner*,¹¹ working with the Academy of Medical Royal Colleges (AoMRC), the Conference of Postgraduate Medical Deans (COPMeD) and the Medical Schools Council.

The new guidance was in answer to calls from medical students, doctors, responsible officers and appraisers for clearer information on what is meant by reflection and how it can be used within medical practice. The short guide illustrates commitment to supporting an open and honest learning culture and offers clarity in a number of areas.

Fairness in fitness to practise

Fitness to practise and reforms in this area

The complaints we receive about doctors continue to reduce. Last year we saw that the decline in complaints had slowed but in 2017 the downward trend continued, with a year-on-year reduction of 8%.

Success of provisional enquiries

In 2017, 40% of complaints that weren't closed immediately or referred back to the employer

are now subject to provisional enquiries. Of these, 68% have not subsequently required a full investigation.

Since being introduced, 951 complaints have been closed after provisional enquiries, reducing considerably the burden on the doctors concerned, compared with what would have been the case had they been subject to a full GMC investigation.

Local first

We want to make sure concerns are dealt with as swiftly and efficiently as possible for everyone involved. We have come a long way, but there is still much more we want to do.

Our long-term aim (requiring legislative reform) is that all complaints and concerns about doctors should be dealt with at the right level and, where appropriate, concerns should be addressed locally, only involving GMC action where necessary.

We are committed to a pilot of a local first approach by 2020. We are doing research to help us understand how this would work, how we can work with others to partially achieve this ambition within current legislation, and where legislative reform is most important.

Fairness

We take our responsibility to be a fair and transparent regulator very seriously.

We know there is disproportionality in the flow of complaints into the GMC and that some groups are more prone to complaints or concerns from particular sources, such as the police or employers, compared with others.

Research has not yet established deeper reasons behind why certain groups of doctors are referred more often. We have commissioned independent research to better understand the referral of doctors by employers, led by Roger Kline and Dr Doyin Atewologun.¹²

Supporting doctors to uphold standards

Raising concerns

There have been reports from our Regional Liaison Service that there is an issue with the processes of reporting and acting on concerns about patient safety. And that doctors are 'inoculated' against problems linked to resource shortages, in the sense that they have become 'normal ways of operating' so may not be reporting those concerns as a result.

Trainees' concerns about patient safety and education

There is a largely positive picture about the reporting of patient safety and educational concerns by trainee doctors, but not uniformly. Our national training survey¹³ findings show substantial minorities of trainees do not feel confident about raising concerns, nor do they feel that any concerns raised will be dealt with appropriately.

- Four out of five trainees say there is a culture of proactively reporting concerns in their post, while 3.8% disagreed or strongly disagreed that there was a culture of reporting concerns.
- GP trainees were more likely to say there is a culture of proactively reporting concerns than surgical or medicine trainees.
- A quarter of trainees do not think patient safety concerns are adequately dealt with, which is potentially worrying.
- One out of ten trainees are not confident that their concern would be addressed. Only two thirds are confident.

We are committed to playing our part in engendering a speak-up culture in the healthcare sector. We have a pivotal role to play in making the health service a place for learning, not blaming.

We are one of nine health and social care regulators in England which have signed a new agreement to more effectively share concerns that may indicate current or future risks to users of services, their carers, families or professionals.

How we and others can build a sustainable workforce (chapter 5)

Looking at the bigger picture, we examine what could be done if there were the wider will for bold change, and if other stakeholders agreed that such action, individually and in collaboration, is the way forward. We identify things that we and others could do if there were general support from stakeholders.

Improving the supply of doctors

There are lots of ways to improve the supply of doctors to the workforce. In this chapter we consider some approaches we could particularly contribute to, alongside others. And we outline some of the activities that we are doing, often in partnership with others to achieve this.

We have been working with NHS England (NHSE), HEE and the Royal College of General Practitioners (RCGP) to support the international GP recruitment programme. We have also supported NHSE to proactively contact overseas doctors currently training in the UK to encourage them to consider primary care for their specialty training and remain in the UK to work following completion of their certificate of completion of training (CCT).

The numbers of international medical graduate doctors seeking to sit the Professional and Linguistic Assessments Board (PLAB) assessment test has increased significantly in the past 12 months. To support this demand we have run more PLAB 2 testing days than ever before. In summer 2019 we will also open a new two-circuit clinical assessment centre in Manchester for the PLAB 2 assessment, which will reduce waiting times and support doctors to obtain

registration more quickly. We have also provided our first PLAB 1 assessments in Scotland.

The introduction of the MLA from 2022 means that UK medical students and international medical graduates will have to demonstrate that they meet a common threshold for safe practice in the UK before we register and license them. This will give greater assurance to patients, employers and educators that doctors entering the UK workplace have the knowledge and clinical and professional skills for safe practice.

Better support to retain and attract doctors

We have started a UK-wide review of medical students and doctors' wellbeing, led by Professor Michael West and Dame Denise Coia. This review will identify factors that affect the wellbeing of medical students and doctors, across the four countries of the UK. This work will be published in 2019.

We are also reviewing our quality assurance processes in education and training. And we will continue to support postgraduate bodies in their work with local education providers who are in enhanced monitoring.

We are engaging on a draft framework for credentials, which we plan to launch in 2019. This will address areas that are not already regulated and enable greater flexibility to meet patient and service needs and the career aspirations of doctors. And it will recognise the experience and knowledge that have previously gone unrecognised.

Supporting doctors who are not on the GP Register or the Specialist Register and not in training is an ongoing aspect of our work. We will survey doctors on neither register and not in training in 2019 to get a better understanding of their motivations, experiences and challenges. This will help us identify the best ways to support and develop this group of doctors.

A coordinated approach is necessary involving governments, arm's-length bodies, professional regulators, regional leaders, providers, patients and the public, and, of course, the professions

Taking a more systemic approach to maintaining and improving standards

We recognise that no single organisation can successfully act alone to reduce the pressures that threaten medical standards or develop the most optimal framework for understanding risk.



A workforce strategy to make sure the progress of the past 70 years does not stall



Doctors deliver good care in very trying circumstances but stark evidence of pressures is threatening standards

Many doctors positive and managing, but stress is causing some to consider reducing or ending their practice, including two thirds of surveyed GPs



Critical juncture: the UK needs to attract and retain sufficient doctors to maintain professional standards that they, and patients, expect

Workplace pressures must be tackled to avoid risking the supply of doctors



New research: doctors tell us how they cope with pressures, but we and they worry these strategies are risky and unsustainable



Workforce strategies need to address clear and present risks such as Brexit, as well as longer-term risks for patient care



The pressures are widespread but we need to learn from places where they have less severe impact

Doctors are telling us what changes they need. We must all work together to make it happen

Introduction

This is our eighth annual report on *The state of medical education and practice in the UK*. In our first seven editions we held up a mirror to the profession through our data, highlighting the many challenges and changes it faced.

This year, that approach continues, with two pieces of in-depth, independent research with doctors (see box 1, page 36), getting underneath the skin of what it means to

be a doctor in 2018, and hearing how the profession is adapting and coping in some very difficult times.

The profession is at a critical juncture

Seventy years on from the founding of the NHS, it is now at a critical juncture.

Demand for care is increasing in both volume and complexity as the overall number of households and the proportion of older people rise. Combined with severe shortages of staff in some areas of the country and in some parts of health and care provision, this creates huge pressures on the medical workforce. Continued uncertainty over Brexit adds to the risk of us and others being unable to plan in a way that enables a sufficient future supply of doctors. Our new research shows further threats to supply with large numbers of existing doctors considering leaving clinical practice or reducing their hours in the face of pressures.² Furthermore, doctors have told us of strategies that the pressures force them to adopt, which have both clear and present risks for patient care and threaten the long-term sustainability of health provision.¹

The healthcare sector faces a decline in what healthcare professionals can offer – to a level of care way below what doctors aspire to, and below what the public expects in the 21st century. The NHS's 70th birthday was celebrated with great plaudits from patients and employees, who highlighted the excellence and breadth of its work. There have been huge improvements in health since the formation of the NHS. But if the pressures presented in this report are not tackled head on, there is a serious risk of stalling and moving backwards after 70 years of healthcare progress.

We are realistic about the pressures and have been highlighting them for some time. In 2016 in a previous edition of this report,¹⁴ we sent a message to governments, employers and regulators about the state of unease within the medical profession and the system could not continue this way. In 2017¹⁵ we said we had reached a crunch point in the development of the

UK's medical workforce and needed to address recruitment concerns to avert greater pressure over the coming years. And our new corporate strategy¹⁶ reflects a determination on our part to provide better support to doctors and help them deliver good medical practice to patients. For example, we have worked both behind the scenes and more publicly to keep patients safe by ensuring good working conditions for trainees where they are being overused to plug gaps in our health services.

In 2018 we are saying loud and clear: the medical profession is at the brink of a breaking point in trying to maintain standards and deliver good patient care. The pressures continue to mount and doctors' stated intentions reported here, to leave or reduce clinical practice, threaten further decline in the supply of doctors. The severe pressures are already affecting services, training environments, and the ability of doctors to do their jobs.

Doctors feel less supported and more vulnerable than ever working in a system under such intense pressure. This is not sustainable, and changes must be made.

Breaking the vicious cycles of workforce supply and pressure-induced short-termism

Tackling the pressures will involve taking advantage of new opportunities such as those presented through the new NHS plan and workforce strategies in England, and Scotland,¹⁷ the already published planning framework and health delivery plans in Wales,¹⁸ and also the *Quality 2020* ten-year strategy in Northern Ireland.¹⁹

In doing so, we need to break two 'vicious cycles'¹ that we explore in this year's report: declining workforce supply and pressure-induced short-termism. Both are leading to a potential acceleration in the mismatch between supply and demand, making action to break these cycles now imperative.

Workforce supply: Staff shortages are creating such pressures that high numbers of doctors cannot cope and intend either to reduce their hours or to leave clinical practice entirely.² Many doctors have indicated that they are working extra hours that are unpaid as a short-term coping strategy,⁶ but they tell us that this goodwill in supplementing supply is coming to an end as it is unsustainable in the long term. Of 700 doctors surveyed,^{*} one out of every four doctors (26%) told us they have already reduced their hours over the past two years to cope with the pressure.⁶ This reduces the supply further, increases the pressure and hence the cycle continues and intensifies. Action is needed to retain more existing doctors and to encourage a greater supply of new doctors.

* 700 doctors were surveyed in the *Adapting, coping, compromising* research project (reference 6 only). See the data note on page 139 for more information.

Pressure-induced short-termism: This is particularly illuminated in new research commissioned for this year's report. Many doctors, having reached the limits of smarter working, are forced to introduce strategies that are storing up problems for the future. Immediate patient safety issues are prioritised to an extent that severely reduces tackling a patient's less urgent needs, with the knock-on effect of increasing future demand on the service.¹

Strategies reported as a response to the pressures of the past two years,² also involve between a quarter and a third of the workforce engaging less in delivering continuing professional development (CPD), mentoring junior doctors, and around a quarter reducing attendance at team and interorganisational meetings.⁶ These strategies potentially reduced skill development, productivity, and the effective working of the health system in the future.

Chapter 2 sets out new evidence on the nature of the workforce supply vicious cycle, noting the high numbers planning to leave the workforce and the threats to the supply of new doctors, exacerbated by Brexit uncertainty.

Chapter 3 examines evidence in relation to the short-termism vicious cycle. It explores the threats to the medical profession's welfare and the potential unsustainability of the health service, as contributions to management, leadership and training/CPD are reduced to prioritise immediate patient care and service needs. The chapter also looks at the threats to patient care that are already clear and present, despite this prioritisation of immediate patient need and the increased use of smarter working.

This picture is not universal. The majority of doctors remain motivated and are still satisfied overall with being a doctor.² This must not be lost sight of, particularly when encouraging people to take up a medical career – vital at a time when an adequate supply of doctors is a serious issue.

But exposure to the pressures is widespread and we are concerned with specific pressures on some groups.

Specific pressures on certain groups of doctors in particular roles and situations

Certain groups of doctors are facing particular pressures and risks.

Doctors in training

Our survey of all doctors in training shows high levels of burnout and increased likelihood of them taking breaks in training, as reported in November 2018.¹³ We worry about their ability to work safely and to the right standards. As less senior doctors, they are the most vulnerable and want and need support. We are listening to their concerns, which they are voicing to us frequently through a range of channels.

We have experience in intervening when pressures affect training and safety. In chapter 4 we describe some of the actions we have taken, unilaterally and with others, to respond (for example, at North Middlesex). Nevertheless we remain concerned in general with the risks to medical education in the NHS.

The responses to our surveys show a profession where many are having to make compromises between delivering a service on the front-line, getting the training they require and their own personal wellbeing. The strategies being adopted put at risk the continuing development of a high-quality workforce.

Senior consultants

A further related problem is that senior consultants are reporting having to 'act down' and do tasks that would have been done by doctors in training or nurses because they need to support the service in the face of workforce shortages.⁶ By doing so, their role, rather than appearing inspiring, becomes less appealing to doctors in training.¹

Senior doctors are reporting having to give out personal phone numbers and encourage doctors in training who may be inadequately supported on shift to contact them.

This inefficient use of skills and experience and this erosion of work-life balance are unsustainable – particularly as over two thirds of doctors reported that maintaining a clear boundary between work and home life is important to them.²

Doctors on neither register and not in training

We are also concerned about the 45,000 doctors who are not in training and not on the GP Register or the Specialist Register (such as service grade doctors, often known as staff grade, specialty, and associate specialist (SAS) doctors) – they account for a sixth of all doctors with a licence to practise.

They are a diverse group of doctors who have a range of medical experience, with many reasons for not being on the Specialist or GP registers. This is an ongoing area of exploration of our work to gain a better understanding of these doctors and we will publishing a segmentation analysis of this group of doctors in 2019

Many have no professional body to support them, many are from black and minority ethnic (BME) backgrounds and, like early career doctors, they particularly rely on the support of senior colleagues and employers to feel satisfied in their work. They are a hidden group of doctors and they need recognition. We want to find out more about them, to gain an appreciation of the roles they carry out and the challenges they encounter. We do this in a small way with some of our data from the surveys commissioned for this year's report, but we will be doing more in 2019, including a major survey of this group of doctors.

The evidence presented throughout this year's report from research we commissioned is reinforced by findings from elsewhere. In a British Medical Association survey of 900 doctors,²⁰ 47% of GPs said they have one or more vacancies at their practice and three quarters of these had been unfilled for more than six months. 71% of hospital doctors said there are gaps on shift rotas in their department. A Royal College of Physicians' census of 8,579 consultants and doctors in training, found that more than half of all consultants and two thirds of doctors in training reported frequent gaps in the rotas for doctors in training.²¹

Supply of new doctors to the UK register

The immediate supply of new doctors is threatened by Brexit uncertainties (see box 2, page 42) and our ability to encourage qualified and experienced doctors from the rest of the world to join the workforce rapidly. We are taking action on these fronts as well as on ensuring in the long term that new UK medical schools can open as quickly as possible.

Supply of new doctors from the European Economic Area

Doctors who graduated in the European Economic Area (EEA graduates) are of course a very significant part of our workforce. For example, a quarter of ophthalmologists, a fifth of surgeons, and one out of ten psychiatrists are EEA graduates.

The UK needs to continue to make the EEA graduates who are already here, and want to stay and develop their career in the UK feel welcome. There must be routes onto the register for EEA graduates in the future, so the UK can continue to benefit from a flow of doctors into the UK. We have written to Brexit ministers on this and we will continue to engage with them.

International medical graduates

International medical graduates (IMGs) – those doctors who have graduated outside the EEA – are also an important part of the workforce, particularly in certain specialties. In April 2018 NHS Employers²² said it was aware of at least 400 doctors who hadn't been able to enter the UK to take up posts because of the cap on Tier 2 visas for skilled workers.

We have successfully lobbied the UK government on this issue. In June 2018 doctors and nurses were excluded from this cap, temporarily ending the restriction.²³

We have seen a significant increase in registration applications from IMGs since the beginning of 2018. In the first four months of 2018, we received 2,284 applications from IMGs – a 49% increase when compared with the same time period last year. While we do not have concrete evidence as to why an increasing number of IMGs are applying for registration in the UK, we expect the number of live vacancies in the UK medical workforce is a significant driver.

There has also been a sustained increase in the volumes of applicants for our Professional and Linguistic Assessments Board tests (PLAB 1 and PLAB 2) over the last five years. We have seen more candidates sit PLAB 1 between January and April 2018 than we did in the whole of 2015. We also provided our first PLAB 1 assessment in our office in Scotland following discussions with the Scottish government. The significant increase in demand for PLAB 1 is having a knock-on impact on demand for places on PLAB 2, which is delivered through the Clinical Assessment Centre (CAC) – our dedicated facility for assessing the clinical and communication skills of doctors. We are now exploring options for delivery of a new or expanded CAC facility so we can continue to assess and register doctors in a timely manner.

But as a proactive regulator it is not enough for us merely to register these new doctors: we must also support them as they make the transition to working in the UK. That is why we are significantly extending the reach of our Welcome

to UK Practice programme,²⁴ which helps doctors new to the UK to understand the context of medical care here, and provides support on a range of ethical issues and dilemmas they may face through free workshops. In the last 12 months, around 2,300 doctors attended one of these workshops, a 44% increase on the previous 12 month period, and we are looking to increase this attendance in 2019.

UK medical schools

This year saw the announcement of five new medical schools opening in England³ – at the University of Sunderland, Edge Hill University in Lancashire, Anglia Ruskin in Chelmsford, the Universities of Kent and Canterbury Christ Church (based in Canterbury), and the Universities of Nottingham and Lincoln (based in Lincoln). These will open over the next three years and are part of a broader programme of creating new medical school places across England, which will add around 1,500 more students every year.

This year also saw an increase in the number of medical school places in Wales, with 40 new places being made available.⁵

The Scottish Government's National Health and Social Care Workforce Plan committed to creating additional undergraduate medical places and announced in June 2018 that 60 new places would begin in 2019–20 at the Universities of Aberdeen and Glasgow – 30 in each. Additionally, 25 places at the University of Edinburgh would begin at the University of Edinburgh in 2020–21.⁴

Given the urgency of increasing the supply of doctors, we will be resourcing a rigorous programme of visits and scrutiny for each new medical school, to help support them to open on schedule, and meet the same high standards already being demonstrated by existing medical schools across all the four countries of the UK.

Medical schools can only award degrees with our approval. If necessary, we can delay the opening of a medical school until it has reached the standards necessary. Where this has previously happened, the medical school has revised its provision and reached the expected standards in time for the following academic year. But we will be acting to avoid any such delay unless absolutely necessary.^{25, 26}

Retaining existing doctors

With the short-term difficulties around providing a supply of new doctors, retaining existing ones is a top priority. But the pressures on some doctors are such that there is a risk of driving them out of practice and compromising their ability to deliver the safe, high-quality care they want to deliver.

Within the next three years, many are considering reducing their hours (around a third), going part time (a fifth), and/or planning to leave UK practice and work abroad (a fifth). Significantly, over a quarter (28%) of those considering career changes said it is because the current system presents too many barriers to patient care, and a similar proportion (27%) said their role demands too much of them.²

A particular issue is that 21% of doctors who are aged between 45–54, and 66% of doctors who are aged between 55–64 are intending to take early retirement in the next three years. In total, 32% of doctors said that the **main** change they are planning in the next three years is to leave clinical practice in the UK and a further 21% said the main change they are considering is to reduce their hours. These figures rise in the case of GPs to 38% planning to leave and 28% planning to go part time or reduce their hours.²

A survey with 700 doctors as part of the *Adapting, coping, compromising* research project asked doctors how they had adjusted their work already as a result of pressure on workload and capacity. Almost two fifths of these doctors reported that they had refused to take on additional work, and a third of doctors had investigated whether they could retire earlier than they had planned. Around a quarter of surveyed doctors (26%) said that they are working fewer hours as a result of going part time or reducing their contracted hours.⁶

Workforce strategy

All the four countries in the UK need to make sure they have a workforce with the right skills in the right places. Without the necessary support, doctors will come under even greater pressure and the UK may reach a point of no return.

Action is needed: not just more money but a commitment to new ways of thinking about how workforce supply can be achieved, and how that workforce can be supported to achieve the professional standards and quality of care that should be expected 70 years on from the founding of the NHS. It is vital to mobilise all available resources to tackle these pressures and to arrest the vicious cycle of declining doctor numbers in the next few years. Strategies in the four countries need to set out a clear plan for making the UK a great place to work for doctors and for having a world-leading healthcare environment that attracts, develops and retains the best doctors and provides fantastic patient care. It must not only set out a compelling vision for the ten-year horizon, but also needs to address clear and present dangers – for example, the potential cliff edge of a no-deal Brexit and some of the workplace culture issues.

In chapter 3 we highlight some of the clear and present dangers of the current situation, made apparent in our research with doctors. A particularly worrying example of this is that around 46% of 700 doctors surveyed have witnessed situations where pressure has placed patient safety at risk at least monthly over the past two years.⁶ Doctors tell us about things that would support them in their roles, such as improved support for doctors no longer in approved training posts, mentoring, and additional support when introducing new initiatives.

We also highlight in chapter 3 the strategies doctors are forced to follow in the face of immediate pressures, which are storing up difficulties for the future. Workforce strategies with a vision that resolves these as well as immediate risks are essential. We have particular opportunities to achieve this with new investment in the NHS in England, new workforce strategies in Scotland and England, and ongoing workforce planning across the UK. We are committed to contributing what we can to make sure doctors are better supported to deliver the standards they aspire to and to maintain patient safety.

We cannot of course do it on our own. It will take a concerted effort by all those with a stake in our health systems to break the vicious cycles of under-resourced services, a stretched and stressed workforce, declining morale, doctors leaving the profession, and forced prioritisation of the short term at the expense of the long term.

We are therefore working with the Care Quality Commission (CQC) and NHS improvement in England, the Regulation and Quality Improvement Authority (RQIA) in Northern Ireland, Healthcare Inspectorate Wales (HIW), and NHS Education for Scotland (NES) and Healthcare Improvement Scotland (HIS), at a system level to make regulation smarter. The aim is to make the health system better able to understand the environment of practice and work to mitigate risks and to intervene early. We are contributing the full range of our regulatory powers, from 'soft' influencing powers to using our 'hard' powers in collaboration with the system, such as removing approval for training where the pressures have become a real problem.

Concerted action is clearly required urgently to make sure the support doctors are telling us they need is more available and retains as much of the current workforce as possible. Two fifths said they have felt unsupported by management in the last year.² Having access to support systems provided by employers was identified as being important or very important by around a third of all doctors in the survey commissioned for this year's report.²

Part of the solution is also resolving cultural challenges such as bullying, and any lack of confidence doctors experience in raising concerns. We have a role in helping to meet these challenges in collaboration with employers, which we describe in chapter 4.

We critically need to make sure doctors are supported to develop and train to meet the challenges of the future and that enablers are put into place so they can be the most effective doctors they can be, such as knowing how to take advantage of the technological and digital innovations set to transform healthcare. Regulation can play a role here too.

Chapters 4 and 5 highlight what we are doing to contribute to the workforce strategies across the UK; to support employers and doctors' in maintaining and improving professional standards' and to meet our particular responsibilities for the standards of training environments. We highlight immediate interventions and, particularly in chapter 5, the possibilities to act with others to improve workforce supply over the longer term:

We report on where we've worked with postgraduate bodies to support trusts and health boards to make improvements such as in providing enhanced monitoring to address issues that we believe could adversely affect patient safety and doctors' progress in training.

Our work on enabling all groups to reach their potential shows how important it is that we enable the whole workforce to fulfil its potential.

New guidance on reflection has been jointly developed with the Academy of Royal Colleges, the Conference of Postgraduate Medical Deans and the Medical Schools Council.¹¹

Reforms to our fitness to practise processes show how we're developing a range of actions to ensure high standards, while also supporting doctors going through those processes.

Engendering a speak-up culture across the healthcare system is something we are fully committed to. Our involvement in the Emerging Concerns Protocol in England and our work on exception reporting and rota monitoring across the UK are summarised in chapter 4 and show how we are working with others to achieve this speak-up culture.

Looking at the bigger picture, we look at what could be done if there was the political will and if other stakeholders agreed that bold moves, individually and in collaboration, were the way forward. Some will require flexibility in regulation that can only be delivered through reform to a legislative framework²⁷ that is over 35 years old and becoming an active block to supporting the health systems and patients.

This year's report – the evidence in support of action

In the ways mentioned above we will continue to contribute to the collaborative agendas that are now developing to tackle the causes and impacts of pressures.

The whole of this year's *The state of medical education and practice in the UK* is dedicated to illuminating evidence to support these agendas. This is not only in terms of a greater understanding of how the profession is experiencing the pressures, but also in highlighting the approaches that doctors and others tell us might begin to address the situation in a realistic and sustainable way.

In summary, there are four main elements to this: workforce **Supply**, **Support** to employers and the profession, **Strategic** interventions to maintain standards, and an exploration of possible **Solutions**.

Supply (chapter 2): Shortages of resources and in particular workforce underpin many of the difficulties. We highlight not only what the unique data we hold on trends in registration tell us about the supply of new doctors, but also crucially what the original research commissioned for this year's report tells us about the retention of existing doctors in clinical practice.

Support (chapter 3): We detail new evidence on what it means to be a doctor, how the continuing pressures in the system are affecting their motivation, satisfaction and health, how doctors are adapting in their work to cope with the pressures, and the strategies they are adopting.

All of this has implications for the sort of support needed at this time.

Strategic interventions to maintain standards (chapter 4): We examine how we are working with others to help doctors achieve the high standards they aspire to throughout their career and particularly how they can realise their potential during training. This is not only critical for patient care, but also to maintain motivation and retain the medical workforce. It includes our work on differential attainment, on new guidance on reflective practice, and how we are on progressing with the development of the Medical Licensing Assessment (MLA). This chapter also provides the latest data on fitness to practise and an update on our reforms in this area to better support doctors who are struggling to meet standards, or where concerns have been raised about their fitness to practise.

Solutions (chapter 5): An exploration of how current activity and future possibilities might particularly contribute solutions to breaking the vicious cycles creating a worsening mismatch between demand and supply – both immediately and in the longer term.

The healthcare sector can avert the risk of the progress of the past 70 years stalling

With concerted action on workforce strategies, the medical workforce can be the catalyst and leader for change across the whole system: pioneering technological innovation and implementation, and identifying and leading the development of new models of care and career development. Though not the whole picture, doctors can be integral to putting health provision on a sustainable footing.

Many of the actions highlighted in chapters 4 and 5 can have immediate effect and some of the longer-term ideas in chapter 5 can be implemented quickly with the support and shared commitment of the system. Some will need a willingness to change the long-established paradigms of what it means to educate and train doctors and what it means to have a sustained career in the profession. Some will require the flexibility of regulation that can only be delivered through legislative reform to a legislative framework that is over 35 years old and becoming an active block to supporting the NHS. With legislative reform, we believe we could shift much of the significant regulatory resource that we have to those areas now essential to supporting education and upholding medical standards.

Getting things right

Many doctors are still highly motivated and satisfied with their choice of career. Most are able to provide good, and often superb, levels of care to patients despite the pressures. The costs for some – in terms of their own wellbeing and work-life balance – are not, however, sustainable. As we have noted, some of the current strategies to maintain good care for patients identified in our research are not sustainable for the health system overall. We also have ongoing and specific concerns in relation to training environments.

But concerted efforts now to build on the high standards most doctors are still providing is clearly possible given the high motivation still reported by many. Our sense is that both the will and the opportunity are there for the taking if we grasp the nettle and act now to develop a workforce fit for the future. We hope that the evidence presented in the following chapters is helpful to this endeavour.

It has been a very challenging year, when our regulatory approach has come under great scrutiny following the case of Dr Bawa-Garba. There was a lesson for us about the way we regulate and we have initiated an independent inquiry into gross negligent manslaughter and culpable homicide.* The case also acted as a lightning rod for issues that had been concerning the profession and us for some time. We have

* An independent review commissioned by the GMC into how gross negligence manslaughter and culpable homicide are applied to medical practice has been under way since February 2018, and is chaired by Dr Leslie Hamilton. This review invited written submissions in June 2018 from doctors, patients, and others, and received over 800 responses. This report will be published in early 2019.

brought together some ongoing and new work on these issues under the umbrella programme of 'supporting a profession under pressure'* and it has accelerated our shift begun several years ago towards more frontline engagement and support for the profession. The issues it highlighted are also central to those covered in this report.

We will continue to analyse the data that we have about doctors' education, qualifications and practice to identify risk as it emerges. This will help us try to establish the underlying structural causes of poor-quality practice and education so that we

can work at a system level to address these. It is important for us as a regulator to be specific about where and why there is patchiness and variation in standards so that we can address these issues, working with our partners and stakeholders to achieve this. There is inevitably a lag between people's understanding of our role, responsibility and approach, and the reality of what we are doing. But we hope our contribution to resolving some of the issues highlighted in this report will help rebuild the confidence of the profession in its regulation.

* This programme includes the following six areas of work: independent review of gross negligence manslaughter and culpable homicide; helping doctors become reflective practitioners; improving support for doctors to raise and act on concerns; making sure doctors are treated fairly; supporting medical students and doctors; and induction and support for doctors returning to work.

Box 1: Primary research used in this year's *The state of medical education and practice in the UK*

In the main, the evidence on pressures comes from primary sources: from the two major research projects we have commissioned, detailed below, as well as from this year's annual national training survey of 70,000 doctors in training and doctors who act as trainers.

First, we commissioned an independent online survey by ComRes of 2,602 UK doctors² on our register, weighted to reflect the register, on the theme of 'What it means to be a doctor.' The project also involved further qualitative in-depth interviews with 25 doctors. They were asked a series of questions on motivation, morale and working pressures over the past three years.

We wanted to try to understand particular differences between the rising generation of younger professionals and their older colleagues: in terms of how their attitudes to being a doctor and their understanding of their role differ' what professional identity means in this new century; and what we as a regulator need to do to vary our approach so that we're providing information and support that's relevant to them.

Second, we commissioned an independent qualitative study by Community Research into the strategies doctors are using to deal with these pressures, and by the trainers of doctors who want to continue providing high-quality training in the face of these pressures. Our *Adapting, coping, compromising*, report explores the day-to-day experiences and examines how sustainable their coping mechanisms are and where the strains may be particularly acute.¹

An additional quantitative phase of this research saw 700 doctors take part in a rapid survey carried out by medeconnect.

We have also drawn on new analysis that triangulates primary data from ourselves and others to understand more about areas of practice where data have traditionally been less available – primary practice, locums and SAS doctors (and other doctors on neither register and not in training). We have published these analyses in working papers on our website during 2018.

More generally, we have analysed intelligence and insights from our field teams from the Employer Liaison Service, our Regional Liaison Service in England, our education visits team and our devolved offices in Scotland, Wales and Northern Ireland, as well as Joint Working Intelligence Groups.

We also draw evidence from information and data collated and coded on our management information systems. This includes our quantitative data from the register, from revalidation and fitness to practise processes and from our recently launched 'Intelligence Module,' which has been developed to capture and code a range of qualitative data that we gather.

Other sources include material from our confidential helpline, ethical enquiries service and telephone/email contact centre. As in previous editions we have supported this primary evidence with secondary material, such as the wider literature and reports from medical royal colleges, think tanks, NHS England, and others.



The medical workforce



Licensed doctors are the pool of labour potentially available for the medical workforce. This pool grew by 4% from 2012–18



GP numbers up 4%; consultants up 11%; but one in four surveyed doctors say they've reduced their hours in last two years



The numbers of licensed doctors in Psychiatry, Pathology, Public Health and Occupational Medicine are declining

Numbers giving up UK licence higher than 2012. Nearly six in ten of these in 2018 under 50 years old

40%

Steady number of EEA doctors taking up a UK licence since the referendum; but sudden increase of 40% from outside the EEA in 2018

Increase of 10% in those taking GP training and 144% in emergency medicine; decline of 12% in psychiatry training



A third of doctors are considering leaving clinical practice within three years



Early retirement challenge: two-thirds over 55, and one in eight aged between 35 and 54 considering retiring within three years

Introduction

In this chapter we start by presenting the shape of the medical profession using the data we hold on the number of doctors registered and those licensed. We look at how trends have differed across primary and specialist care and between the countries of the UK. We can see, for instance, how the number of doctors on the Specialist Register has grown nearly three times as much as the number on the GP Register. The number of doctors is in a sense the pool of doctors currently available to the workforce and the trends in these numbers that we report are the net effect of those joining and those leaving.

Many of the pressures discussed throughout this report reflect shortages of doctors relative to demand. Although this is affected by many things, such as the average hours worked by a doctor or organisational efficiency, it is important to consider how the pool of available doctors is changing as a result of those joining and leaving.

This chapter looks at trends in those joining the profession and some of the associated recruitment issues. There were over 14,000 doctors joining the medical register in 2018 and around half of those were non-UK doctors – this chapter explores who those doctors are, and what areas of practice have the greatest changes in the number of practising doctors.

Nearly ten thousand doctors left the UK medical register in 2017, a fifth higher proportionately and in terms of numbers than in 2012. We can see from our data that the proportion of doctors aged under 30 years old who have left has nearly doubled, and that a quarter of UK leavers were aged between 30 and 49 years. It is concerning to see younger

doctors leaving, although some of this will reflect more trainees taking breaks and then returning, as previously reported. Furthermore, results of the research projects commissioned for this report that explore their future plans show high numbers considering leaving clinical practice or reducing their hours.² If a high proportion of these intentions were put into practice, this would increase the pressures of staff shortages. Retention is key and we explore further in chapter 3 the support that may help increase retention.

The data presented here mainly draw on our unique data from the register and from our two research projects commissioned for this report: *What it means to be a doctor* and *Adapting, coping, compromising* – the full results of which will be published in 2019.

Where we talk about the number of doctors in each year throughout this chapter, these data are taken as at 30 June each year. Further data notes are provided in the research and data notes section from page 139.

The changing shape of the medical register

Figure 1: An overview of the diversity of the medical register, by gender, age, ethnicity and primary medical qualification (PMQ) of licensed doctors, from 2012 to 2018

		2012		% change	2018	
		% total	Number of doctors		% total	Number of doctors
TOTAL		100%	232,250	4%	100%	242,433
GENDER	Male	57%	132,553	-4%	53%	127,624
	Female	43%	99,697	15%	47%	114,809
AGE	<30	14%	32,263	7%	14%	34,643
	30–49	58%	134,881	5%	59%	142,021
	50+	28%	65,106	1%	27%	65,769
ETHNICITY	White	52%	120,733	7%	53%	129,087
	BME	29%	68,349	22%	34%	83,575
	Not recorded	19%	43,168	-31%	12%	29,771
PMQ	UK	63%	147,354	9%	66%	161,070
	EEA	10%	22,967	-5%	9%	21,791
	IMG	27%	61,929	-4%	25%	59,572

Number of licensed doctors grew faster than the UK population in the past two years

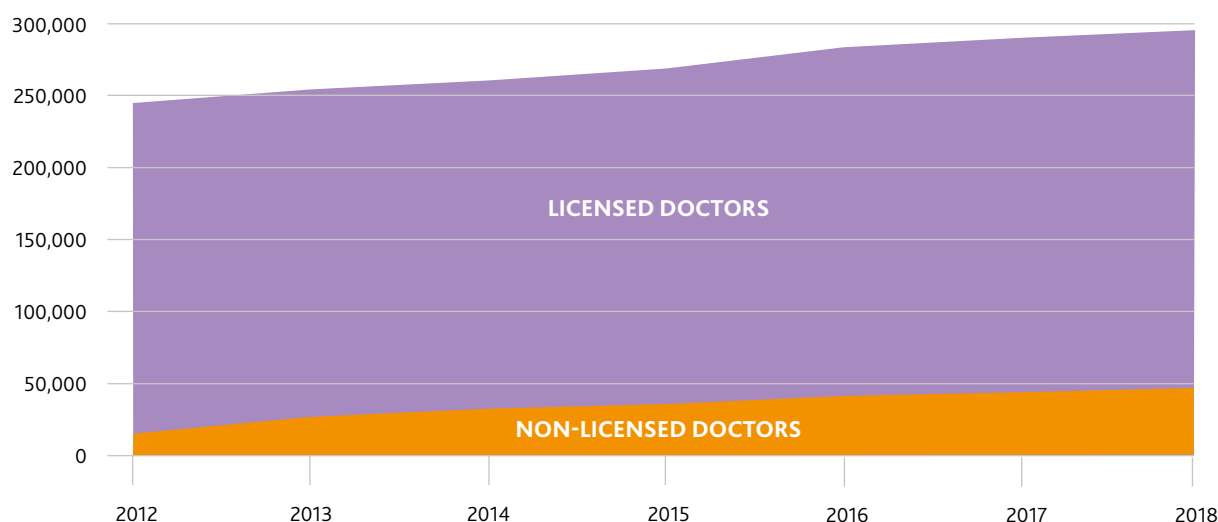
After the introduction of revalidation in 2012, some doctors, particularly those based outside the UK or not practising in the UK, decided to relinquish their licence to practise because they were unable to maintain a connection to a UK responsible body in order to revalidate.

As the effect of introducing revalidation has stabilised, we are seeing a rise in doctor numbers larger than the growth in the UK population, with 2.0% growth in licensed doctors in 2016–17, and 2.4% in 2017–18 (figure 2). The latest population growth estimate was 0.6% from 2017–18,²⁸

indicating that the number of licensed doctors on the medical register is now increasing faster than the population of the UK. This should however be taken in the context of an ageing population. One in every five is aged 65 years and older and this is projected to increase to one in every four by 2037. Adding further to demand are increased expectations of patients and complexity of healthcare treatments.

The 4.4% growth in licensed doctors 2012–17 is similar in scale to the 4.3% population growth across the UK. The number of licensed doctors per 10,000 population has remained relatively steady, with an increase from 36.46 to 36.47 (2012–17).

Figure 2: Number of doctors on the medical register, by whether licensed, from 2012 to 2018



Number of licensed EEA doctors remains steady

The slight reduction in the number of EEA doctors over the past five years is largely due to decreases in 2014–16 when we saw a 9% drop. Since June 2014, EEA graduates have been required to show proof of their English language capability before they gain a licence to practise, which may explain this one-off fall in numbers. It is noteworthy that, since then, the number of licensed EEA doctors has increased slightly each year, rising by 0.3% in 2016–17, and 0.8% in 2017–18. We have no evidence of an overall decrease in EEA doctors since the outcome of the June 2016 referendum to leave the EU.

UK-trained doctors increasing in numbers

The medical workforce in the UK is increasingly being trained within the UK itself. While the numbers of EEA and IMG doctors have decreased, this has been made up for by a 9% increase (to 161,070) in the number of UK graduate doctors on the medical register from 2012 to 2018. The previous increases in UK medical school places are now affecting the overall make-up of the medical workforce.

Box 2: Brexit – preparing for the potential impact of leaving the EU on the UK’s medical workforce

Leaving the EU could have a significant impact on the regulation, movement, and education of doctors. The impact could be significant in all four UK countries, but (for different reasons) there are particular challenges potentially facing Scotland, Wales and Northern Ireland.

We are therefore concerned that, with less than six months to go before EU exit and increasing talk of the possibility of a ‘no deal’, we still do not know how, and how quickly, EEA qualified doctors will be able to join the UK medical register.

In maintaining the UK’s medical workforce, it is essential that exiting the EU does not either deliberately or inadvertently deter the approximately 2,000 EEA qualified doctors who come here each year and contribute to the NHS.

As the UK medical regulator we are doing all that we can to prepare for the various scenarios that we may face in March 2019, while we await the outcome of the negotiations. Although we are devoting a lot of attention and time to these preparations as government negotiations are still ongoing, there is increasingly little time to implement a route to the register for this important cohort of doctors.

We need clarity from the UK government on how EEA qualified doctors will join the medical register after Brexit so that we can design and implement the systems that we need to put in place in the event of a ‘no-deal’ Brexit.

EEA doctors in the UK

Doctors from Europe make a vital contribution to the health services across the UK: Nearly one out of every ten licensed doctors in 2018 were EEA graduates.

Brexit will instigate significant questions for workforce arrangements in all four countries of the UK, especially in Northern Ireland, which is the only part of the UK that shares a land border with another EU country. This is compounded by an increase in cross-border working in recent years and by the integration of some medical services across the whole of Ireland.

Our data show that there are a similar proportion of EEA graduates in each broad area of practice in Scotland and Wales. Northern Ireland has the greatest proportion of EEA graduates who are GPs. England has the highest proportion of EEA graduates who are specialists or on neither register and not in training. This means that each country has particular vulnerabilities should the supply of EEA doctors slow down.

There are also certain regions of the UK that have a relatively high dependency on EEA qualified doctors. For example, we know that, in some remote and rural areas of Scotland and Wales, there is a higher percentage of non-UK licensed doctors than the overall UK figure. In Scotland this includes Argyll and Bute, Eileanan Siar (Western Isles), Orkney, and Shetland. In Wales, Hywel Dda University Health Board covering west Wales has the highest percentage of doctors with an EEA primary medical qualification of all Welsh health boards, standing at 10.6% of its 887 connected doctors.

The potential impact of a 'no-deal' Brexit

In the event that the UK government and EU leaders are unable to reach agreement on the terms of the UK's withdrawal from the EU, we foresee three possible scenarios for medical regulation after March 2019.

- **Option 1:** Applications for registration from EEA qualified doctors are considered via the existing routes for international medical graduates (IMGs).
- **Option 2:** The UK government invites Parliament to unilaterally maintain the current system of automatic recognition granted by virtue of the Mutual Recognition of Professional Qualifications (MRPQ) Directive* – but for a time-limited period.
- **Option 3:** A bespoke framework is created for EEA qualified doctors which would straddle the above two options to limit the impact of a 'no-deal' Brexit.

There are challenges and limitations to each of these options. In our view, the best is option 2,

which would be a framework already set out in law, mirroring the system currently used under the MRPQ Directive. This would be used for a time-limited period only. This system would mitigate the short term workforce risks and provide a breathing space for the development in the long term of a new, more robust but more flexible regime to register doctors regardless of where they qualified outside of the UK. Under this system we would be mandated to continue to automatically recognise EEA qualifications. The strict legal basis would avoid the risk of challenge on the grounds of equality and discrimination.

In the long term, we would like to work with the UK government to design a new registration system that is fair for all doctors joining the medical register, regardless of where in the world they qualified. This would set a clear threshold for medical practice in the UK and would ensure patient safety in the post-Brexit healthcare environment.

* The Mutual Recognition of Professional Qualifications (MRPQ) Directive is an EU directive which allows the free movements of professionals, including nurses, midwives, doctors (general practitioners and specialists), dental practitioners, pharmacists, architects and veterinary surgeons, within the EU. This is based on recognising a common standard among professional qualifications gained throughout the EU.

Number of GPs continues to grow, but at a slower rate than specialists

The GP Register has only grown by 4% in the period 2012-18, compared with the Specialist

Register, which has grown by 11%. This is significant given the shortages of GPs generally and the fact that so many GPs intend to retire or go part time, as we will see later in this chapter.

Figure 3: Number of licensed doctors, by whether they are on the GP or Specialist Register, or are in training, from 2012 to 2018

	2012		2018
	Number of licensed doctors	% change	Number of licensed doctors
Total	232,250	4%	242,433
GP	57,736	4%	60,279
Specialist	68,019	11%	75,788
GP and Specialist	1,293	-5%	1,232
Neither register and not in training	46,514	-1%	45,858
Neither register and in training	58,688	1%	59,276

GP growth is largest in England

The number of GPs in England grew by 6.8%, creating 3,231 extra GPs between 2012 and 2018. Over the same period, Northern Ireland

and Scotland showed very small increases in the number of GPs, of 3.1% and 1.0% respectively. Wales showed a decrease of 1.1%.

Box 3: Improved data about protected characteristics

The GMC has recently begun requesting doctors to provide additional details in their registration profiles about their protected characteristics (protected under the Equality Act 2010). Improved data will allow us to better analyse the medical register and allow insight into the challenges faced by different groups of doctors.

orientation or religion. We are working on ways to encourage all doctors to provide these details (with of course a 'prefer not to say' option) to help us ensure that our processes are fair and transparent. Further meaningful analysis of these data cannot be conducted until a greater proportion of doctors have provided their data.

Around three quarters of doctors have not yet provided these details about their sexual

Figure 4: An overview of the diversity of the medical register, by religion, sexual orientation, and disability, from 2012 to 2018

		2012		% change	2018	
		% total	Number of doctors		% total	Number of doctors
RELIGION	Total declared	100%	36,838	89%	100%	69,725
	Christian	39%	14,503	75%	36%	25,308
	No religion	24%	8,989	105%	26%	18,406
	Muslim	12%	4,402	132%	15%	10,197
	Hindu	12%	4,291	60%	10%	6,846
	Other	5%	1,771	100%	5%	3,537
	Prefer not to say	8%	2,882	88%	8%	5,431

		2012		% change	2018	
		% total	Number of doctors		% total	Number of doctors
SEXUAL ORIENTATION						
	Total declared	100%	36,825	89%	100%	69,721
	Heterosexual/straight	87%	32,063	90%	87%	60,957
	Lesbian/gay	2%	892	92%	2%	1,713
	Bisexual	1%	242	139%	1%	578
	Other	<1%	114	60%	<1%	182
	Prefer not to say	10%	3,514	79%	9%	6,291
DISABILITY						
	Total declared	100%	37,347	89%	100%	70,530
	Disability declared	7%	2,563	78%	6%	4,562
	No disability or long-term illness	88%	32,903	92%	90%	63,226
	Prefer not to say	5%	1,881	46%	4%	2,742

Trends in the numbers of specialists vary by specialty

Within the 11% growth in the number on the Specialist Register there is a considerable difference between specialties. Notable is the very strong growth of a third in emergency medicine doctors over the past five years,

but reports suggest this has not been sufficient to alleviate pressures in emergency departments.^{7, 8, 9}

As in 2017, our most up-to-date figures for 2012–18 re-emphasise that psychiatry and pathology are still the only large specialties not to be increasing in size.

Figure 5: Number of licensed doctors on the Specialist Register, by specialty group, from 2012 to 2018

	2012		2018
	Number of doctors	% change	Number of doctors
Medicine	16,626	20.4%	20,015
Surgery	12,479	10.3%	13,764
Anaesthetics and intensive care medicine	9,408	9.3%	10,281
Psychiatry	8,137	-0.1%	8,126
Radiology	5,180	12.6%	5,832
Paediatrics	4,823	20.3%	5,804
Obstetrics and gynaecology	3,598	8.9%	3,919
Pathology	3,113	-4.5%	2,974
Ophthalmology	2,048	11.8%	2,289
Emergency medicine	1,676	32.6%	2,222
Public health	1,331	-20.4%	1,060
Occupational medicine	708	-19.4%	571
Other or multiple specialty groups	185	-11.9%	163

Some smaller specialties are shrinking in size and ageing

Occupational medicine and public health specialties are both reducing in numbers, and an increasing proportion of each specialty is aged 60 years and over. Public health and occupational medicine specialists both declined by around a fifth from 2012 to 2018, to 1,060 and 571 respectively (figure 5, page 47). The proportion of these respective specialty groups who are aged 60 and over increased from 17% to 21% and from 24% to 29% respectively over the same period.

These are concerning trends as these medical specialties will further shrink as more doctors approach retirement. This overall pattern however may be a reflection of these specialties being increasingly delivered by non-medically trained staff.

In most cases, public health practitioners in England have recently been transferred managerially from NHS contracts to local authority management or Public Health England.²⁹ This was part of the health system reforms at the beginning of the decade. The British Medical Association has stated that public health doctors in England have low morale, and are unhappy at some of the changes that have happened, and feel that the specialty is being organised in a way that could negatively affect its long-term viability as a continuing specialty group.

Despite public health specialists being employed by the NHS directly in Scotland and Wales, the number of public health doctors has also fallen in these countries since 2012.

There are recruitment challenges across certain localities

There is evidence of certain localities and environments having specific individual challenges in sustaining a high-quality medical workforce. Rural and remote areas are known to have difficulties attracting clinicians,³⁰ as do some coastal areas.

For example, the Lincolnshire Local Medical Committee, which represents GPs in the area, began a recruitment drive in 2017 because of a diminishing workforce after intelligence revealed that 75 GPs were due to retire in the next five years. They recruited doctors from 16 European countries and 12 have been offered three-year salaried posts.³¹

The Department of Health and Social Care announced a £20,000 'golden hello' in late 2017 to attract GPs in training to start their careers in 20 rural or coastal areas that have struggled to fill posts in the previous three years.³²

Box 4: Use of more temporary staff linked to staff wellbeing issues

Employers report that having to fill vacant posts with agency staff appears to have an adverse impact on staff wellbeing. A study of data on 134 NHS hospital trusts in England found that those with a higher spend on agency staff had lower proportions of staff reporting getting support from managers and colleagues. Fewer of these staff reported that there was organisational interest in the health and wellbeing of staff, and (to a lesser extent) that they were not feeling work-related stress and pressures.³³ One of the surveys carried out for this 2018 report showed that doctors viewed

increased use of locums negatively, but at the same time a significant proportion of doctors were considering becoming a locum in the next three years, partly as a possible response to the increased pressure in work environments.² It is clearly important not to view locums or temporary staff as potentially 'poor doctors', but to ensure that the service provider is supporting them and the staff around them adequately in a situation where they may not be as knowledgeable about the service or as networked with those around them as permanent staff.³⁴

Figure 6: Number of licensed doctors on the GP Register, shown for each UK country and region of England, from 2012 to 2018

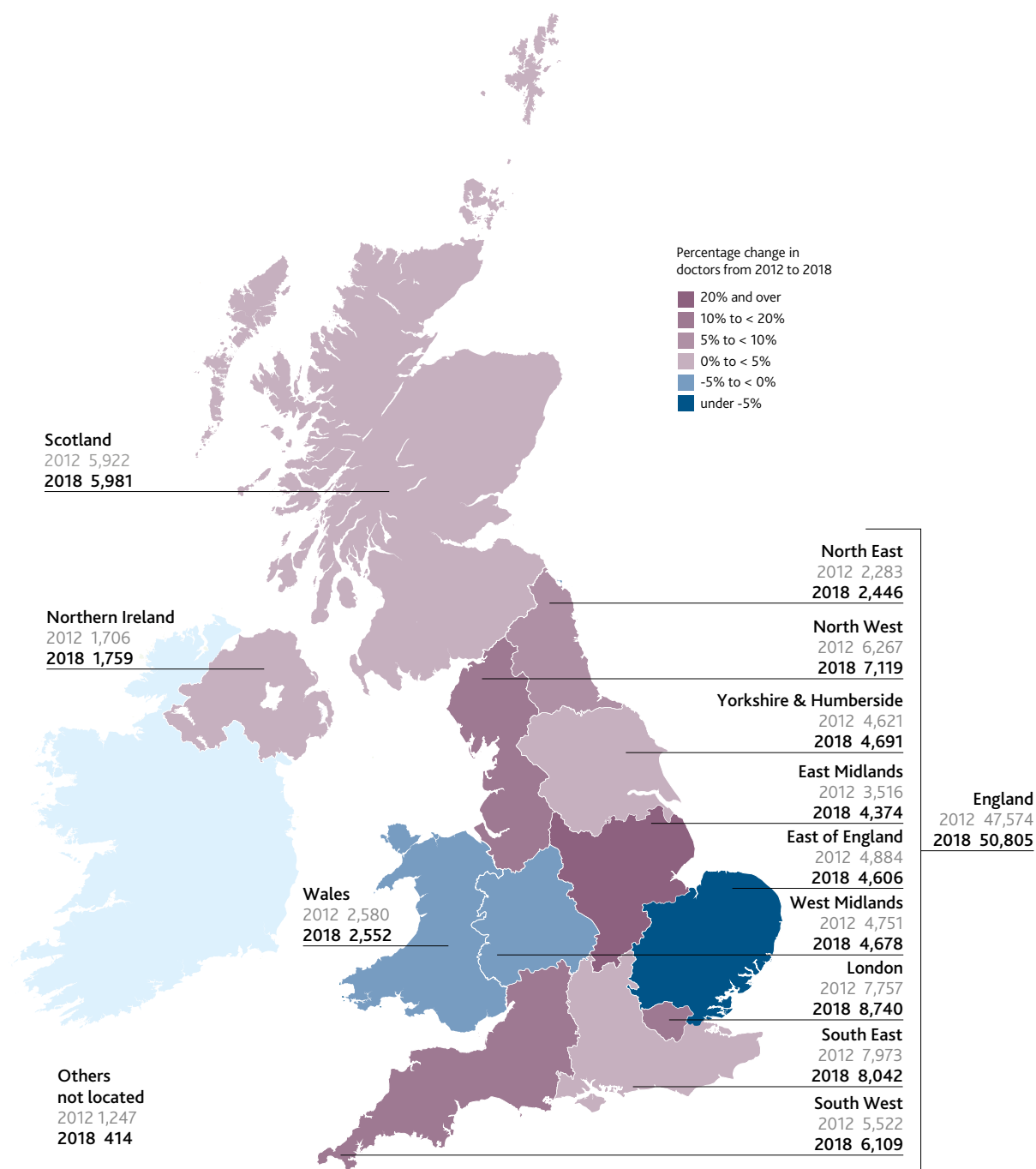


Figure 7: Number of licensed doctors on the Specialist Register, shown for each UK country and region of England, from 2012 to 2018

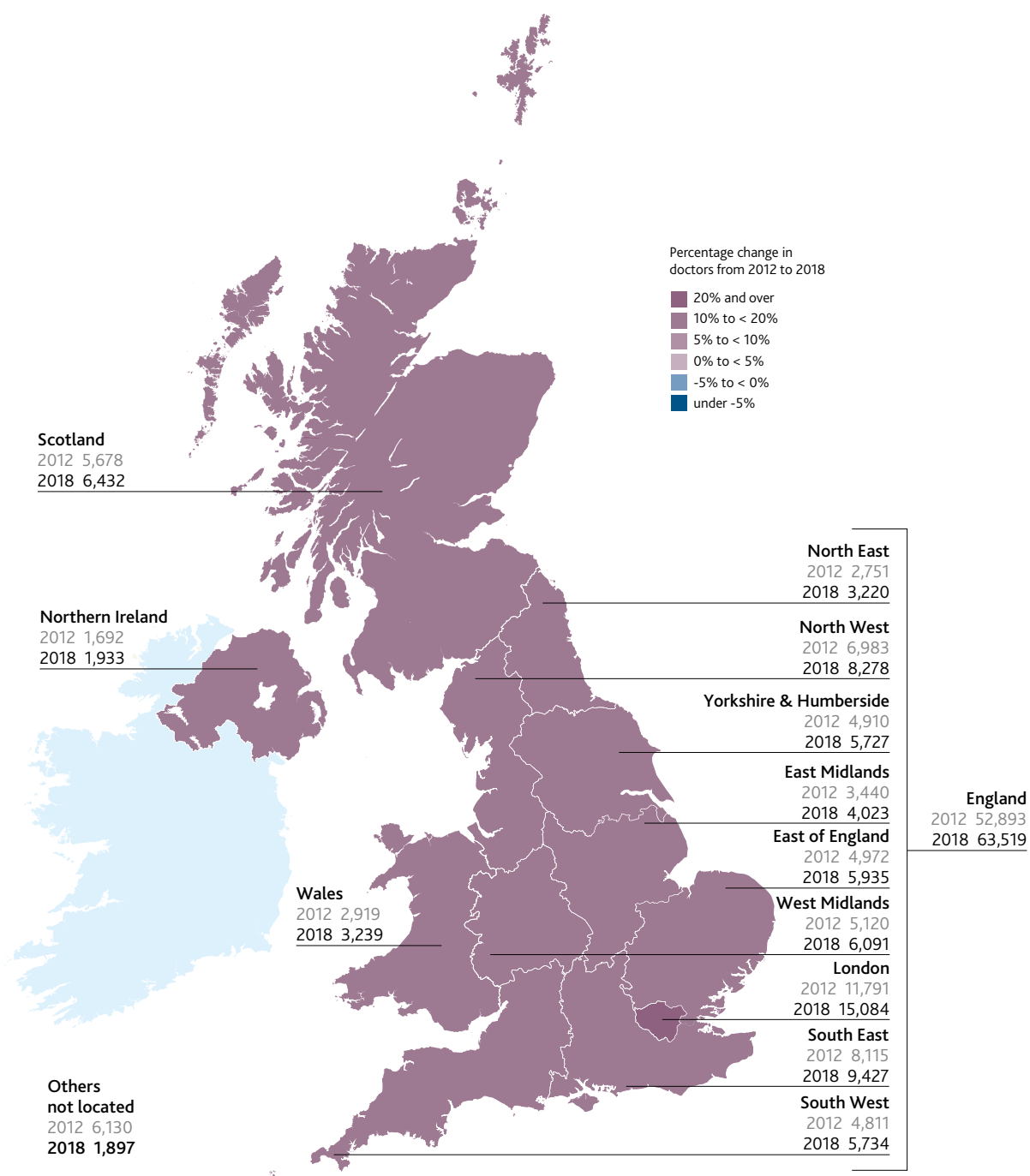


Figure 8: Number of licensed doctors on neither register and not in training, shown for each UK country and region of England, from 2012 to 2018

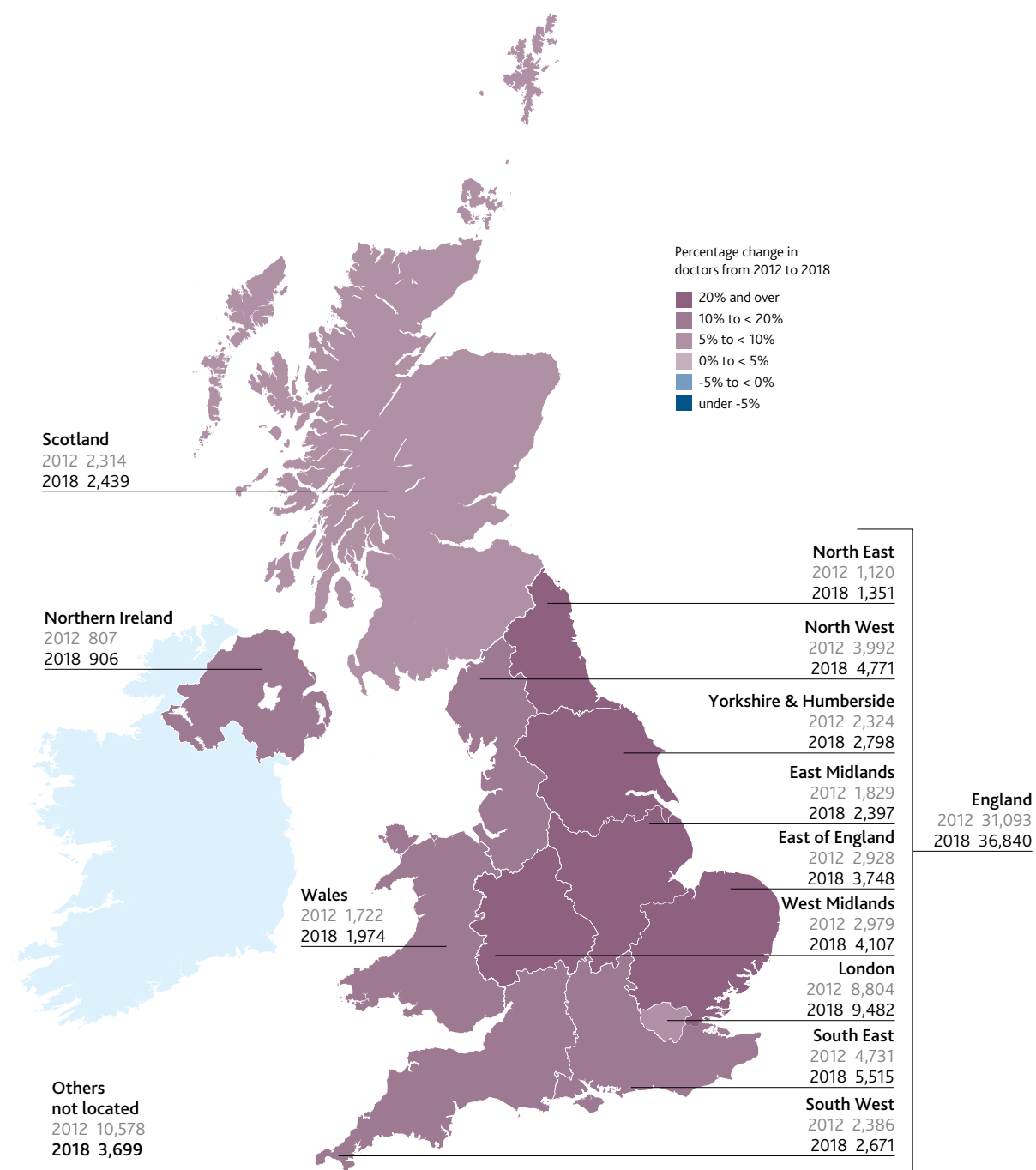
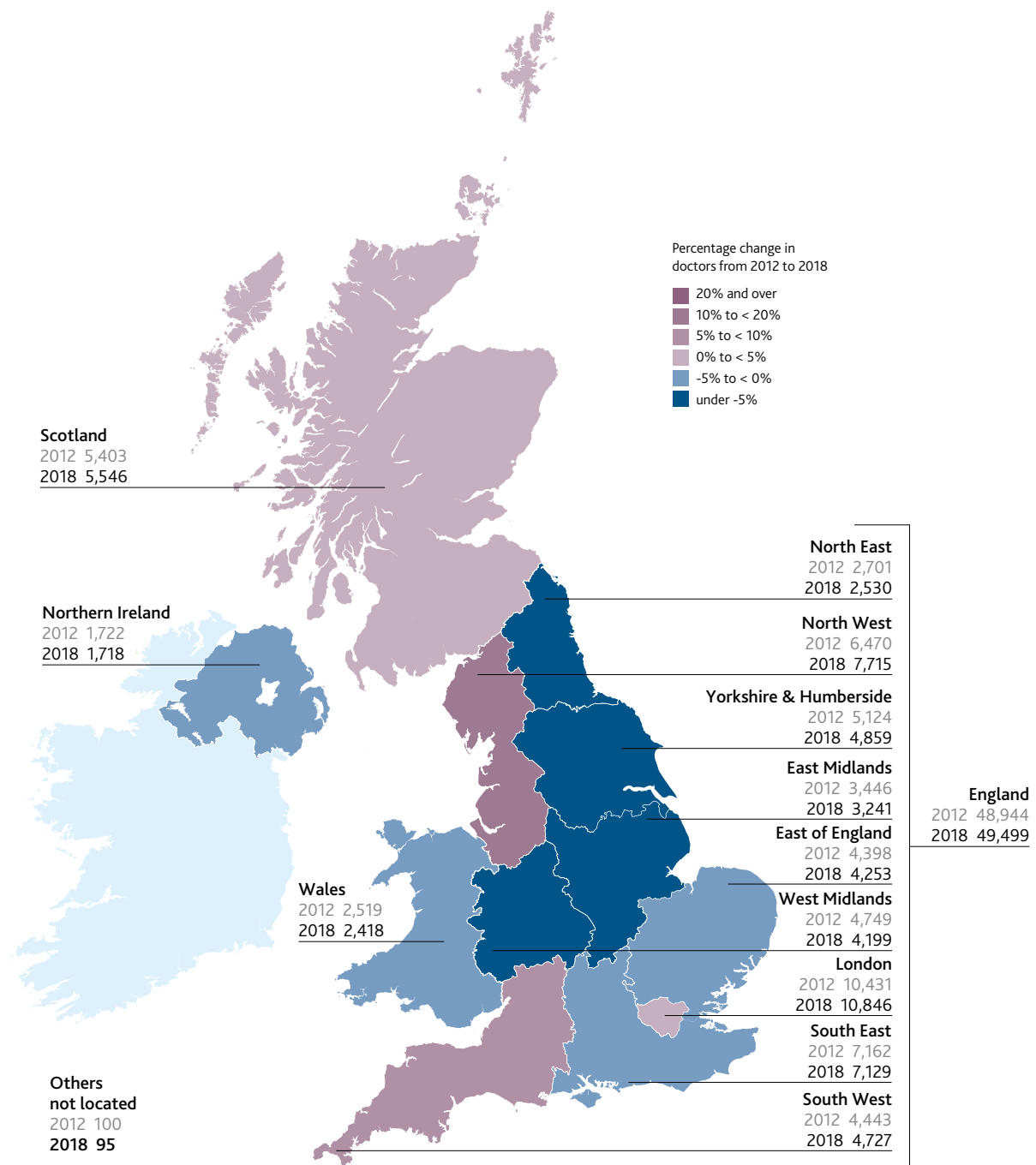


Figure 9: Number of licensed doctors on neither register and in training, shown for each UK country and region of England, from 2012 to 2018



Box 5: Vacancies

It is hard to compare vacancy data across the four countries of the UK as they are recorded in different ways. Sometimes only absolute numbers are published and sometimes only vacancy rates are published. This is an area where there needs to be a concerted effort to improve the data, and caution needs to be exercised in interpretation.

In the period April to June 2015 the number of medical and dental vacancies in NHS employment in England (which covers trusts, regional health bodies, Clinical Commissioning Groups and Health Education England regions, but not GPs or the private sector) was 8,687.³⁵

This rose steadily to a peak of 11,155 for January to March 2017 and has since fallen to 10,215 for January to March 2018. It isn't clear yet if this recent improvement is part of a longer-term trend, but it is important to note. These are NHS trust figures and do not include GP vacancies.

In Scotland the consultant vacancy rate for April to June 2018 was 7.6% of the total whole time equivalent, which is a dip from 8.5% for the same quarter in 2017. In June of 2011, however, the vacancy rate was just 2.8%.³⁶

Northern Ireland has not published any vacancy data rate since March 2015.³⁷ Comparable and up-to-date vacancy data for Wales could not be found for inclusion here.

Publishing vacancy rates can have unintended consequences

Vacancies can be a delicate area – some might see vacancies at a site and see an opportunity, but others might see a pressured situation. The concerns are that publishing vacancy data could put doctors off working in the areas most under pressure but often in most need of encouraging the brightest and best doctors to join willingly.

The balance between avoiding unintended consequences and the need for good data for policy setting and workforce planning is difficult to strike. Given the system is under pressure, ensuring transparency, through helping maintaining lines of accountability and visibility of the issues faced across the healthcare systems in the UK, is one way in which public confidence can be maintained.

An uncertain picture

The difficulties associated with the vacancy data make it difficult to be certain about the significance of short-term changes. In the period 2008 to 2018 it would seem, however, that vacancies have increased across the whole of the UK. In 2017 there has been a small reduction in vacancies. It is not clear if this is because of posts being filled or vacancies not being filled but not re-advertised.

More work is needed to ascertain the exact situation. For example, we cannot be sure of how many vacant roles are being filled by locums, and what the impact of this is.

The supply of new doctors into the workforce

Declines and rises in the number of doctors overall, within each specialty and within each geographic area are the net effect of new doctors joining the workforce and existing doctors leaving. In this section we consider trends in the supply of new doctors that increase the pool of doctors who can be recruited, looking first at doctors coming from outside the UK and then at the future supply of UK doctors as determined by trends in UK medical training. The following sections go on to consider trends in doctors leaving the profession and some of the increasing retention issues in a system under pressure.

Half of all new doctors are non-UK graduates (EEA graduates or IMGs)

EEA and IMG doctors continue to be a source of experienced and older doctors coming into the UK workforce. In 2018 half of new joiners were non-UK graduates, up from 44% in 2012.

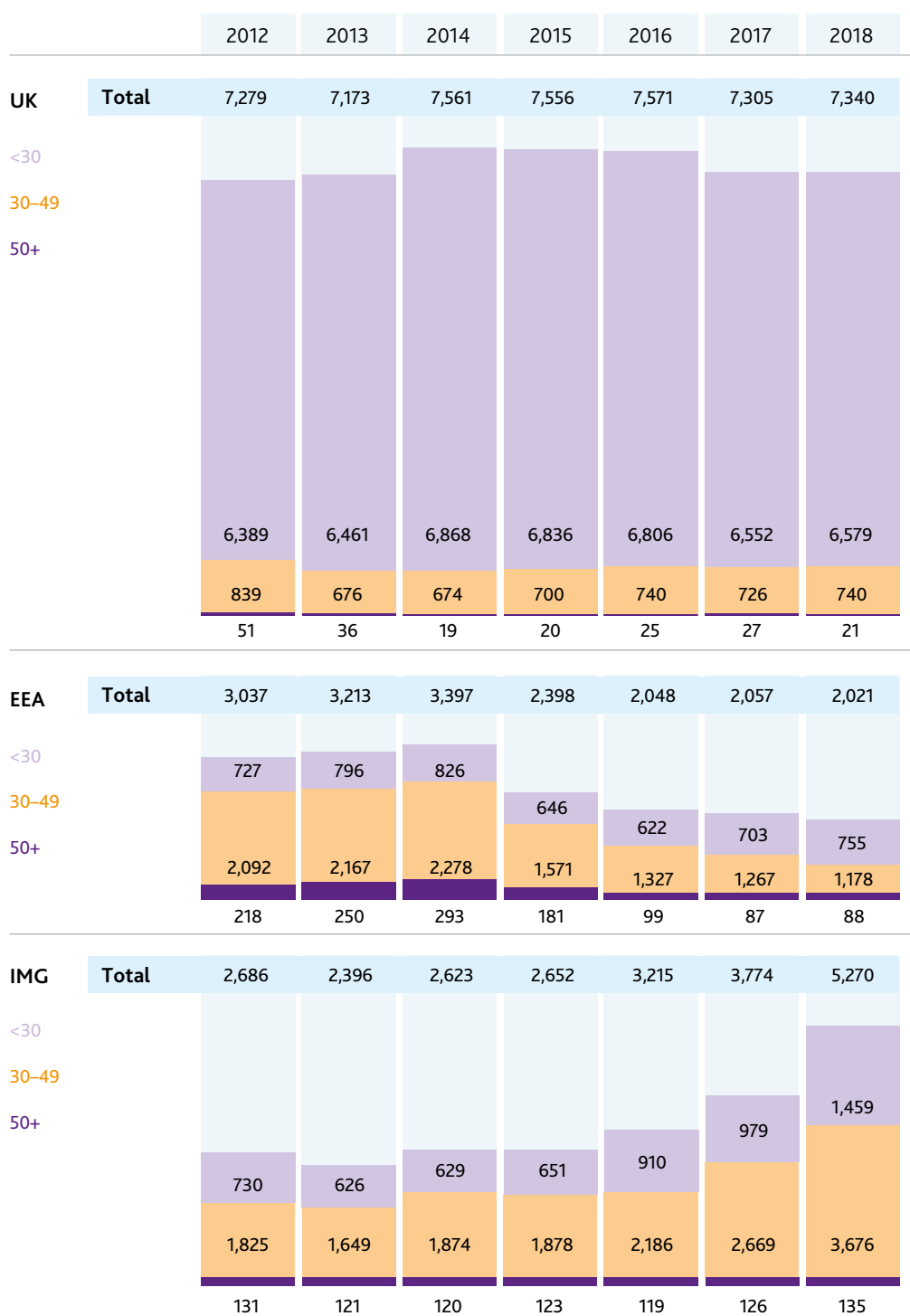
The increase in the relative proportion of non-UK graduates joining is primarily driven by an increase between 2017 and 2018 of IMGs joining the workforce for the first time. The number of EEA graduates joining has remained relatively stable (declining by just 1%) from 2016 to 2018, though we know that an increasing number of European nationals are now gaining their PMQ in the UK and practising medicine here.³⁸

The relatively high inflow of non-UK doctors presents opportunities in terms of their potential for supporting locations short of doctors. Migrants joining the workforce may have higher mobility at least when they first come to the country. Their choice of location may be amenable to influence via incentives. A greater understanding of the motivations involved in the international migration of doctors and in particular how they select a place of work initially would be helpful.

As we reported in 2017,¹⁵ there has been a growing reliance in recent years on non-UK doctors in some specialties and this hasn't changed in 2017–18. The risk of the UK becoming a less attractive place for doctors to come and work may be particularly concerning for these specialties.

There is already a body of literature that examines why doctors consider migration, and the reasons are broadly similar globally. There is less literature around the challenges or barriers doctors may face in emigrating to the UK. In chapter 5 we share some of our proposals on how we can help doctors and workforce planners in this area.

Figure 10: Doctors joining the medical register or gaining a licence for the first time, by PMQ and age group, from 2012 to 2018



In 2010 a tightening of rules for non-EU immigrants saw the elimination of general visas for highly skilled workers from outside the EU who did not have a UK job offer. At the same time, migration for most categories of worker who did hold a job offer was capped. Some analysis has suggested that over the years this has had a subtle but clear impact on NHS recruitment.³⁹ As we have mentioned in chapter 1, in May, NHS Employers said it was aware of at least 400 doctors who hadn't been able to enter the UK to take up posts because of the cap on Tier 2 visas for skilled workers.

We have worked with others to successfully lobby the UK government to reconsider this issue. In June 2018 doctors and nurses were excluded from this cap, ending the restriction.

Increase in doctors joining from eastern and central Europe and the Baltic countries, relative to the rest of the EEA

In 2018, we see a continued slight increase in doctors from Central and Eastern Europe and the Baltic countries on the medical register. The numbers from other EEA regions have continued to decrease, with a notable 21% reduction over the 2012 to 2018 period in the number coming from Northwest Europe. However, as noted earlier, we can see no evidence yet of an impact from the Brexit referendum on the overall numbers of licensed EEA graduate doctors.

Decline in doctors joining the workforce from North America and Australia

The number of doctors joining from North America has declined by a fifth (from 303 to 237 during 2012–18) and from Oceania – which includes Australia – by over a third (35.8%, from 1,980 to 1,271 during 2012–18), the largest relative decline from any region. There have been widespread small increases from most other parts of the non-EEA world (figure 11, page 58).

We also believe that the decline in overall doctor numbers following the introduction of revalidation, mentioned earlier in this chapter and caused by doctors who were not practising relinquishing their licences, also affected the number of EEA and IMG doctors joining from 2014 to 2016.

Figure 11: Licensed doctors on the medical register, by part of world in which they gained their PMQ, from 2012 to 2018

	2012	2013	2014	2015	2016	2017	2018	% change	
								2012–18	2017–18
UK	147,354	150,047	151,507	153,005	155,032	158,121	161,070	9.3%	1.9%
EEA – Central Europe, Eastern Europe, Baltic countries	6,926	7,062	7,095	6,903	6,724	6,874	7,138	3.1%	3.8%
EEA – North West Europe	9,011	8,681	8,153	7,625	7,227	7,205	7,131	-20.9%	-1.0%
EEA – Southern Europe	7,030	7,974	8,544	8,345	7,588	7,530	7,522	7.0%	-0.1%
Africa	11,485	11,032	10,066	9,612	9,463	9,862	10,598	-7.7%	7.5%
Middle East	7,152	7,169	6,918	6,785	6,674	6,980	7,480	4.6%	7.2%
Non-EEA Europe	1,560	1,617	1,645	1,645	1,631	1,678	1,764	13.1%	5.1%
North America	303	300	268	239	218	230	237	-21.8%	3.0%
Oceania	1,980	1,782	1,501	1,350	1,216	1,252	1,271	-35.8%	1.5%
Rest of Asia	1,725	1,709	1,610	1,600	1,637	1,724	1,869	8.3%	8.4%
South Asia	36,191	35,737	34,595	33,662	33,243	33,682	34,647	-4.3%	2.9%
South, Central and Latin America	1,533	1,565	1,596	1,559	1,539	1,594	1,706	11.3%	7.0%

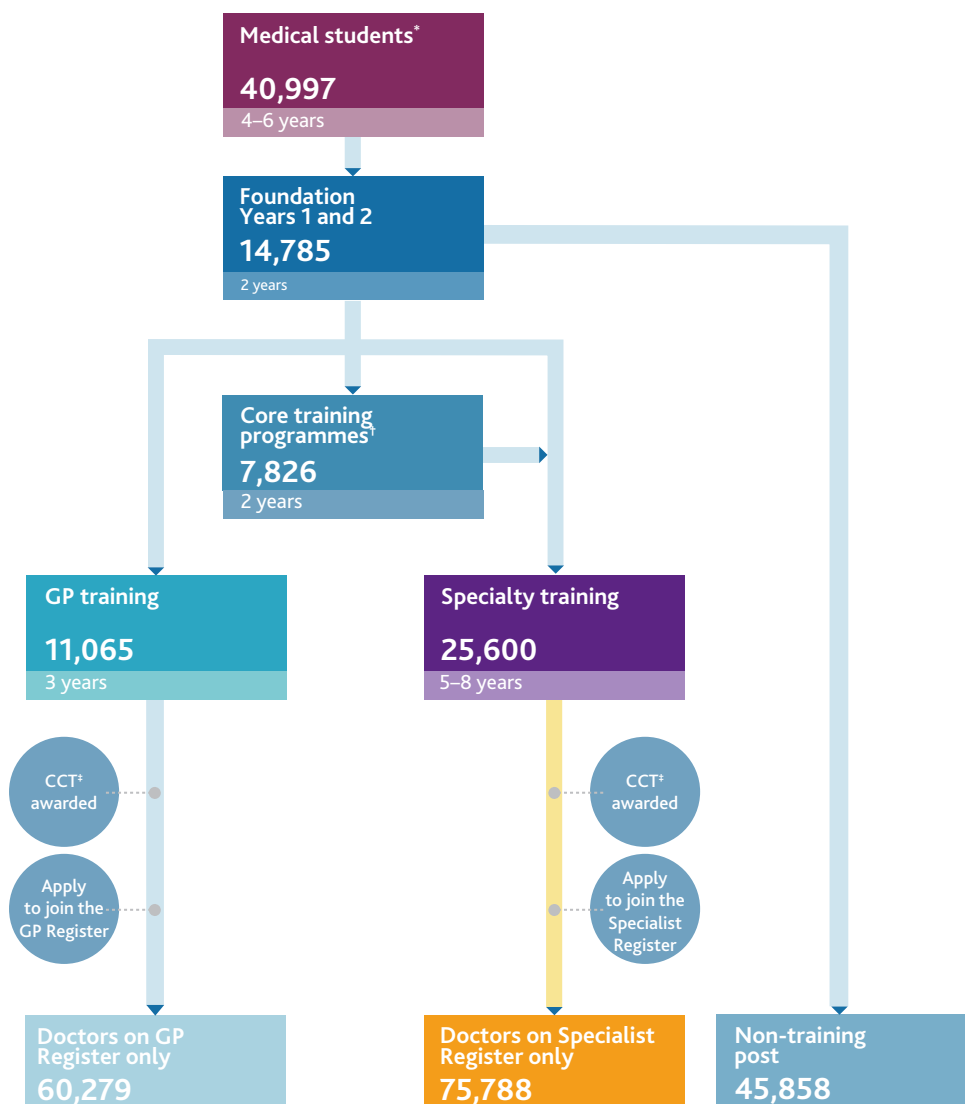
Future supply of UK-trained doctors

Medical students pass 40,000 mark

In 2017¹⁵ we reported that there were 39,185 medical students in 2016, but by 2017 (the most recent year for which we have data) this had risen to 40,997. The enduring popularity of medicine

as a degree is encouraging and reassuring, particularly because it comes amidst a dip in the population of UK 18-year-olds, who provide a significant proportion of the new medical students each year.¹⁰

Figure 12: Medical students and doctors at each stage of medical education in 2017



* Not all medical students and doctors in training will continue to the next stage – they may pause their training, leave the profession or change their training programme. Doctors who are on both the Specialist and the GP Registers are not counted in this figure.

† Core training programmes include acute care common stem, broad based training, and other core training programmes.

‡ Certificate of Completion of Training (CCT).

Welcome increase in doctors entering training in general practice and emergency medicine, but decline in psychiatry worrying

Over the seven years from 2012 to 2018 observed in this report, the total number of doctors in training has gone up only 1%, and still falls short of the number of training posts available. The number of GP doctors in training is up by more than 10%, which is welcome given the shortages

we noted earlier. Emergency medicine also increased by 144% to 1,520.

At the same time, the need for mental health support in the UK is increasing, and psychiatry is a specialism reducing in number overall at a UK level. There has been a reduction in the number of trainees opting for psychiatry of almost 12%, highlighting the need for a strategy to recruit these doctors from outside the UK, at least in the short term.

Figure 13: Doctors in training by programme specialty group, showing Foundation Programme training, and the ten largest specialty programmes from 2012 to 2018

	2012		2018
	Number of doctors	% change	Number of doctors
TOTAL (including all other programmes)	58,688	1.0%	59,276
Foundation Programme	15,028	-1.6%	14,785
General practice	10,029	10.3%	11,065
Core elements of specialty training	8,710	-10.1%	7,826
Medicine	6,497	2.3%	6,646
Surgery	4,371	-5.9%	4,115
Paediatrics and child health	3,629	2.7%	3,727
Anaesthetics	2,844	-6.5%	2,660
Obstetrics and gynaecology	2,311	-6.8%	2,155
Radiology	1,501	16.9%	1,754
Emergency medicine	624	143.6%	1,520
Psychiatry	1,370	-11.8%	1,208

Breaks in training

Taking time out of approved training is common for a variety of reasons, only some of which include not practising medicine at all. An exploration of doctors' experiences found that taking a break in training does not necessarily mean a break from working in medicine. Many doctors spend the time working in UK healthcare, in medicine abroad or studying.⁴⁰

Around a third of the current training population has taken a break in the past five years, and breaks immediately after completing the Foundation Programme are increasing, from 30% in 2012 to 54% in 2016.

A very small number of doctors who completed the Foundation Programme have not returned to approved training programmes in the UK after five years (525 or 7% of the 2012 Foundation Year two cohort). However nearly 90% of doctors who

complete the Foundation Programme go on to enter specialty or core training in the UK within three years. We are still looking at why more doctors are taking a break after completing the Foundation Programme.

In July 2018 we published the second in a series of GMC reports into doctors' training pathways, looking at the reasons, motivations and experiences of doctors who choose to take a break during their training.⁴⁰

The report found the three main reasons for taking a break in training were:⁴⁰

- doctors' health and wellbeing (including their work-life balance)
- uncertainty about their choice of specialty and career direction
- dissatisfaction with their training environment.

Doctors leaving the workforce

We define a doctor as leaving the profession – ie leaving the pool of doctors able to work in the UK – if they have given up their licence to practise for any reason and do not regain a licence within the next year. This means that we have reliable data only to 2017. Figure 14 shows that 9,314 doctors left the profession in 2017 out of the 236,732 licensed doctors – 3.9%.

The total number leaving each year rose from 7,637 in 2012 to a peak of 14,542 in 2015 as the introduction of revalidation led to some doctors – particularly those not practising in the UK – relinquishing their licences as described in our 2017 report.¹⁵ This effect has now worked its way through as all doctors have had the date for their first revalidation within the past five years. The overall proportion of those leaving the profession in 2017 (3.9%) was up from 2012 (3.4%).

It is notable though that the number and proportion leaving in 2017 were about a fifth higher than in 2012. This may in part be due to doctors already feeling the pressures that those still practising have reported to us in 2018, leading to high numbers of these intending to leave over the next three years. The issue of how to retain doctors in the workforce is critical. Before turning to this, however, we need to note that the numbers leaving vary between doctors of different ages and between doctors whose PMQs are from the UK, EEA and elsewhere.

Younger UK graduate and IMG doctors are increasingly leaving the profession to go overseas

The greatest number of doctors leaving the profession are those aged 50 years and over, where 6.5% of UK graduates, 8.2% of EEA

graduates and 5.4% of IMGs left the profession in 2017, primarily to retire (for UK graduates) or go overseas (for EEA graduates and IMGs).

The number and proportion of UK graduates and IMG doctors under 30 years old leaving are considerably higher in 2017 than in 2012, which is concerning, although some of this will be due to trainees taking breaks as we discussed above.

The proportion of UK graduate doctors under 30 years old leaving nearly doubled from 1.5% (415) in 2012 to 2.7% (822) in 2017. Similar increases are seen for IMG doctors (from 3.1% (55) to 5.7% (120)). This pattern is also true for UK and IMG doctors aged 30 to 49 years, as shown in more detail in figure 14. This has a significant impact for future workforce planning.

We know from the reasons doctors give us for relinquishing their licence or undergoing voluntary erasure that younger doctors are most likely to be moving overseas, potentially to work abroad, and so may return to UK practice, though many also report they are leaving the profession for other reasons (figure 15, page 64).

The number of older doctors, aged 50 years and over, who left the profession was 15% higher in 2017 compared with 2012 for UK graduates and 28% higher for those from the EEA. Intentions to take early retirement reported to us in 2018 are also worryingly high (see below).

Figure 14: Number and proportion of doctors leaving (giving up a licence to practise for at least one year), by PMQ and age group, from 2012 to 2017

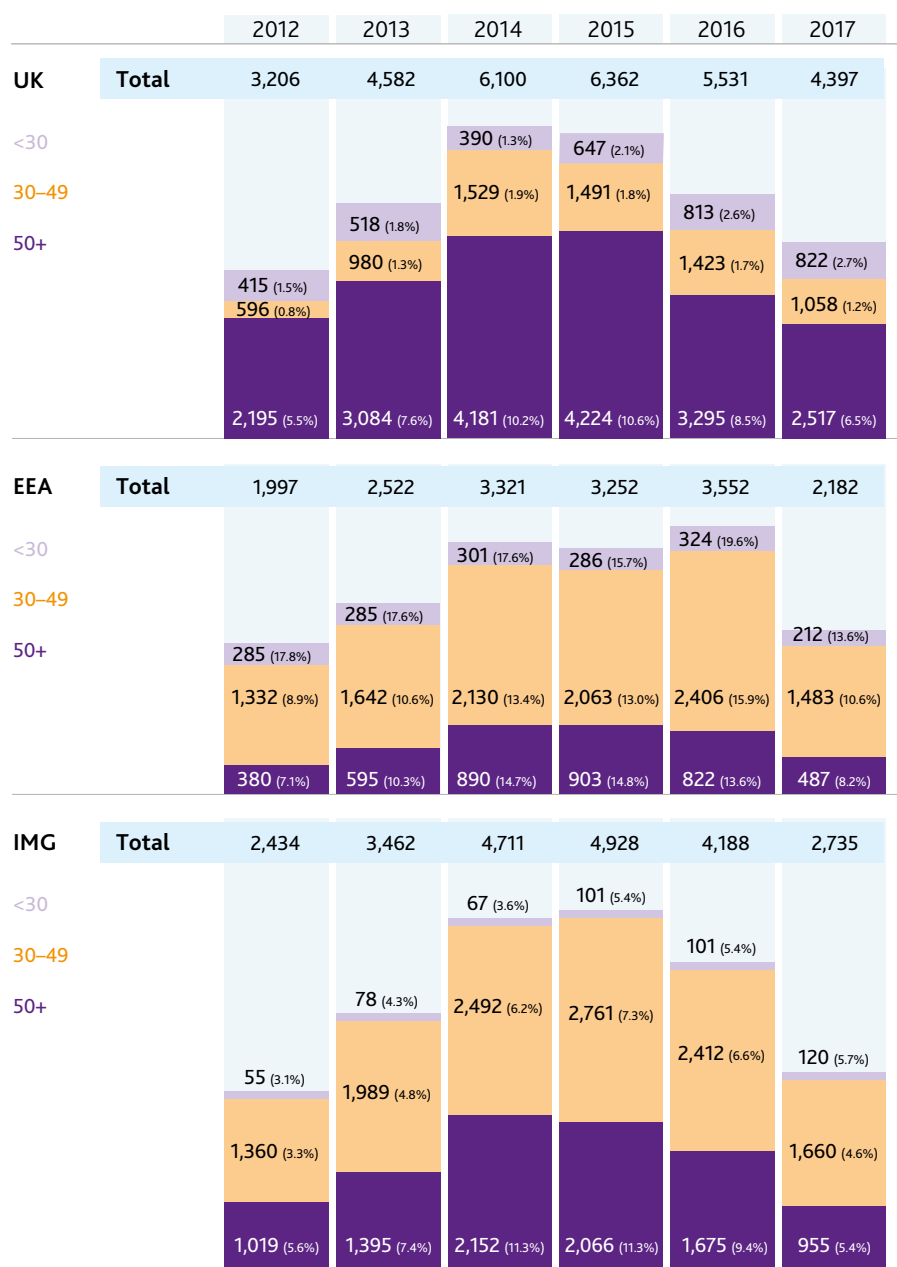
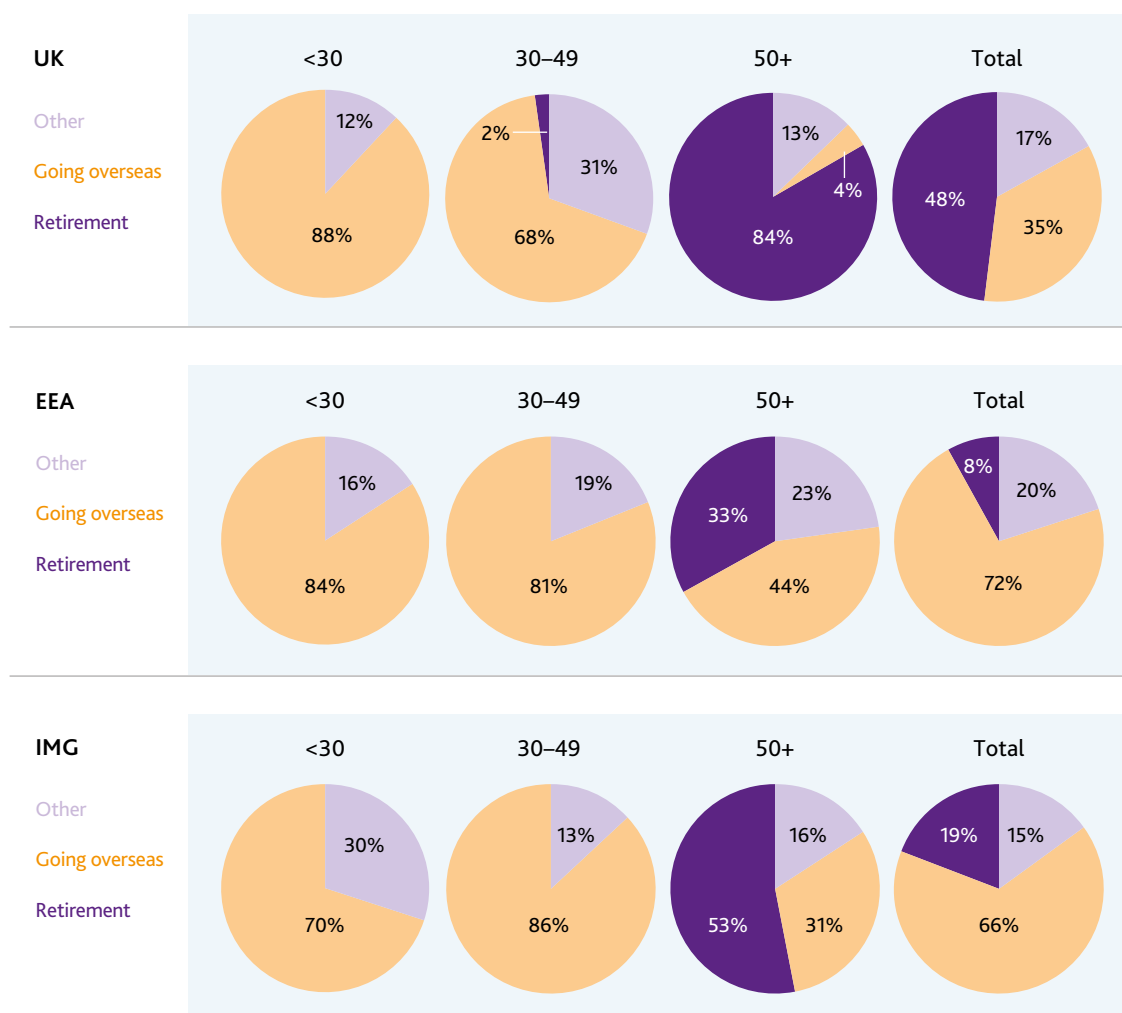


Figure 15: Doctors latest reason given for relinquishing their licence or voluntarily erasing from the medical register in 2017*



Over half of doctors leaving the profession for at least one year are under 50 years old

Obviously a high proportion of those leaving the profession will be older doctors retiring, but in 2017 57% of the doctors who did so were aged 50 years and under, broadly similar to the proportion in 2012 (53%).

Many of the doctors leaving the profession aged 30 to 49 years are doctors with IMG or EEA PMQs leaving practice in this country, often to return home to their country of origin. Over two-thirds (68%) of EEA graduate doctors and 61% of IMG doctors leaving in 2017 were aged 30 to 49 years.

* Note that doctors are counted once in this table – if they gave multiple reasons only their latest reason is used. Not all doctors provide a reason for leaving the profession, and not all who give a reason for leaving will remain without a licence to practise for a full year and therefore count as leaving the profession in our other data. In 2017 10,199 reasons for leaving were given, and 9,314 individual doctors were counted as leavers in figure 14, on page 63.

However, 24% of those with a UK PMQ who left were aged 30 to 49 years and this proportion has risen – as it has also for IMGs.

As with doctors under 30 years old, the main reason doctors aged 30 to 50 years give for voluntary erasure or relinquishing their licence is to go overseas. We do not know if these are permanent decisions. Some of these doctors may have taken a break from clinical practice for temporary non-clinical placements lasting over a year in non-clinical work, or to conduct research, or take other forms of leave, and may return to the profession later. It would be reasonable to assume however that many of the doctors leaving do not later return to clinical practice in the UK.

Doctors' future intentions to leave the profession

Evidence of doctors changing their work patterns in response to pressures

We have seen that by 2017 there are some signs of a small increase in the numbers and proportions of doctors leaving the profession.

Both of the primary research studies we commissioned for this 2018 report have shown that many doctors have made, or are considering making, changes to their working patterns including leaving or reducing their hours.^{2, 6} Doctors cite a range of reasons for this, which we discuss in more detail in chapter 3.

It is of course uncertain the degree to which intentions will be put into practice and what the overall impact on the supply of doctors will be. The raw numbers and the tenor of the comments made to us suggest that urgent action is needed to ensure that doctors are supported so that they do not leave just because the pressures on the system make their role as a doctor feel untenable.

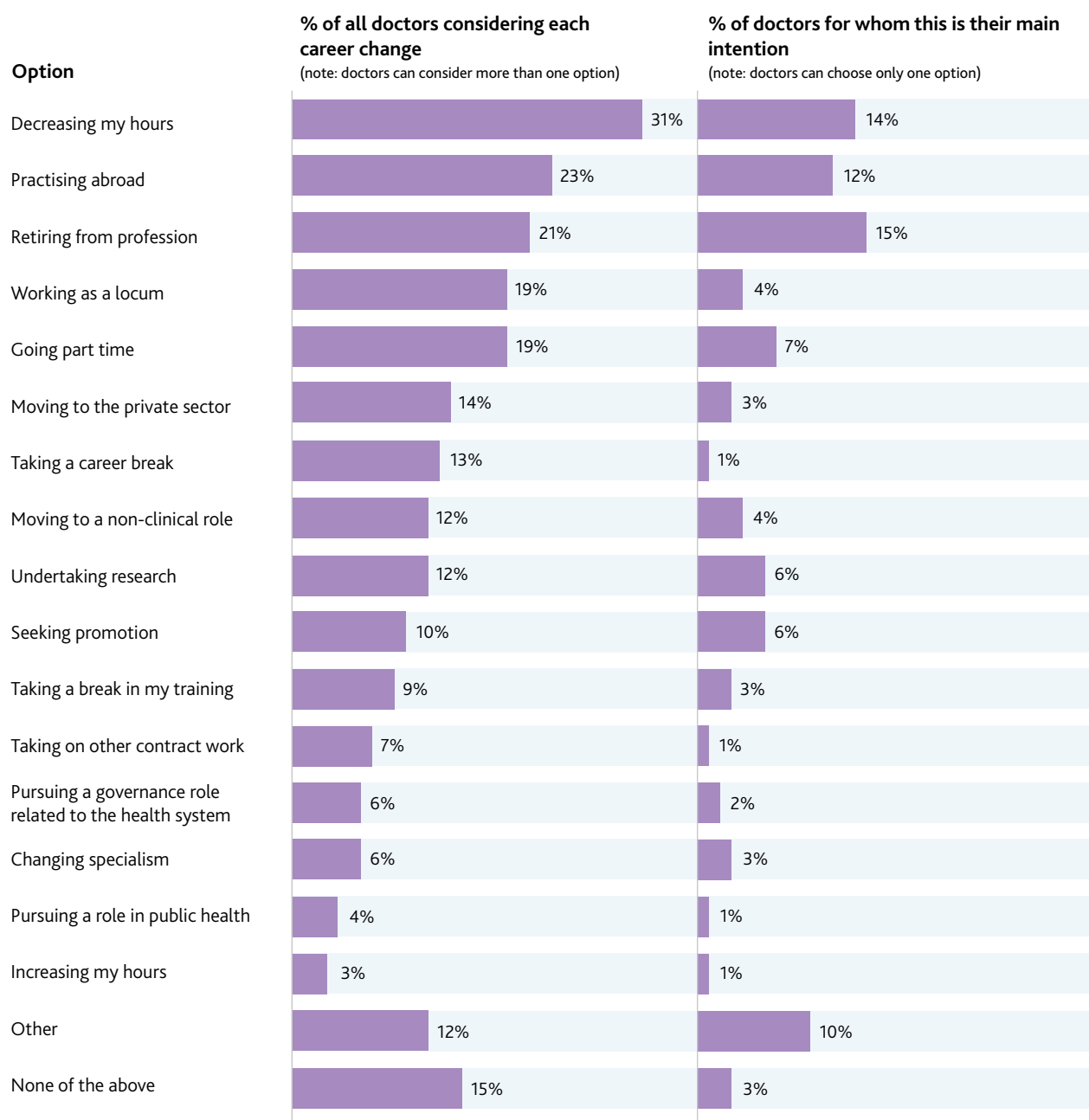
Intentions to reduce hours and work part time

Almost two fifths (38%) of all practising doctors are considering either (or both) going part time or reducing the hours that they are working. 21% of doctors gave these as the main career change they intend to make over the next three years (figure 16, see page 66).

Part-time work can mean different things to different people, especially in medicine, but it does represent a reduction in the number of hours worked.

Going part time in the next three years is more likely to be considered by younger doctors (those aged 18 to 34); 28% said that they had considered this change compared with 16% of doctors aged 35 to 54 years, and 16% of doctors aged 55 years and over.²

Figure 16: Survey results showing doctors stating they are considering a change to their career, by type of change 2018



WIMTBAD, table Q27 and Q27a

Younger doctors' intentions to leave the UK workforce are concerning

The research explored doctors' career intentions over the next three years. Almost a quarter of doctors (23%) reported that they are considering practising abroad and 21% are considering retiring. GPs and specialists are almost equally likely to be considering retiring (29% and 28% respectively).²

Two thirds of older doctors aged 55 years and over are looking at retiring as one of their options, and 52% said this was the main career change they were planning.² This pattern is broadly similar across GPs, specialists and doctors on neither register and not in training.

It was concerning that the survey found 13% of doctors aged 35 to 54 years were also considering retiring in the next three years as one of their options, with one in every 14 of these doctors (7%) saying that retirement is the main career change they are considering.²

The findings also showed that younger doctors (18–34 years) are more likely to be looking at practising abroad (28% of this age range).²

This represents a considerable risk to the workforce if a high proportion of those intending to leave and/or reduce hours actually do so over the next three years.

Non-UK doctors are more likely to be considering leaving to go abroad

Unsurprisingly, the survey found that doctors who qualified outside of the UK were much more likely to be considering leaving the UK to practise abroad (35%) than those who qualified in the UK (19%).² For non-UK qualified doctors, practising abroad is by far the main change to their careers that they have been considering. This may be

particularly concerning for regions of the UK where there are a higher proportion of non-UK PMQ doctors such as the East Midlands, West Midlands and East of England, which all have above-average numbers of non-UK PMQ doctors, as we show in the reference tables supplied alongside this report.

However, the fact that one in five of those who qualified in the UK is also considering leaving to practise abroad is also concerning.² Some reasons doctors gave for leaving the UK were related to comparing the current conditions of working in the UK unfavourably with those perceived abroad, rather than a positive desire to get experience overseas.

Intentions will not always turn into action, but a third are considering leaving clinical practice

We must proceed with caution when considering the likely impact of these intentions. A stated intention in a survey might translate into action by the doctor – but it might not.

Nevertheless the findings exploring career change intentions do indicate that a third of doctors are considering as their main career intention a course of action that would result in them no longer working in clinical facing roles* (figure 16).²

Further research is needed to understand how doctors' intentions may in future convert into action in the context of the current environment. But it is apparent that substantial numbers of doctors who have not yet left the profession are already taking the action of reducing their hours. We now turn to this.

* This includes doctors who said they intended to retire from the profession and/or take a career break and/or move to a non-clinical or governance related role and/or practise abroad.

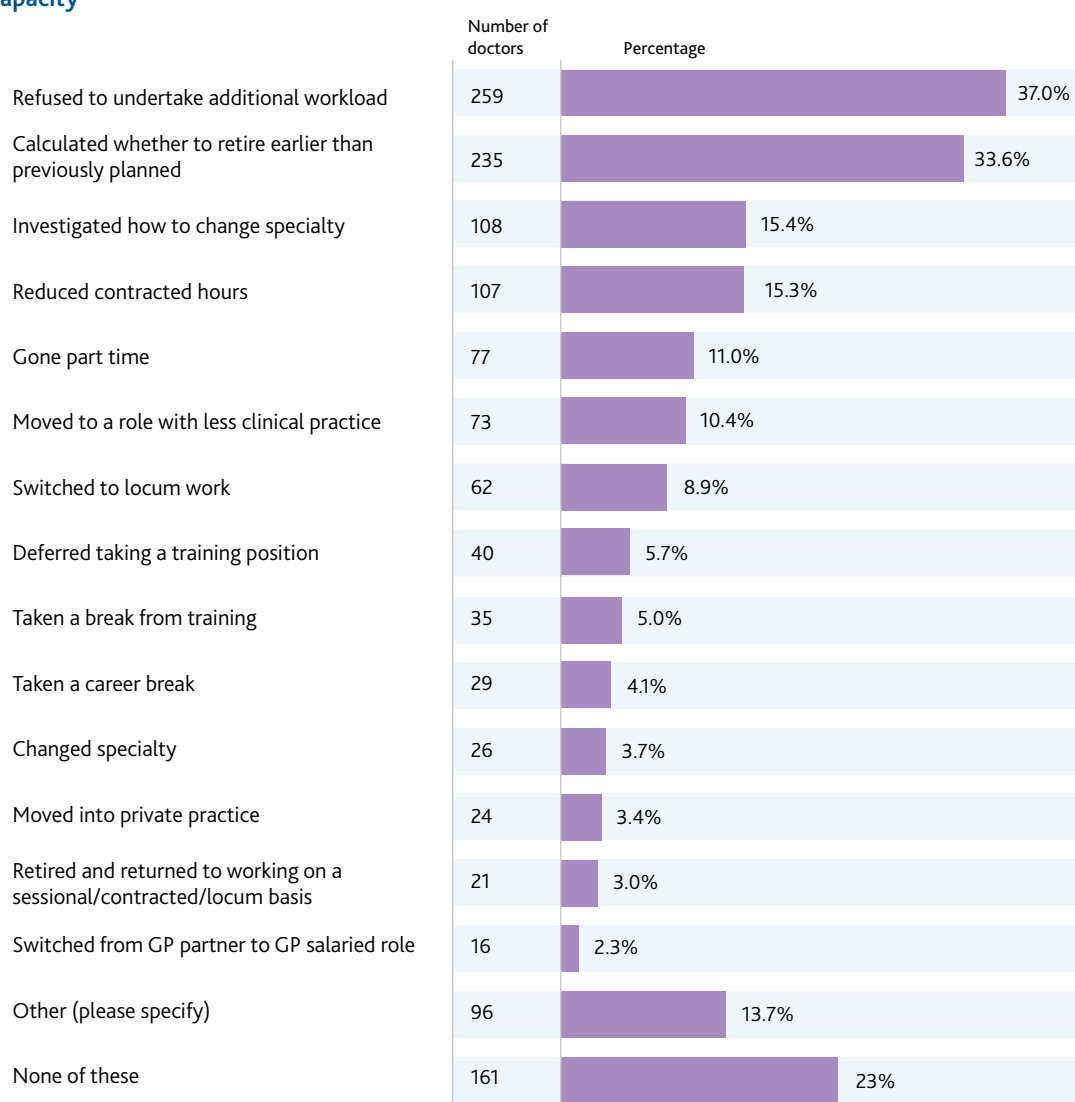
One in four doctors has already reduced their hours as a result of pressures

The number of doctors intending to leave or reduce their hours in the future is worrying, particularly as many doctors still practising have already taken steps to reduce their hours in the face of pressures.

Around a quarter (26%) of surveyed doctors* have said that they are working fewer hours by either going part-time or reducing their contracted hours, with the proportion of younger doctors aged 45 years and under reporting this being only a little below that of doctors older than 45 years (18% compared with 23%).⁶

One tenth of the surveyed doctors (10%) reported that they have moved to a role with less clinical practice.⁶

Figure 17: Doctors reported adjustments to their work in the past two years as a result of pressure on workload and capacity



ACC: Q5

* 700 doctors were surveyed in the *Adapting, coping, compromising* research project (reference 6 only). See the data note on page 139 for more information.

A third of surveyed doctors said they have calculated whether they can retire earlier than previously planned, which confirms the potential strength of the retirement intentions of doctors under retirement age.⁶ Furthermore, almost two fifths (37%) of surveyed doctors reported that they have refused to undertake an additional workload in the past two years (figure 17).⁶

System and environment pressures leading to nearly 30% of doctors considering career changes

Doctors were asked why they were considering making changes to their career in the next three years.

Work-life balance is a strong motivation for many with almost two fifths (38%) saying they want to be able to spend more time with their family.²

System and environment pressures are cited as reasons for considering change by sizeable proportions of doctors, with over a quarter (28%) saying that they are considering career changes because the current system presents too many barriers to patient care. A similar proportion (27%) said that their role demands too much of them.²

Individual reasons related to career development and progression were also important. Wanting to fulfil their potential was cited by 28% of doctors, and wanting a new challenge was mentioned by 23% of doctors.²

Doctors who had left the medical profession were asked why, with some of the reasons provided verbatim below:²

“Working in the NHS is a toxic environment. Moreover short rotas were ruining my life and health.”

“After 25 years working in the NHS as a non-consultant career grade doctor, I had been working in the same job for ten years. External pressures within the service meant that my role had been changed.”

“As a trainee, I was not given the resources or support that I needed to care for patients successfully.”

Those who said they had moved abroad also provided reasons for doing so:²

“Better lifestyle, better pay and benefits than the UK.”

“Better working conditions, better pay. Not as stressful. Life is more affordable. More respected as a profession. Better care provided for patients.”

“Brexit and the political situation in the UK with a health and social policy which did not resonate with me...”

There are positive signs that the shape of the workforce is improving, but much still needs doing

There are many positive signs about the UK workforce in this chapter. We are seeing an increasing pool of doctors potentially available for the workforce with the number of licensed doctors on the register and students studying medicine rising. We are also seeing signs that gaps in the workforce for GPs are being improved through the increase in doctors undertaking training in general practice. Moreover, the GMC is taking steps to address supply issues. As part of our flexibility review we have:

- introduced new curricula standards and generic professional capabilities which focus on the generic skills that doctors need, so enabling greater movement between specialty areas
- consulted on our guidance for supporting doctors in training with health and disability issues, *Welcomed and Valued*,⁴¹ which can help to ensure that the profession is open to all

- aimed to move towards a system where outcomes are measured rather than being based on time spent in approved training, helping to remove artificial blocks that stop doctors from moving through training.

However, there is much to do to address the concerns of the profession and the areas of risk we have highlighted in this chapter. Chapters 3 and 4 explore in more detail how some of these issues are affecting the profession, and the implications for maintaining in the future both the supply of doctors and the high professional standards that doctors aspire to. There are some particular actions that can be taken – both short and medium term – by the GMC itself and in collaboration with others directly to mitigate some of the workforce risks highlighted in this chapter and the following ones, and we set these out in chapter 5.



Supporting doctors working under pressure



More patients, plus increased complexity of

cases, combined with a shortage of experienced staff causing steep rise in pressures



A quarter of doctors can't cope with their workload at least weekly



Two-thirds of doctors work beyond rostered hours every week. 60% of those surveyed say work-life balance down in past two years

Doctors' sense of responsibility to patients and colleagues means they take on more work than they can sustain

Around

25%

of surveyed doctors have witnessed patient safety being compromised at least weekly

Smarter working is being applied and is helpful, but many feel limits of this already reached

Prioritising only urgent care needs leads to reduction in CPD, reflection and other activities essential to the long-term wellbeing of health systems and patients

Doctors frequently work beyond their role, 'acting-up' and 'acting down' in response to staff shortages. They see this as risky, demotivating and inefficient

Introduction

In our 2016 and 2017 *The state of medical education and practice in the UK*, we've reported that the system is under pressure, and that the profession is at a 'crunch point' in continuing to provide safe care for patients with limited resources.^{14, 15}

Through the research we've commissioned and the data we've analysed, we believe that the situation has steadily deteriorated and the system is coming dangerously close to being unsustainable despite doctors' dedication to patient care and safety. Many environments are clearly not working – risking driving doctors out of practice and compromising their ability to deliver the safe, high-quality care they want to deliver.

The pressures our health system is facing are well known. The UK government is responding with new investment in the NHS in England, a new NHS plan and workforce strategy in England, the already published *National health and social care workforce plan* in Scotland,¹⁷ the planning framework and health delivery plans in Wales,¹⁸ and the *Quality 2020* ten year strategy in Northern Ireland.¹⁹ These represent timely opportunities, which need to be acted on fully to make sure they target the areas where doctors are telling us loud and clear they need more support.

Urgent calls to action on specific issues have been highlighted by specific professions and groups of doctors.

- GPs in Wales have called on the Welsh government to provide more funding to reduce the pressures of understaffing and rising workloads in primary care.⁴²
- The Royal College of Radiologists in Scotland has said their specialty is on 'red alert' because of a staff shortage and its effect on cancer tests.⁴³ This has been echoed by the Care Quality Commission (CQC) in England calling for the variation in radiology reporting timescales to be addressed.⁴⁴
- In early 2018 the Royal College of Emergency Medicine urged patients to write to their MPs asking for action to address the serious challenges facing emergency departments across the country as a result of the severe winter pressures A&E departments faced last winter.⁴⁵

In our submission to the Williams review into gross negligence manslaughter in healthcare⁴⁶ we made it clear that the underlying pressures in the system are widespread, not isolated, and are likely to remain.

Evidence from our primary research sources and wider literature shows that the pressures are affecting doctors' ability to care – the motivating factor of many doctors choosing to go into medicine being the opportunity to help and care for others – and that the aspects that are fundamental to them achieving job satisfaction are being hindered. Doctors are working long hours, with many finding it hard to cope, and feel unsupported by management.

And as we saw in chapter 2, a number are regularly thinking about stopping practising medicine altogether.

In this chapter, we look at doctors' experiences of training and working in a system under pressure. Doctors are doing their best to manage pressure

and maintain levels of patient care and safety, and we examine some of the strategies and coping mechanisms they are adopting. We also identify the concerns we have about the impact of pressures and how sustainable the strategies and coping mechanisms are, and consider the support doctors tell us they need.

Evidence sources used in this chapter

The data we present in this chapter mainly come from two commissioned independent research projects: *What it means to be a doctor*; and *Adapting, coping, compromising*. The fieldwork stages for these projects recently concluded, and have produced a wealth of data and evidence that we are in the process of analysing. Each study involved a mixed methods approach, such as in-depth interviews and online surveys.*

There are some emerging findings that illuminate the impact of pressured environments on patient care, which we feel are important to share at this stage. We will publish the full report of each of these projects in the first part of 2019, providing a more nuanced exploration of these findings for doctors at different career stages and in different areas of practice and localities.

* For further details of these research projects, see research and data notes from page 139.

Doctors' experiences of working in a pressurised environment

We saw in chapter 2 that concerning numbers of doctors are considering reducing their hours or leaving clinical practice in the UK altogether for reasons other than retirement at the usual retirement age. For example during 2017–18, a quarter of doctors surveyed said they had considered leaving the medical profession at least once a month.² Low morale and a decline in optimism may underlie these considerations.

The primary research for this 2018 report indicates that the doctors considering leaving and reducing their hours are often contemplating these as a final resort in the face of the increasing pressure they have been working in.

Types of pressure

Research interviews with doctors found they experience both external and internal pressures.¹ External pressures relate to whether they will be able to do their job with the limited time and resources available. Internal pressures are about whether they believe they will be able to do that job well. The research found that external pressures often exacerbate internal pressures.

In the interviews, doctors also discussed how their own feelings of responsibility lead them to take on more work than they can strictly manage. They know they will put themselves under pressure, but feel an obligation to patients and colleagues. An example is feeling obliged to take on extra work to avoid unfilled shifts, though the doctors are aware they may not be technically responsible, and that it will adversely affect their work-life balance.¹

External pressures: workload and administration

In the interviews, doctors identified a range of external factors that cause them to feel pressured. The sources of pressure most commonly cited include:¹

- **increasing number of patients**, particularly those with **co-morbidities**
- **specific time periods**, when there is high demand and/or a shortage of experienced staff
- the overall system, including **targets and administrative requirements**.

Also mentioned in the interviews were cuts to other services, such as mental health services, which left doctors to pick up the pieces. Doctors said external factors, including media reporting that triggers patient concerns, contribute to pressure too.¹

There was broad consensus that pressures had worsened in recent years. Even those who remembered having worked exceptionally long hours earlier in their careers felt that pressure had intensified in terms of the volume of patients and the responsibility taken on by doctors.¹

Increasing numbers of patients and co-morbidities

In the interviews, many doctors felt there were more patients than it was possible to see and the amount of time in which to see each patient was more limited than at earlier stages in their careers.¹

Doctors have consistently reported that difficulty coping with high workload and intensity is exacerbated by the increasing complexity of patients' cases. One aspect of this is more patients having multiple long-term medical conditions. Three out of five doctors believed this increased multimorbidity has had a negative effect on their work. GPs felt this in particular, with four out of five stating it has had a negative impact.²

Specific time periods

In the interviews, doctors identified specific periods of time associated with high pressure. These are periods of either:¹

- high demand, such as winter or Monday mornings, leading to staff being stretched to meet demand or
- shortage of experienced doctors, such as August rotation or over weekends.

Targets and administrative requirements

Several administrative aspects of the healthcare system were raised as sources of pressure in the interviews. Some doctors identified meeting targets, particularly the A&E four-hour waiting time, as a significant source of pressure. It was expressed that meeting this target is difficult, because there are so many patients to see and not enough staff to see them. And because pressure is put on doctors to meet the target, this becomes the priority, rather than making sure the patient receives the right standard of care.¹

Other sources of administrative pressure were cited. Managing rotas by swapping with colleagues to make sure shifts are covered was mentioned as a burden. Doctors in more senior positions identified non-medical administration associated with their role, such as contributing to campaigns and preparing business cases,

while also maintaining a high-quality service to patients.¹

Doctors are also seeing an increase in the amount of audit documentation they must complete. Half of doctors said audit documentation associated with their role has increased over the past three years. Only one in ten said it has decreased.²

External pressures: staff and other resource availability

Doctors interviewed also identified particularly significant sources of pressure relating to resources (with consequent time pressures) and other doctors.

Lack of staff

A shortage of experienced staff was by far the most cited source of pressure in the interviews. Sometimes this was simply too few doctors, or other healthcare professionals, overall. But often the issue was insufficient doctors with the right level of experience and skills.¹ In this context, the reported intentions of many experienced doctors to give up on clinical practice in the next three years, reported in chapter 2, is exceptionally worrying.

Lack of resources

For many doctors, a lack of hospital beds caused significant pressure. These doctors reported a huge amount of time and energy is spent trying to source beds. If they can't get the required beds, or feel they may be unable to do so, doctors can find this incredibly frustrating and stressful.¹

Some doctors also mentioned computer system issues as a contributor to pressure because they did not work, were inefficient, or were prohibitively complicated.¹

Unnecessary referrals

Unnecessary referrals from other doctors were identified as a source of pressure for GPs in particular. Though GPs recognised the referring doctors were under pressures of their own, they felt the use of referrals in this way needed to change. Examples in the interviews illustrated that as well as the transfer of pressure from referring doctor to GP, such referrals also cause unnecessary delays to patients' treatment.¹

Reliance on locums

Locum doctors are often relied on in times of high pressure. But the interviews revealed a feeling that locums were usually not as beneficial as an employed doctor. Locums were regarded as less able, or less committed, to providing high-quality care. At the same time many doctors saw becoming a locum as a strategy they might adopt, sometimes as a method of addressing issues with their work-life balance, in a system under pressure.¹

It has been known for some time that the system shouldn't assume locums are intrinsically a problem, but should address issues new locums face such as lack of familiarity with local staff and systems, to enable locums to be more effective members of a clinical team.³⁴ The increase in the number of locums and other temporary workers mentioned in this 2018 report and elsewhere means these issues need to be prioritised.

How doctors are experiencing pressures

Most doctors generally felt that pressure levels had risen over the past few years. However, the extent to which they as individuals felt they were working under high pressure varied according

to a number of factors. These factors include the doctor's specialty, seniority, location and frame of mind, and the extent to which they felt supported by their organisation, or had control over their workloads or careers.¹

Many doctors felt working under pressure has come to be accepted as the new 'normal'. This pressure has been experienced by doctors in two main ways:¹

- increased volume and intensity of work, leading to working longer and harder
- deterioration in work-life balance and more days of particularly high pressure.

Working beyond contracted hours to keep up with increased workload

The research interviews found that the strategy most likely to be adopted by doctors to deal with working in a system under pressure was simply to work more.¹ This is achieved both by increased work intensity and by more time spent working.

Most doctors interviewed were working beyond their contracted hours, and many were missing out on breaks during their shifts. Doctors also found themselves catching up on work or training in their free time or on annual leave. Though these strategies were not adopted willingly, doctors felt that sometimes they were the only available options.¹

Interview findings were strongly echoed by survey results exploring hours worked by doctors. Over two thirds (68%) of doctors reported that they worked beyond their rostered hours at least once a week in the last year. Over four fifths said they did this at least once a month (81%).²

Figure 18: Indications of pressures experienced by doctors: overwork

Over the last year how frequently have you experienced the following?

	At least once a week	At least once a month	Less than monthly	Don't know or prefer not to say
Worked beyond my rostered hours	68%	81%	17%	2%
Felt unable to cope with my workload	25%	40%	58%	2%

n=2,249 (all practising doctors), WIMTBAD Q24, weighted, net values used – see research notes on page 139 and web annexe

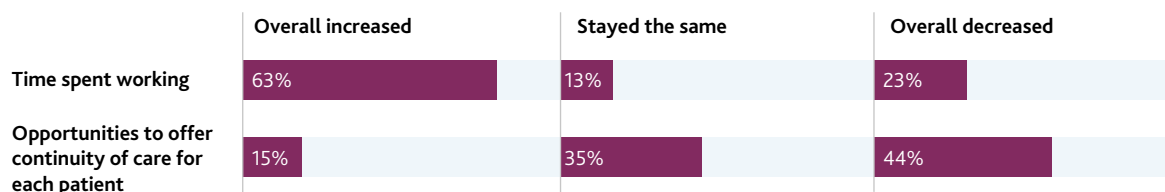
Additionally, in the past year a quarter (25%) of doctors felt unable to cope with their workload at least once a week, and two fifths (40%) at least once a month.²

Three out of five doctors (63%) said the time they spend working has increased over the past three years, and only 23% said they now spend less time working. This is in stark contrast with

feelings around patient continuity of care. 44% of doctors said that opportunities to offer patients continuity of care have decreased, with just 15% saying they have increased.² Doctors are working longer, but are less able to provide continuity of care in the face of increased work and system pressures.

Figure 19: Changes over the past three years: time working and patient care

In the past three years, have any of the following increased or decreased for reasons other than changes in your level of seniority?



n = 2,119 (all respondents who have been practising as a doctor for over three years), WIMTBAD Q22, weighted, net values used – see research notes on page 139 and web annexe

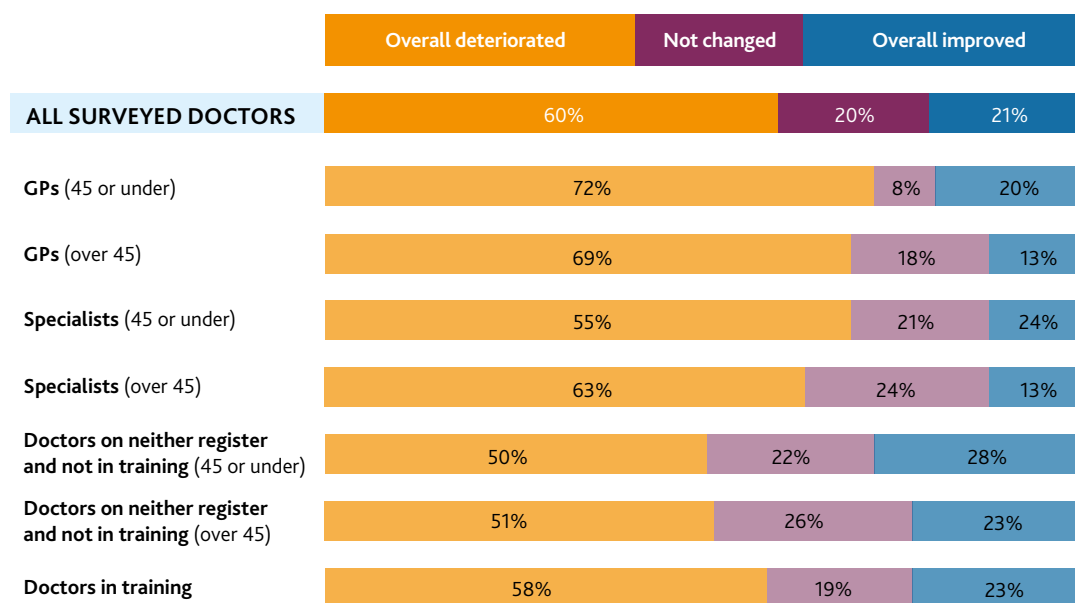
Deterioration of work-life balance

The majority of surveyed doctors* (60%) reported that their satisfaction with their work-life balance has deteriorated (either somewhat or significantly) in the past two years. A fifth of surveyed doctors (21%) reported that it has improved.⁶

This deterioration is most pronounced for GPs, and is worst among younger GPs. Almost three quarters of the younger GPs surveyed (72%) felt their work-life balance has deteriorated. A third of younger GPs (33%) said their satisfaction has significantly deteriorated; the highest proportion of any group, and 11% greater than the rate for all doctors (22%).⁶

Figure 20: Change in satisfaction with work-life balance over past two years

To what extent has your level of satisfaction or dissatisfaction regarding your current work-life balance in your practice changed over the last 2 years? (Single response)



n = 700 (all respondents), ACC Q2, unweighted, net values used – see research notes on page 139

* 700 doctors were surveyed in the *Adapting, coping, compromising* research project (reference 6 only). See the data note on page 139 for more information.

More high-pressure working days: over half are high pressure

The surveyed doctors were asked to assess their activity over a typical four-week (28-day) period. They estimated the number of days they would work and the pressure they would expect to be under on those days. The results for all doctor types indicate that in this period a doctor would be contracted to work 19 days, with seven nominally non-working days.⁶

Of the 19 days contracted to work, surveyed doctors rated around eight or nine of these days as being high pressure and two days unsustainable pressure. This means over half of

the working days are at least high pressure. Of the nine days not contracted to work, two 'non-work' days involve catching up on work.⁶

GPs who were surveyed estimated a greater number of pressured days. They said about twice as many days are high or unacceptable pressure as are lower pressure. Other doctor types reported about an even split of higher and lower pressure days. Doctors in training who were surveyed have fewer days that are higher pressure than lower pressure, but even they estimated nine out of 19 working days are high or unsustainable pressure.⁶

Figure 21: Different types of doctors' work pressure in a typical four-week period

How many days would you allocate to each of the following in a typical four-week (28-day) period?

	High or unsustainable pressure work days	Low or moderate pressure work days	Non-contracted work catch-up days	Non-working days
ALL SURVEYED DOCTORS	10.3	8.5	2	7.2
GPs (45 or under)	11.3	6	2.3	8.5
GPs (over 45)	11.9	5.6	2.3	8.1
Specialists (45 or under)	10.9	9	2.3	5.8
Specialists (over 45)	10.6	9.1	1.9	6.4
Doctors on neither register and not in training (45 or under)	8.8	9.9	1.9	7.5
Doctors on neither register and not in training (over 45)	10	9.3	1.6	7.3
Doctors in training	8.6	10.6	2.1	6.7

n = 700 (all respondents), ACC Q3, unweighted

The number of highly pressured days faced by surveyed doctors appears to have increased over recent years, while the number of non-work days has decreased. The surveyed doctors were asked to estimate how the number of days they would allocate to each category has changed over the past two years:⁶

- Just over a third of doctors (34%) said the number of unsustainable pressure days has increased. Only 13% said the number has decreased.
- More than half of doctors (56%) said the number of high-pressure work days has increased. Only 13% said the number has decreased.
- Around a third of doctors (32%) said the number of days not working at all has decreased. Only 16% said the number has increased.
- Over a third of doctors (37%) said the number of days they catch up on work though not contracted to do so has increased. Only around 14% said the number has decreased.

These findings support doctors' statements, in the interviews, that the pressures they experience affect their ability to support one another and function effectively.¹ The pressures also affect doctors' commitment to staying in the medical profession. The consequences of pressure appear to have had a concerning effect on doctors' ability to support each other and on patient care. We turn to the first of these in the next section and then consider four groups of strategies that doctors are using in the face of these pressures. Some of these strategies indirectly affect patient care, while the last has a more direct impact – not necessarily on immediate patient safety, but certainly on the longer-term quality of care a patient receives.

Effects of pressure on doctors

Support from management

It appears that pressure on doctors is disrupting the ability of those in senior positions to fully support more junior doctors. Three out of ten doctors said they felt unsupported by management or senior management each week.²

Doctors on neither register and not in training and older specialists seem to be least well supported by management. 35% of doctors under 50 years old on neither register and not in training, and 37% of the same group aged 50 years and over, reported feeling unsupported by management or senior management once a week or more, as did 35% of specialists aged 50 years and over.²

The findings could indicate a risk that older specialists are more likely to be poorly supported by management, and therefore be more prone to take more work, pressure and responsibility upon themselves. However, it might be the case that older specialists as a group are more likely to come into more frequent and direct contact with management or senior management, which could affect their experiences.

Figure 22: Indications of pressure: lack of support from management

Over the last year how frequently have you felt unsupported by the management or senior management?

	At least once a week	At least once a month	Less than monthly
ALL DOCTORS	30%	44%	50%
GPs (under 50)	23%	36%	51%
GPs (50 and over)	29%	41%	47%
Specialists (under 50)	30%	43%	55%
Specialists (50 and over)	35%	49%	47%
Doctors on neither register and not in training (under 50)	35%	49%	45%
Doctors on neither register and not in training (50 and over)	37%	51%	46%
Doctors in training	24%	41%	52%

n = 2,249 (all practising doctors), WIMTBAD Q24_6, weighted, net values used – see research notes on page 139 and web annexe

Support from colleagues

Just under a quarter of doctors (23%) felt unsupported by immediate colleagues at least once a month.²

The most striking finding is that doctors on neither register and not in training under 50 years old felt relatively poorly supported by their colleagues. 18% of doctors in this group reported that they had felt unsupported by their immediate colleagues once a week or more, compared with 12% of doctors overall (and no other group is

above 13%). And only two thirds of doctors on neither register and not in training under 50 years old (64%) said they had felt this way less than monthly (ie rarely or never), compared with three quarters of doctors overall.²

Coupled with the relatively high level of lack of management support also reported by doctors on neither register and not in training under 50 years old, these findings highlight that this group is particularly at risk of feeling poorly supported.

Figure 23: Indications of pressure: lack of support from colleagues

Over the last year how frequently have you felt unsupported by your immediate colleagues?

	At least once a week	At least once a month	Less than monthly
ALL DOCTORS	12%	23%	75%
GPs (under 50)	12%	22%	76%
GPs (50 and over)	12%	19%	78%
Specialists (under 50)	9%	17%	82%
Specialists (50 and over)	10%	16%	83%
Doctors on neither register and not in training (under 50)	18%	33%	64%
Doctors on neither register and not in training (50 and over)	13%	23%	69%
Doctors in training	8%	23%	75%

n = 2,249 (all practising doctors), WIMTBAD Q24_7, weighted, net values used – see research notes on page 139 and web annexe

Mentoring and reflection

Asked about work changes over the past three years, three out of ten doctors (30%) said that the mentoring provided to them as part of their role had decreased. Only 18% said the mentoring they received had increased (figure 24).

GPs under 50 years old have the highest proportion reporting a decrease (41%) in the

mentoring provided compared with 30% of doctors overall. This group also has one of the lowest proportions that say mentoring has increased (7%). Though not quite as pronounced, a high proportion of doctors over 50 years old on neither register and not in training said the mentoring provided has decreased (37%), and few say it has increased (11%).²

Figure 24: Changes over the past three years: mentoring

In the past three years, has mentoring provided to you as part of your role increased or decreased for reasons other than changes in your level of seniority?

	Overall decreased	Stayed the same	Overall increased
ALL DOCTORS	30%	41%	18%
GPs (under 50)	41%	37%	7%
GPs (50 and over)	27%	40%	9%
Specialists (under 50)	31%	45%	13%
Specialists (50 and over)	28%	49%	6%
Doctors on neither register and not in training (under 50)	33%	32%	28%
Doctors on neither register and not in training (50 and over)	37%	36%	11%
Doctors in training	18%	43%	37%

n = 2,119 (all respondents who have been practising as a doctor for over three years), WIMTBAD Q22_5, net values used – see research notes on page 139 and web annexe

Just under half of doctors (49%) said the time available to them to reflect on their practice had decreased, with only 16% saying it had increased.² The situation appears particularly bad for GPs under 50 years old. Over two thirds of doctors in this group (67%) said time available to reflect

had decreased – the highest proportion by far. Only 7% of GPs under 50 years old said reflection time increased.² This is in line with other findings that have shown this group of doctors is under significant pressure.

Figure 25: Changes over the past three years: time available to reflect

In the past three years, has time available to spend reflecting on your practice increased or decreased for reasons other than changes in your level of seniority?

	Overall decreased	Stayed the same	Overall increased
ALL DOCTORS	49%	33%	16%
GPs (under 50)	67%	25%	7%
GPs (50 and over)	53%	29%	16%
Specialists (under 50)	50%	34%	14%
Specialists (50 and over)	46%	41%	12%
Doctors on neither register and not in training (under 50)	45%	28%	23%
Doctors on neither register and not in training (50 and over)	37%	41%	18%
Doctors in training	39%	40%	20%

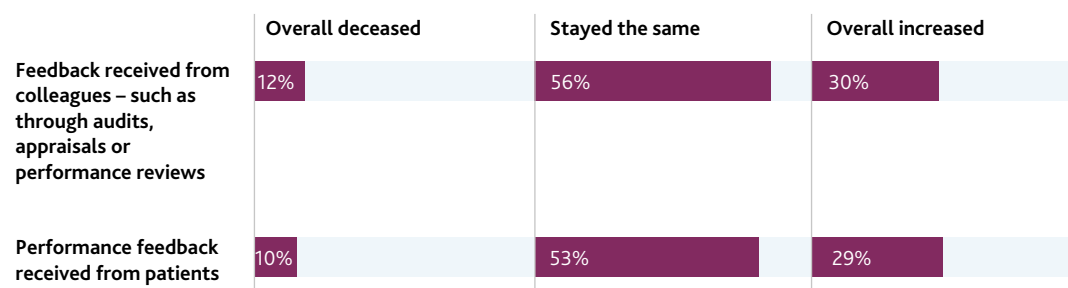
n = 2,119 (all respondents who have been practising as a doctor for over three years), WIMTBAD Q22, weighted, net values used – see research notes on page 139 and web annexe

On the other hand, doctors are receiving more feedback from colleagues and patients, possibly stimulated in part by the introduction of revalidation and the annual consideration of such material for appraisal. This may mean that, while

doctors are spending more time producing and considering feedback, many are unlikely to fully benefit from it because they have less time to reflect on feedback and less opportunity to benefit from mentoring.

Figure 26: Changes over the past three years: feedback

In the past three years, have any of the following increased or decreased for reasons other than changes in your level of seniority?



n = 2,119 (all respondents who have been practising as a doctor for over three years), WIMTBAD Q22, weighted, net values used – see research notes on page 139 and web annexe

Stress-related absences and thoughts of leaving the profession

As a result of the pressures they face, one out of four doctors surveyed (25%) reported that at least monthly in the past year they had considered leaving the medical profession.²

GPs reported having such thoughts more often than other types of doctors. Just over a third of

GPs said that at least once a month they had considered leaving the profession, compared with a quarter of doctors overall.²

14% of GPs under 50 years old said every day or almost every day they consider leaving. This is almost double the proportion of doctors overall that said this (8%).² This reflects how under pressure this group of doctors is.

Figure 27: Indications of pressure: thoughts of leaving

Over the last year how frequently have you considered leaving the medical profession?

	At least once a week	At least once a month	Less than monthly
ALL DOCTORS	17%	25%	74%
GPs (under 50)	27%	34%	64%
GPs (50 and over)	24%	35%	65%
Specialists (under 50)	11%	19%	80%
Specialists (50 and over)	16%	20%	77%
Doctors on neither register and not in training (under 50)	22%	27%	71%
Doctors on neither register and not in training (50 and over)	13%	19%	79%
Doctors in training	11%	21%	78%

n = 2,249 (all practising doctors), WIMTBAD Q24_5, weighted, net values used – see research notes on page 139 and web annexe

Pressure is having a clear impact on the ability of some doctors to function in their roles. During 2017–18 two out of every 100 doctors had to take

a leave of absence at least once a month due to stress. This increases to four out of every 100 for doctors on neither register and not in training.²

Strategies doctors are implementing to manage pressures

The research interviews and surveys explored how doctors are employing a range of different work-related strategies and personal coping mechanisms to deal with pressures in order to give patients the best care possible. Some strategies and coping mechanisms are designed to reduce or minimise pressure, while others are used to try to manage its impact.

Work-related strategies

Doctors have reported how the work-related strategies that they have implemented in response to pressures revolve around a number of areas:¹

- **Smarter ways of working** to reduce some of the pressures and help manage workloads. While many developments in this area are seen as positive, there is a sense for many that the limits of smarter working have been reached.
- **Prioritising at the expense of other activities.** Often this means withdrawal from continuing professional development (CPD), less time spent reflecting and a drop in attendance at meetings or activities that are important for the overall health system to operate efficiently and safely in the longer term. Not only is this potentially detrimental for the health system as a whole, but it is very damaging to motivation and morale as we know that some of these activities are important to doctors.
- **Changing ways of working.** This involves doctors needing to work outside of their grade and experience level (ie acting up or acting down), delegating and spreading workloads

to colleagues to help ease the pressures, and relying on patients to take more responsibility for their own health. But this can come at a cost for the individual and the team when it becomes the norm and may not be sustainable.

- **Compromising longer-term patient outcomes.** When previous strategies have been exhausted, doctors often adopt strategies that prioritise immediate patient care and safety, but potentially compromise longer-term patient outcomes. These include making referrals, simply to move the patient on, not spending sufficient time with patients and bypassing the use of clinical checklists and protocols. These are often small things but can have longer-term consequences even when they are not an immediate threat to patients. And cumulatively these strategies will potentially have a huge and widespread effect on patient care.

We now look at each of these strategies in more detail.

Smarter ways of working

The surveyed doctors have reported how they have been applying the new ways of 'smarter' working to help manage workloads more efficiently. Making such adaptations is common amongst the surveyed doctors, with around three out of four (77%) agreeing that they had been obliged to adapt their individual practice in the past two years to keep on top of their workload.⁶ The following are some examples of smarter working, which the surveyed doctors said they have used over the past two years.

Telephone communication and consultation

The increased reliance on telephone-based communication and consultation with patients was mentioned by doctors from across practice areas and recognised by them as part of everyday practice. Around half (52%) of doctors surveyed told us they had increased the number of telephone consultations over the past two years (figure 28) and doctors explained that most patient follow-ups were done over the telephone to ease the pressure on clinics.

Use of technology

Doctors have described a broad range of ways that technology is increasingly being used to help create efficiencies. Doctors talked about electronic prescribing, digitisation of records, online ordering and test result systems as ways to introduce time efficiencies.

Over half (54%) of doctors surveyed said that the digitisation in recording and accessing patient records has had a positive effect on their work; and to help ease workloads three out of four doctors have accessed blood tests online and around two thirds (66%) have accessed imaging results online (figure 28).

While technology is being used to help create efficiencies, a number of doctors in the interviews spoke about issues with computer systems, either not working or being inefficient – or being prohibitively complicated. To counter this some doctors said they use mobile apps to bypass cumbersome hospital technology.¹

More effective triage

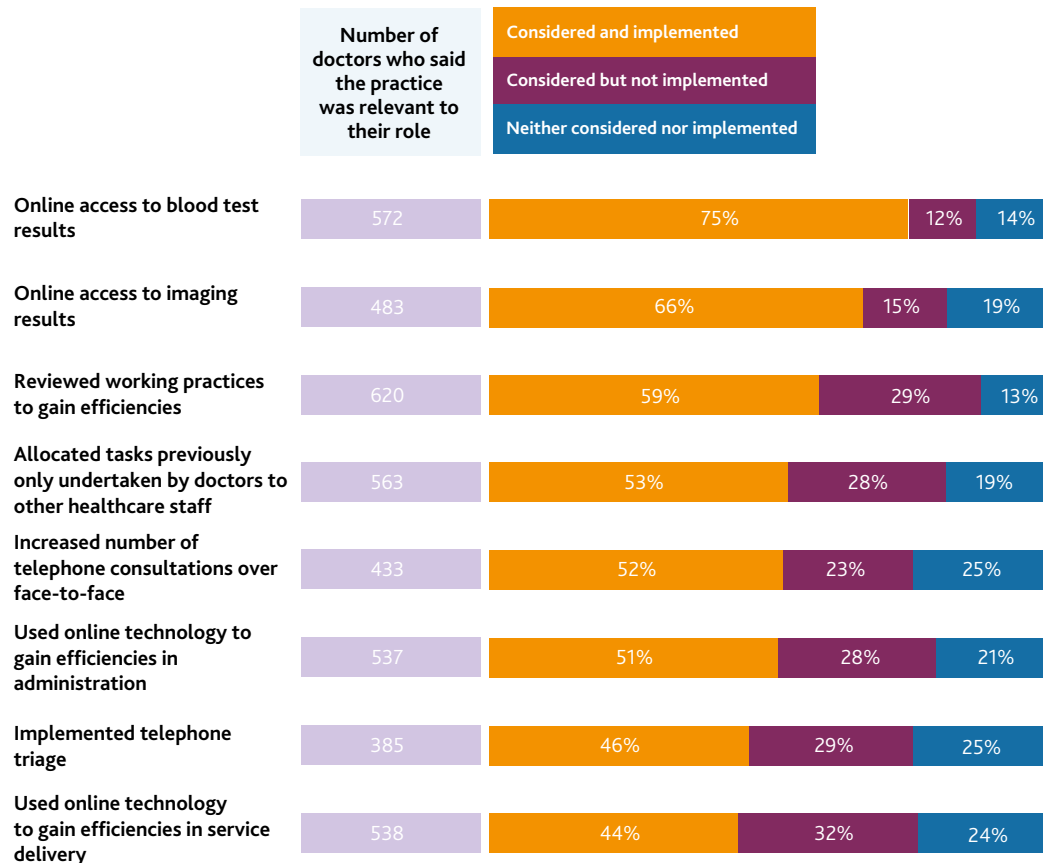
Smarter ways of approaching triage have been implemented through encouraging multidisciplinary working (such as having nurses in A&E conduct and order initial tests to save time down the line) and making more use of telephone communications. Over two fifths of surveyed doctors (46%) said they have implemented a telephone triage to alleviate pressures (figure 28).

Reducing administration

Administrative requirements were discussed by doctors as adding to the pressures they are under. Therefore, doctors told us they are often looking for ways to reduce or minimise paperwork. This includes writing patient notes in the format of a referral letter to save duplication later, only noting down 'abnormal' results in notes.¹ Around half of surveyed doctors (51%) said that by using online systems they had been able to increase efficiencies in administration duties (figure 28). While many of the time-saving techniques doctors used only saved seconds they were seen to be valuable as the time saved adds up.

Figure 28: Consideration and implementation of 'smarter' working practices

In the past two years have you considered or implemented any of the following to adjust your working practices, in order to try and alleviate pressure on workload and capacity?



n = doctors who said the practice was relevant to their role, ACC Q8, unweighted

Limitations and sustainability of smarter working

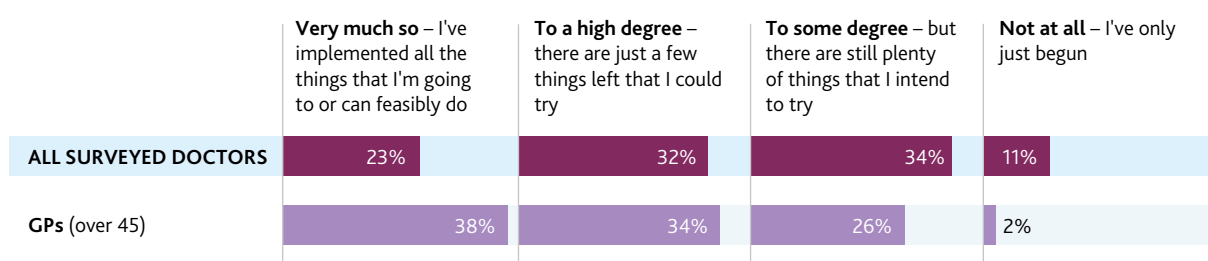
While smarter working is overall a positive phenomenon that is helping to streamline workloads, there is a sense that the limits of smarter working have been reached. Over half of doctors surveyed (55%) felt that either there are only a few things left they could try or they have reached the limit of new strategies they can put in

place to adapt to the pressures. The older GPs who were surveyed felt this strongest with nearly two out of five saying they have tried everything (figure 29, page 90).

In addition many doctors surveyed reported that they hadn't considered implementing some of these strategies. Or while they had considered them, they hadn't put them into practice.⁶

Figure 29: How much doctors feel 'smarter' working has been exhausted

To what extent do you feel that you have now exhausted/reached the limit of 'smarter' working?



n = 700 (all respondents), ACC Q8b, unweighted

For example, one in four of surveyed doctors said they have neither considered nor tried using online technology to gain efficiencies in service delivery. Between one in four and one in five haven't deliberated or tried using online technology to increase efficiencies in administrative tasks. Moreover a quarter of surveyed doctors said they hadn't considered or tried using telephones for triage or consultations (figure 28, page 89).

While it may be that this is because these new ways of working are not seen as appropriate or best for patient care it is important the reasons for not considering or implementing these strategies are investigated further to better understand why. We need to find out what we and others can do to help support doctors to implement these new ways of working where appropriate.

Finally, doctors surveyed said new, smarter ways of working are often implemented from the top down and cultural buy-in is necessary to make them successful. It is therefore essential that more support is provided to help make sure these initiatives are successfully implemented.

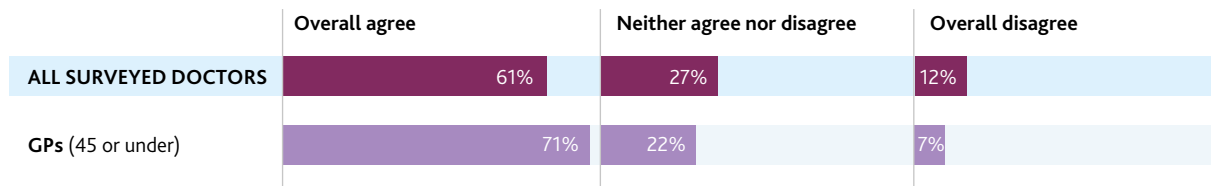
Prioritising immediate patient care at the expense of other activities

To better manage heavy workloads, doctors described how they have been finding ways to prioritise the tasks most important for immediate patient care. They have done this by prioritising individual workloads, patient problems and what the service can offer. This has, however, involved de-prioritising, or even stopping, engagement in other activities that in the long term may be critical to an effective health system or to doctors' CPD. This may partly explain also the concerns that are being raised about the supply of medical leaders in the future.

Prioritising individual workloads

Doctors prioritise their individual workloads by identifying and focusing on the most urgent tasks. For example, they will deal with the most ill patients first in A&E, reduce in-person follow-up appointments, or focus on clinical work over and above administrative duties or training. Overall, two thirds of surveyed doctors agreed that they had made trade-offs in their individual practice in the past two years.⁷⁴ This is felt most strongly by younger GPs, with seven out of ten saying so (figure 30).

Figure 30: I have had to make compromises or trade-offs regarding what I do in my day-to-day practice and how I perform those duties in the past two years



n = 700 (all respondents), ACC Q12, unweighted, net values used – see research notes on page 139

Prioritising patient problems

When patients presented with multiple issues, some doctors felt they only had time to deal with the main or first issue being presented. Half of doctors (49%) reported that there are problems in patients' lives that can't be addressed in a consultation either all the time or more than half the time.² This was particularly the case for GPs who often explained that patients came in with a list of concerns. However, they recognised that not having the time to discuss all of a patient's problems had the potential consequences of patients possibly omitting the issue that was of the most concern.¹

More experienced specialists also described how they make decisions based on results sheets rather than looking for problems by fully exploring patient histories.¹

Prioritising what their service can offer

Doctors reported that in some cases they had been, or were going through, the process of establishing what their service could and could no longer deliver by limiting themselves to a 'core' service.¹

Limitations and sustainability of prioritisation

While some of the different ways in which doctors prioritise to deal with pressure are working for now, it is clear that many of them are not sustainable in the longer term. Doctors discussed that by choosing certain tasks to do first, other tasks simply didn't happen, or were not done as well. For example:¹

- many doctors felt that because they had to focus on what patients *told* them was the problem, they might miss other issues
- doctors often talked about having to sacrifice spending time getting to know patients and building a rapport with them. Almost half (47%) of doctors said that time pressures kept them from developing the relationships with patients that they would like either all the time or more than half the time.² Doctors told us that they felt that losing the opportunity to build a relationship meant that at the very least patients would have a lower-quality experience, but the worst outcome would be that something could be missed
- while it was usually clear which patients to prioritise, doctors told us there were times when this was not so straightforward, and potentially ill people could miss out on treatment

- putting off or trying to reduce the amount of paperwork could mean that less detail would be provided on patients' notes, potentially compromising their treatment further down the line
- having to forgo training, CPD and team meetings, as well as case and clinical conferences, due to workload pressures and prioritisation of other more important tasks (figures 31–33). This is worrying for morale and motivation as four out of five doctors told us that keeping up to date with developments in medicine is extremely important or important to them and three out of four said participating in training courses related to their CPD is extremely important or important.² Participation in activities that support doctors in their learning, reflection and development

have suffered due to the pressure of work. This would appear to directly affect learning and development, but is also concerning due to the effect on doctors' satisfaction in their roles.

Different doctors in different places are choosing a different mix of things to sacrifice when prioritising the things immediately critical to patient care. Individual departments or practices may need to review what is happening in their particular areas, and benchmark it against the situation shown in figures 31 to 33 and consider the sustainability of what is happening. It may also be worth identifying the minority of cases where the activities that many are sacrificing have actually increased and seeing if there is any transferable learning from the different choices made.

Figure 31: How participation in personal development activities has changed over the past two years due to pressure of work

	Number of doctors who said the activity was relevant to their practice	Overall decreased	Overall increased
Clinical conferences	690	47%	13%
Participating in CPD	664	39%	18%

Data include only the doctors who indicated the activity was relevant to them, ACC Q10, net values used – see research notes on page 139

Figure 32: How participation in training activities has changed over the past two years due to pressure of work

	Number of doctors who said the activity was relevant to their practice	Overall decreased	Overall increased
Delivering CPD	605	40%	19%
Mentoring junior doctors	595	32%	29%

Data include only the doctors who indicated the activity was relevant to them, ACC Q10, net values used – see research notes on page 139

Figure 33: How participation in activities to sustain the system/service has changed over the past two years due to pressure of work

	Number of doctors who said the activity was relevant to their practice	Overall decreased	Overall increased
Practice/team meetings	645	33%	23%
CCG/trust meetings	494	37%	26%

Data include only the doctors who indicated the activity was relevant to them, ACC Q10, net values used – see research notes on page 139

	Number of doctors who said the activity was relevant to their practice	Overall decreased	Overall increased
Interdisciplinary activities	628	38%	19%
Safeguarding meetings	532	25%	21%
Case conferences	576	39%	12%

Data include only the doctors who indicated the activity was relevant to them, ACC Q10, net values used – see research notes on page 139

Prioritisation is necessary in many professions. But for doctors it is too frequently affecting other factors that are important to them. Overall, it was felt that a key consequence of having to prioritise was that the bigger picture would be lost. Doctors were having to be reactive, achieving quick fixes and just doing what was needed, rather than working proactively. While the urgent task might be accomplished in the short term, in the long term they might be setting themselves up for more problems further down the line. And cumulatively big problems may be building for the health system in the UK as a whole.¹

Changing ways of working

Working outside grade and experience level

The in-depth interviews explored how doctors are frequently working outside their grade levels, often referred to as 'acting up' or 'acting down'.¹ Many felt that it was now a normalised aspect of being a doctor, particularly at busy times. Senior doctors expressed concern that frequently, if not constantly, working like this can contribute to burn out at all levels.

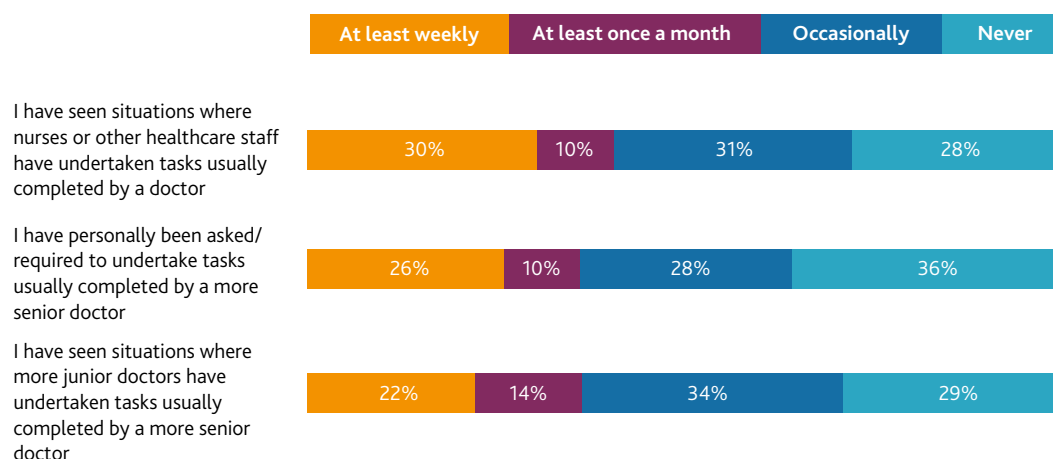
Acting up

Around a quarter (26%) of surveyed doctors reported they had to act up at least once a week or more over the past two years. This is fairly consistent across different areas of practice, however doctors on neither register and not in training report this most heavily (34%).⁶

Around three out of ten doctors surveyed told us that at least weekly they are seeing situations where nurses or other healthcare staff are acting up to do tasks usually completed by a doctor (figure 34).

Figure 34: 'Acting up' by doctors and others over the last two years

How often have you been asked/required to act up and undertake tasks usually completed by doctors at a higher grade/level over the last two years (or seen others do so)? Question asked to all doctors below specialist grade.



n = 500 (excludes specialists), ACC Q6, unweighted, net values used for 'at least weekly' only – see research notes on page 139

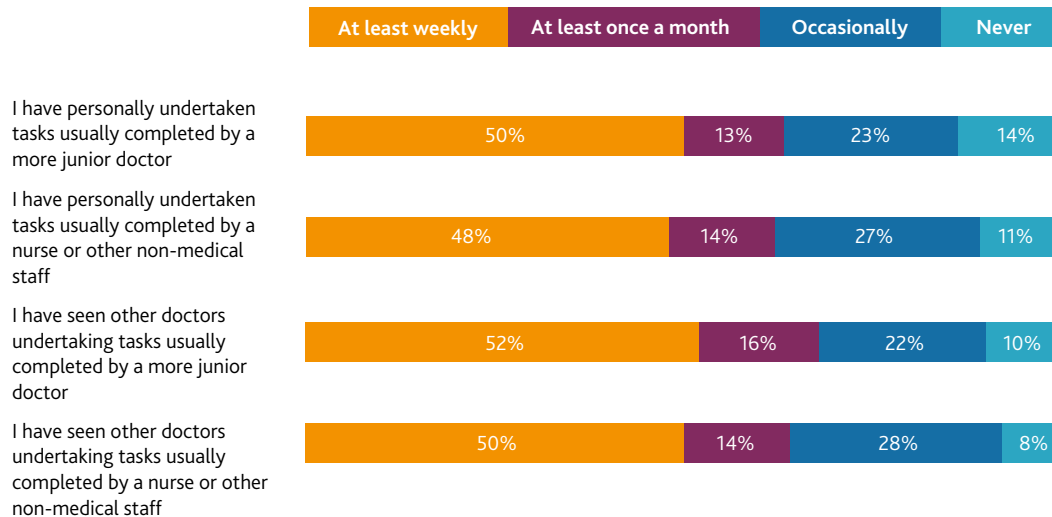
Acting down

Half of doctors surveyed (50%) said they acted down at least every week, with between a quarter and a fifth (23%) saying that they did so every day.⁶ Almost half of surveyed doctors (48%) said they had done tasks usually completed by a nurse or other non-medical staff at least once a week or more (figure 35).

Many senior doctors interviewed as part of the research reported they are being required to act down due to staff shortages, particularly at nursing level.¹

Figure 35: 'Acting down' by doctors and others over the past two years

How often have you acted down to undertake tasks usually completed by more junior doctors or other healthcare professionals over the last two years (or seen others do so)?



n = 700 (all respondents), ACC Q7, unweighted, net values used for 'at least weekly' only – see research notes on page 139

Delegation and spreading workloads

Just over half of surveyed doctors (53%) have allocated tasks, previously only done by doctors, to other healthcare staff to help alleviate workloads.⁶ Doctors reported that delegation involved spreading workloads to less experienced doctors and by upskilling nurses and administrative staff.

Some doctors felt that pressure was somewhat relieved when they could 'share the pain', that is spread the workload a bit. They would, therefore, rotate more administrative-focused roles or tasks (for example, safeguarding role, duty doctor etc) and be meticulous about planning these fairly.¹

Increasing patient and family involvement

Doctors described how they have encouraged their patients to take on more responsibility for their own health, for example, by monitoring their conditions and putting the onus on them to report any changes.¹

Limits to and sustainability of changing ways of working

Doctors felt that frequently 'acting up' or 'acting down' can both have negative impacts. Acting up contributes to pressure. Acting down is usually necessitated by excessive workloads, exacerbated by staff shortfalls – it disrupts the scheduled learning of doctors in training, prevents experienced doctors undertaking personal development, and adds additional tasks and pressures to an already heavy workload.

Although there is acceptance that acting down is part of the role, the impact of this being a substantial aspect of doctors' roles was felt to be detrimental to doctors in training, and their trainers, who expressed concern that working down contributes to insufficient exposure to patients.¹

Doctors performing roles or tasks usually carried out by more junior doctors reported that they were concerned that this may affect the recruitment and retention of doctors in training. These more senior doctors stated that being seen to act down frequently can make progression to senior roles appear less attractive to more junior doctors and doctors in training.

As well as reducing the time doctors can spend on the duties of their role, acting down can negatively affect standards of care. Though 'acting down' may imply the doctor is overqualified for the task they are undertaking, this is not necessarily accurate. The interviews revealed the example of specialists covering the role of critical care nurses, noting they are not trained to provide the nursing interventions needed for high-quality specialised critical nursing care.¹

Delegating and spreading workloads was reported as sometimes being positive as it can free up a doctor's time for more important tasks. But in cases where nurses were being upskilled to take on tasks usually carried out by a doctor this can then have a negative effect on the learning opportunities for doctors in training.

Compromising longer-term patient outcomes

It was clear from the research interviews that doctors are dedicated to ensuring patient safety and delivering a high standard of care.¹ Doctors do not necessarily implement the strategies reported above and in the sequence presented here in this section, and may have overlapping strategies in place at any one time.

However, it is clear that doctors are reluctant to implement the strategies reported in this section that involve compromising longer-term patient outcomes. Doctors turn to these as a last resort, and only after other strategies have been exhausted. But the pressures that many doctors are under mean that to cope they sometimes find it difficult, or impossible, to maintain standards and focus on longer-term patient outcomes.

In the research interviews, doctors told us that, despite their best efforts, patient safety was being negatively affected.¹ One in 14 doctors reported witnessing situations every day where pressure of work puts patient safety at risk and around one in four doctors said they see this weekly.⁶

Unnecessary referrals

The surveyed doctors told us that at times they are making unnecessary referrals in order to reduce their own workloads. Around three in ten of these doctors (33%) told us that they agreed they were making more referrals than strictly necessary now as compared with two years ago. The surveyed doctors indicated that the proportion of patients this has affected has doubled over the past two years from one in 14 patients to one in every seven patients.⁶

This was reported most strongly by the younger GPs surveyed with over half (58%) indicating they agreed they are referring more as compared to two years ago as a direct result of higher workloads (figure 36).

Figure 36: Increase in referrals due to higher workloads

Please rate how much you agree or disagree with the following statement, 'Compared to two years ago, I refer more often due to the higher workload pressure that I'm experiencing'

	Overall agree	Overall disagree
ALL SURVEYED DOCTORS	33%	25%
GPs (45 or under)	58%	16%
GPs (over 45)	44%	21%
Specialists	27%	28%
Doctors on neither register and not in training	25%	32%
Doctors in training	29%	22%

n = 700 (all respondents), ACC Q9a, unweighted, net values used – see research notes on page 139

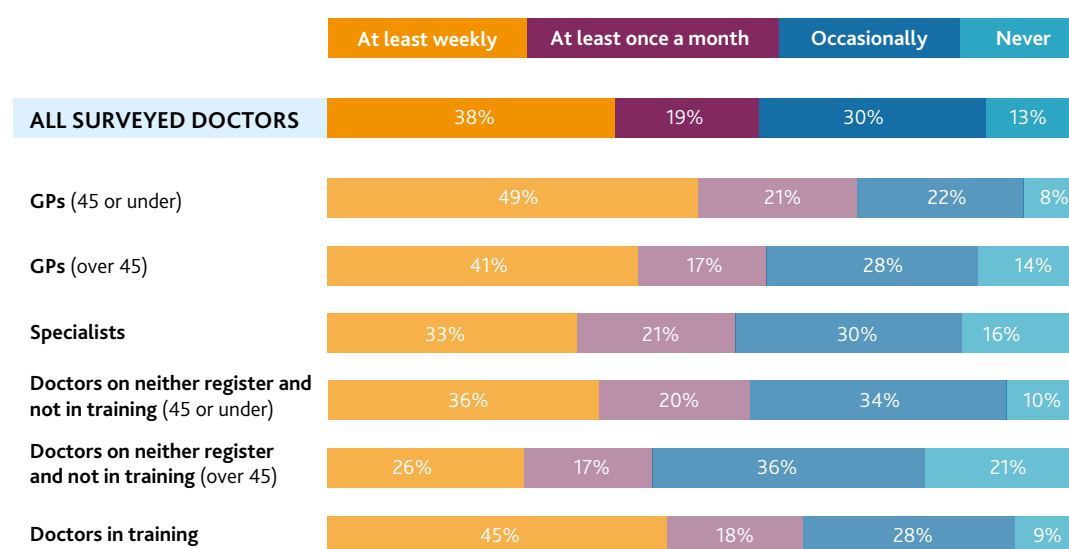
Insufficient time spent with patients

Almost two fifths (38%) of surveyed doctors said that at least weekly they have witnessed insufficient time with a patient affecting the quality of treatment (figure 37). Worryingly around 13% of doctors surveyed said they have witnessed this at least once a day.⁶

The GPs who were surveyed report having witnessed this most frequently, with half of younger GPs (49%) and two fifths of older GPs (41%) saying they see this weekly. Older doctors on neither register are least likely to have seen a lack of time affect quality of treatment with one in five saying they have never witnessed this in the past two years (figure 37).

Figure 37: Insufficient time with a patient affecting quality of treatment

How frequently, if at all, does 'I have witnessed insufficient time with a patient affect quality of treatment' apply based on your practice experience over the last two years?



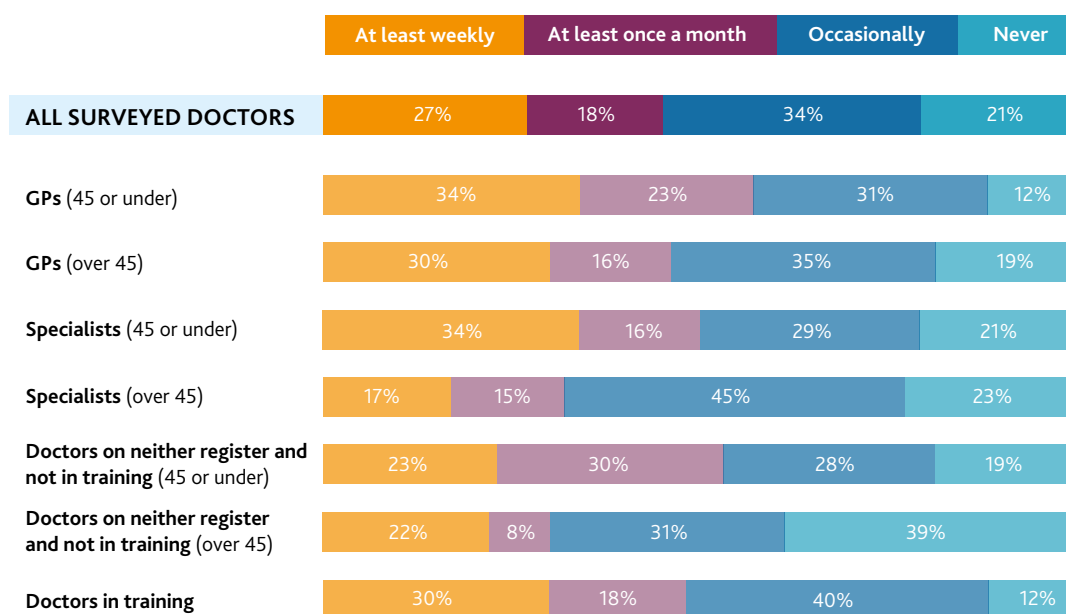
n = 700 (all respondents), ACC Q11a, unweighted, net values used for 'at least weekly' only – see research notes on page 139

Just over a quarter (27%) of surveyed doctors reported having seen insufficient time with a patient affect the accuracy of a diagnosis on a weekly basis. Around a third of GPs, younger

specialists and doctors in training who were surveyed said they have witnessed this weekly (figure 38). Older doctors on neither register reported witnessing seeing such occurrences less.

Figure 38: Insufficient time with a patient affecting accuracy of diagnosis

How frequently, if at all, does 'I have witnessed insufficient time with a patient affect accuracy of diagnosis' apply based on your practice experience over the last two years?



n = 700 (all respondents), ACC Q11a, unweighted, net values used for 'at least weekly' only – see research notes on page 139

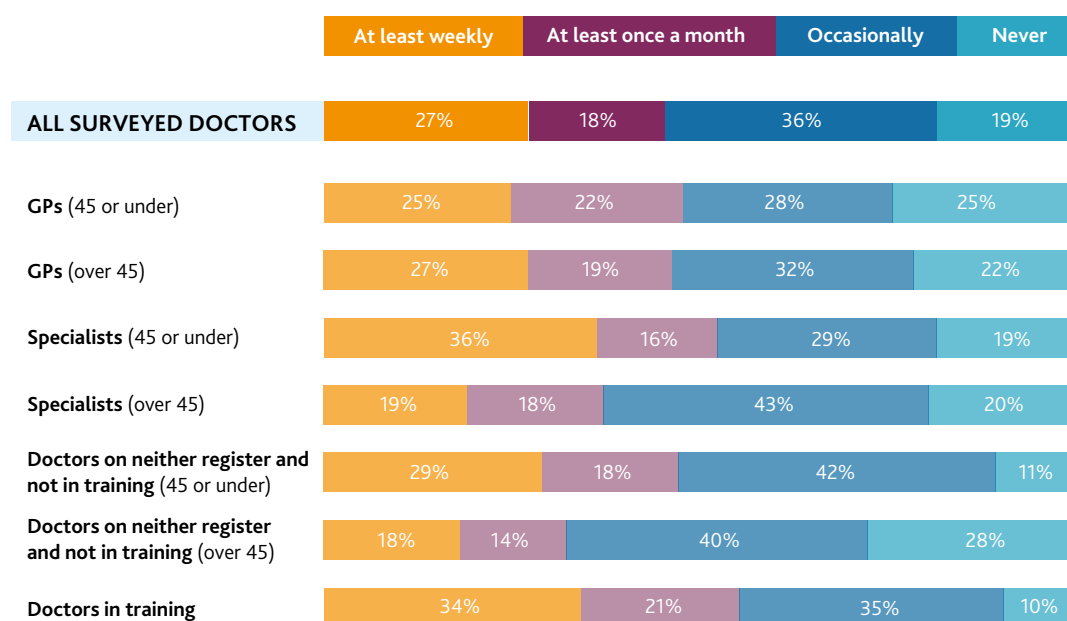
Bypassing clinical checklists and protocols

In the research interviews some doctors told us that they often felt the only way they could get through their workload was by relying on their experience and expertise to discharge or admit a patient at the expense of following set

guidelines and protocols.¹ Almost three out of ten surveyed doctors reported seeing, at least once a week, clinical protocols and clinical checklists not followed correctly owing to pressure of work (figures 39 & 40).

Figure 39: Clinical protocols not followed correctly

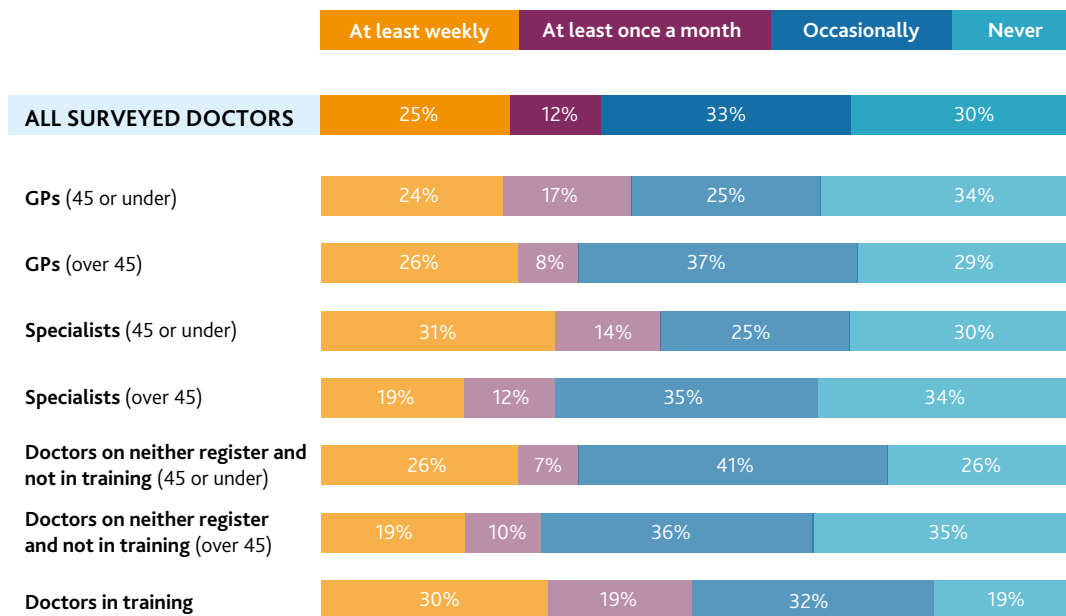
How frequently, if at all, does 'I have seen clinical protocols not followed correctly owing to pressure of work' apply based on your practice experience over the last two years?



n = 700 (all respondents), ACC Q11a_2, unweighted, net values used for 'at least weekly' only – see research notes on page 139

Figure 40: Clinical checklists not completed

How frequently, if at all, does 'I have seen clinical check lists not completed owing to pressure of work apply based on your practice experience over the last two years?



n = 700 (all respondents) ACC Q11a_3, unweighted, net values used for 'at least weekly' only – see research notes on page 139

These findings are consistent with doctors' personal experiences of providing care to patients. A third of doctors (33%) reported that they experienced difficulties providing a sufficient level of patient care on a weekly basis.²

Limits to and sustainability of compromising patient care

The evidence gathered from the primary research shows that the pressure and heavy workloads doctors reported experiencing are presenting risks to standards in patient safety and slips in the quality of care. The evidence is very concerning and demonstrates the urgent need to relieve the pressure our medical workforce is under.

While some doctors in the research interviews did not accept that there were any issues in patient safety, most acknowledged that the quality of the 'service' received by patients was reduced as a result of the pressures doctors were working under. However a sizable proportion of doctors thought that the pressure had reached the point where it was inevitably compromising patient safety (not just care or service). While they tried to minimise compromises in care, they felt problems would still trickle through that may have an impact on patients.¹

Personal coping mechanisms

Doctors' own approaches to managing working under pressure were explored. Maintaining one's own personal health and wellbeing was rated as being very important or important by around four fifths of all doctors, both for physical and for mental health (figure 41). This pattern holds across genders, age groups and ethnicity.

Most doctors reported that maintaining a clear boundary between work and home life is very important or important to them, with around

three out of four saying this (figure 41). This is equally true for both male and female doctors. Younger doctors aged 25–44 years reported this being of more importance to them (around three quarters) than doctors aged 45 years and older (nearly seven out of ten).² Asian and British Asian doctors also reported this as being more important than white doctors, with four out of five saying this is important or very important compared with over two thirds of white doctors.² This makes the compromises having to be made in work-life balance, reported in the early part of this chapter, even more concerning.

Figure 41: What is important to doctors in their life outside of practice?

	Extremely important or important	Extremely unimportant or unimportant
My mental health and wellbeing	85%	1%
My own physical health	80%	1%
Having access to people who support me outside of work	75%	2%
Maintaining a clear boundary between work and home life	71%	2%
Having access to additional support systems provided by my employers	33%	11%

n = 2,249 (all practising doctors), WIMTBAD, Q18, weighted net values used – see research notes on page 139

These aspects that are important to doctors are mirrored in the strategies they employ to help them manage both physically and mentally with the pressures they face at work.

The coping mechanisms doctors discussed in the research include:¹

- within their working environments, they looked for reassurance that they had made the right clinical decisions, they tried to get some downtime or breaks during the working day, or they tried to keep their role varied
- outside of work they tried to look after their emotional wellbeing and avoid burnout by making the most of their holiday time, taking exercise, spending time with family or friends, and by 'offloading' onto peers and colleagues
- some doctors also discussed the importance of training the mind to deal with the mental pressures, from informal approaches, such as compartmentalising, to more formal strategies, such as cognitive behavioural therapy (CBT) and meditation

- some doctors felt able to push back when they felt the demands being made on them were unreasonable. Nearly two fifths (37%) of doctors said they had refused to undertake additional workload over the past two years as a result of pressure on workload and capacity⁶

Employers may need to consider the extent to which they can make these sorts of strategies possible, particularly in periods of particularly high pressure.

Achieving work-life balance, avoiding burnout

We have reviewed a range of evidence that suggests that work-life balance seems to be interpreted differently by different age groups of doctor. Trust chief executives have spoken anonymously to newspapers about the fact it is increasingly difficult to meet the younger generation of doctors' expectations. They say that younger doctors want flexibility, variety and options and are thinking in terms of five-year horizons, not 20-year horizons.⁴⁷

But while we are hearing from doctors that taking care of their mental and physical health and having a clear boundary between work and home life are very important or important to them – many are struggling to prioritise these day to day. A fifth of doctors said they found it challenging to look after their mental health and wellbeing, and maintain a clear boundary between work and home.²

It is critical that doctors are supported in prioritising health and work-life balance in order to prevent burnout.

Pressures are felt differently amongst the profession

The extent to which pressures apply, the way pressures are felt by individuals, and the degree to which the various strategies and coping mechanisms are adopted varies from place to place and doctor to doctor.¹

Most doctors are exposed to at least some of the pressures and negative impacts of some of the strategies doctors are forced to adopt in the current environment. One in four doctors said they are at least somewhat dissatisfied. However, two thirds of doctors said they remain at least somewhat satisfied.² Further investigation is required to understand the factors that may contribute to this satisfaction in spite of pressures. Some factors are unsurprisingly associated with a higher level of dissatisfaction:²

- One in five doctors work beyond their rostered hours several times a week. Over a third of these doctors said they are at least somewhat dissatisfied.
- One in twelve doctors said they feel unable to cope with their workload several times a week. Nearly two thirds of these doctors said they are at least somewhat dissatisfied.

These factors appear likely to be contributing significantly to the high numbers of doctors intending to reduce clinical practice or leave the profession.

We have consistently seen that GPs are reporting pressures at the higher end of the scale.

Figure 42: Summary of pressures GPs are reporting as compared with doctors overall

Working beyond rostered hours	Feeling unable to cope with workload	Satisfaction with work-life balance
79% of GPs have worked beyond their rostered hours on a weekly basis as compared with 68% of doctors overall. ²	39% of GPs felt unable to cope with their workload at least once a week compared with 25% of doctors overall. ²	71% of GPs surveyed said satisfaction with their work-life balance has deteriorated compared with 60% of doctors overall. ⁶
Proportion of high pressure days	Exhausted smarter working options	Increase in the number of referrals to manage workload pressures
Surveyed GPs said about twice as many days are high or unsustainable pressure as are lower pressure. Other doctor types reported about an even split of higher and lower pressure days. ⁶	38% of surveyed GPs over 45 felt strongly that they have implemented all the things that they can feasibly do to implement smarter ways of working. This is in comparison with 23% of surveyed doctors feeling this way overall. ⁶	58% of surveyed GPs under 45 agreed that they refer more often now as compared with two years go due to the higher pressures they are under. This is in comparison with around three out of ten doctors overall. ⁶

Doctors on neither the GP or Specialist Register and not in training

Analysis of the research findings also indicate that particular challenges may exist for doctors who are on neither register and not in training, particularly around their access to support. In particular this group of doctors:

- felt least supported by management – 35% under 50 years old and 37% aged 50 years and over reported feeling unsupported by management/senior management once a week or more. Only specialists aged 50 years and over reported a similar lack of support (figure 22, see page 81)
- felt least supported by colleagues – 18% under 50 years old and 13% aged 50 years and over reported that they had felt unsupported by their immediate colleagues once a week or more. No other group had a proportion greater than 12% (figure 23, see page 82)
- reported some of the largest decreases in mentoring – 33% aged under 50 years old and 37% aged 50 years and over reported mentoring provided to them had decreased. Only GPs under 50 years old had a higher proportion that said this (figure 24, see page 83)
- 27% under 50 years old reported they considered leaving the profession at least once a month. Only GPs (all ages) had a higher proportion that said this (figure 27, see page 86).

These findings might imply that, compared with other groups, the pressure felt by doctors on neither register and not in training results less from workload (figure 21, see page 79), and is more likely to be an effect of failures in support. Addressing pressure in this group might therefore require different approaches – or a different emphasis in the approaches used – than for other groups of doctors.

Conclusion: pressing need for more support

Doctors face a range of significant pressures. These pressures are having substantial impacts on doctors themselves and on their ability to deliver care to patients. Amongst the impacts are stress-related absences by doctors, thoughts of leaving the profession, and compromises that affect patient care and safety.

Doctors have been implementing various strategies to help manage these pressures but many feel these are not sustainable in the long term. Our primary research found several doctors felt that they are at risk of approaching burnout, and nearly all of them felt that the system itself is reaching breaking point. They were concerned about the safety and care provided to patients, and about the long-term implications for the NHS as a whole.

To tackle these pressures and effects, it is vital to respond to what doctors are telling us they need. Part of this is providing resources to reduce doctors' need for strategies that compromise patient care and safety, prevent doctors from supporting each other and developing professionally, and store up problems for the health system in the long term. Our response must also involve creative ways to directly implement those things doctors have told us would support them.

Many of the ways we and others can improve support for doctors are clear from the findings set out in this chapter. There are also additional areas of support raised by doctors as part of the research. Key areas of support doctors are telling us they need are:²

- **support and mentoring from colleagues and senior doctors/management** – nearly a third of surveyed doctors felt unsupported by management or senior management at least once a week with the same proportion saying mentoring over the past three years has decreased
- **prioritisation of mental and physical health and wellbeing as well as a clear boundary between work and home life** – four out of five doctors said their mental and physical health was extremely important or important to them. And almost two thirds (60%) of doctors said their satisfaction with work-life balance has deteriorated despite seven out of ten stating that maintaining a clear boundary between work and home life is important to them
- **implementation of work-based support systems** – a third of doctors said that having access to additional support systems provided by employers is extremely important or important to them
- **promotion of the importance of CPD, additional learning and non-clinical activities** – almost half of doctors said that time available to reflect on their practice has decreased in the past three years. Four out of five doctors said that keeping up to date with developments in medicine is extremely important or important to them and three out four said participating in training courses related to their CPD is extremely important or important. Therefore the promotion and protection of these activities should be increased.

We have already started a programme of work to tackle the issues that have been raised about the environments in which doctors work, and the effects of systems pressures on medical practice under our 'Supporting a profession under pressure' workstream.⁴⁸

The findings from the research reported here will help to develop this body of work further. 'Supporting a profession under pressure' includes the following work programmes.

- **Independent review of gross negligence manslaughter and culpable homicide:** an independent UK-wide review into how gross negligence manslaughter and culpable homicide are applied to the medical profession.
- **Helping doctors become reflective practitioners:** new guidance for doctors and medical students on reflective practice is being produced by the Academy of Medical Royal Colleges, the Conference of Postgraduate Medical Deans, the General Medical Council and the Medical Schools Council.
- **Improving support for doctors to raise and act on concerns:** working with partners in the health services in England, Scotland, Wales and Northern Ireland to make sure doctors at all career stages feel supported to raise concerns and that these will be acted upon by those responsible.
- **Making sure doctors are treated fairly:** it's well established that some groups of doctors are referred to us for fitness to practise concerns more or less than others. In 2018 we commissioned a major, independent research programme to help us understand what drives this disparity.¹²
- **Supporting medical students' and doctors' wellbeing:** starting a UK-wide review of medical students' and doctors' wellbeing, led by Professor Michael West and Dame Denise Coia.
- **Induction and support for doctors returning to work:** stepping up work with healthcare providers to make sure doctors feel supported when they begin a new role or return to practice after time away.

In the final two chapters we set out what we and others are doing to support doctors and the environments they work and train in, as well as outlining some ways in which we contribute to building and maintaining a sustainable workforce.



A quality workforce: ensuring standards, applying fairness

We're working with doctors on the frontline to better understand the risks they face, and to help develop solutions to tackle the pressures of modern medical practice



In medical education we're taking action to support training environments; we're creating a new Medical Licensing Assessment, and have issued new guidance on reflective practice

We are taking steps to ensure groups of doctors with lower attainment, unrelated to ability, are supported

Pressures impact on work environments. In 2018 we joined other regulators to sign the Emerging Concerns Protocol to share concerns about particular places early



We are monitoring the fairness of our fitness to practise processes and reforming them to minimise burden, while ensuring standards and patient safety are maintained



We're working with others on a joint approach to improving exception reporting in England, and rota monitoring in the devolved countries

Introduction

As the regulator of the medical profession, we set the standards doctors need to follow throughout their careers, and oversee UK medical education and training to ensure a quality workforce that is fit for purpose and capable of adapting to changing environments.

While we can play a pivotal role, ensuring a quality workforce needs to be a collective action by all in the health system. We need collective knowledge on where the risks are in the modern medical profession, particularly given the pressures discussed in the previous two chapters. We are always developing our understanding of these risks so that we can take action wherever there is an identified risk to patient safety. In this chapter we examine the measures we are taking to ensure standards and how we support all groups of doctors to achieve high standards throughout all stages of their career, and particularly how they can realise their potential during training.

The first section of this chapter includes our work in relation to medical education, the development of skills, and training environments. This includes: supporting groups of doctors who have different achievement levels from others, known as differential attainment; enhanced monitoring of training environments; and the development of the Medical Licensing Assessment. This is intended to create an environment where UK medical graduates and IMG doctors can meet a common threshold for safe practice and our new guidance to support reflective practitioners.

The second section of this chapter describes some of the collaborative action we are taking to improve working environments. The environments that doctors work in can have a strong influence on their ability to maintain high

standards, and we are increasingly using the intelligence we gather from engagement with the profession to work jointly with others where problems, in particular workplace problems, have come to light that affect the profession or patient safety.

Finally a culture that allows doctors to raise concerns confidently, and have those concerns acted on, and encourages learning is vital to maintaining and improving standards. The section on raising concerns highlights the importance of having a culture. This is vital to maintaining and improving standards.

We are always aiming to identify risks in a way that allows us to support doctors before problems occur. But when we become aware of situations where doctors may have failed to uphold the standards required, they may face fitness to practise procedures. Our final section provides our latest data on this and an update on the reforms we are making to these procedures.

We are committed to proportionate regulation and have been making strides in this area. We are doing the best we can to reduce pressures on doctors and not put them through the stress of these processes unnecessarily.

This includes our introduction of provisional enquiries – a way of ensuring the facts about a doctor's standards are discovered and dealt with quickly. Other reforms include an emphasis on local first – moving consideration of issues to local level with the hope that that this will enable quicker and more effective learning of any lessons to improve standards. This would bring fitness to practise processes in line with the local approach already being taken in education.

A theme throughout is fairness – fairness in our attempts to make sure that different doctors are treated fairly when they are trying to maintain

high standards, and in the processes they face when their professional standards are brought into question.

Medical education

Our national training surveys* (NTS)¹³ continues to show that medical education is highly rated by doctors in training, with eight out of 10 (81%) considering the quality of their experience in their current post to be good or excellent. This continuing confidence in the system reflects well on the hard work of trainers and doctors in training, and is to be celebrated. However, this should not prevent us from identifying where issues exist.

In particular, doctors in training face many of the same high work pressures as those identified in chapter 3 – with over 40% working describing their workload as heavy or very heavy, and nearly half (48.5%) stating that they go over their contracted/rostered hours on a weekly or daily basis. In addition, around a third (30.9%) of trainers disagreed or strongly disagreed that they were always able to use the time allocated to them as a trainer specifically for that purpose.

As a regulator we want to ensure quality, fairness and high standards in all aspects of the education of our doctors in training.

Our approaches to addressing this include:

- enhanced monitoring of training locations where training is not meeting our standards
- ensuring good support is in place for all medical students and doctors throughout

their training, informed by our work on differential attainment

- the establishment of our Medical Licensing Assessment (MLA), which will ensure that all those who wish to work as a doctor in the UK can demonstrate that they meet a common threshold before we grant a licence to practise.

Enhanced monitoring

When postgraduate bodies[†] are concerned about the training of doctors, they work directly with trusts and health boards to make improvements.

If the situation doesn't improve, they tell us. We also receive reports from the medical royal colleges, faculties, and others if they have concerns, so we can see evidence of pressures building from different sources.

We then work with all the organisations involved to address the concerns, improve the quality of training, and develop a sustainable solution through what we refer to as our 'enhanced monitoring' process.

Issues that need enhanced monitoring are those which we believe could adversely affect patient safety, doctors' progress in training, or the quality of the training environment, and which have not shown progress through local management.

* For further information on the NTS, see research notes on page 139

† Postgraduate bodies include: NHS Education for Scotland and The Northern Ireland Medical & Dental Training Agency, Health Education England, and the recently established Health Education and Improvement Wales.

We then work with healthcare educators to ensure standards are met. We receive updates from postgraduate bodies, and we can provide representatives on a locally led visit to investigate a concern or check on progress. We publish information on enhanced monitoring cases on our website and share information with other healthcare regulators and improvement bodies where appropriate.

When serious concerns persist, we may decide to use our legal powers to place conditions on the approval of postgraduate training posts.

We may attach conditions to any approval that we have already given. If it becomes clear that it is unlikely the conditions will be met, we may decide to withdraw our approval for training, which means that doctors in training are removed from the training environment.

We have now undertaken statutory action at six organisations: North Middlesex University

Hospital NHS Trust (box 5), Weston Area Health NHS Trust, East Kent Hospitals University NHS Foundation Trust, Brighton and Sussex University Hospitals Trust, NHS Ayrshire and Arran, and Isle of Wight NHS Trust. In most of these cases, this was to intervene where there had been a lack of support for foundation doctors. However it has taken other collaborative action to influence care, as at Southampton University NHS Foundation Trust (box 6, see page 112).

On an operational level, there is a significant amount of collaboration involved in the monitoring and oversight required for assurance between the GMC, Health Education England (HEE), NHS Education for Scotland (NES), Health Education and Improvement Wales (HEIW) and the Northern Ireland Medical & Dental Training Agency (NIMDTA).

Box 5: North Middlesex University Hospital NHS Trust

Background

North Middlesex is a large trust in London which has an extremely busy emergency department. A Health Education England (HEE) and GMC visit in 2016 investigated a steep decline in NTS results, with particularly negative outcomes in the emergency department. We found a culture of bullying, deficient equipment, and competence and supervision issues among doctors.

Challenges

North Middlesex has experienced a range of problems. Recruitment and retention of staff

is difficult and this leads to rota gaps and problems with supervising doctors in training. These issues have a detrimental effect on the culture of the department, with service requirements being prioritised over education. We needed to intervene and offer significant support and guidance.

Actions

Following the 2016 visit, requirements were immediately set for the trust by HEE. A follow-up check by HEE and the GMC six weeks later showed that, although the equipment issues had been resolved, there was still a lack of appropriate supervision for doctors

in training, and pressure on staff within the department had not been alleviated. We were obliged by the seriousness of the situation to set new conditions, which, if not met, would result in the removal of doctors in training from the department. We took this step after much serious consideration.

Following this, North Middlesex requested help, including a loan of staff, from neighbouring trusts for the emergency department. There were also leadership changes at the trust. Subsequent visits and the NTS results in 2017 were more encouraging, but once loaned staff returned to their home trusts North Middlesex began to deteriorate again. We then set additional conditions, which were more prescriptive, with specific requirements around

how supervision of doctors in training should be structured. This was in order to help guide the trust in its activities, and offer it the benefit of our experience and knowledge by providing guidance through conditions.

A series of visits throughout late 2017 and early 2018 confirmed that the conditions have been enacted, resulting in a safer and more supportive environment.

Outcomes

Threatening to withdraw doctors in training led directly to improvements at the trust; although it should be noted that we are always careful to balance any risks that this course of action might involve.

Impact of enhanced monitoring and statutory action

Feedback from our stakeholders tells us that enhanced monitoring is effective. We know that our direct involvement raises the profile of education issues; for example, it ensures Trust and Health Board discussions and monitoring. It also means that local education providers will dedicate resources to education and training. This is important for influencing longer-term cultural change at struggling organisations, and ensures education is given appropriate weight.

Enhanced monitoring cases are complex, and local education providers involved with this process will commonly be struggling with wider system pressures such as workforce issues. These issues are not easily resolved, which is why organisations tend to stay within enhanced monitoring for some time. 22 out of the 43 open concerns (51%) under enhanced monitoring have been open for more

than two years. When a serious issue arises, we work with the postgraduate organisation and the local education provider to ensure an action plan is in place and being delivered, but it can take some time for improvement to be embedded and sustainable so that we can remove the site from the process.

It may be that, in some cases, improvements take longer to materialise. There is also the possibility that some underlying problems may not be solved by enhanced monitoring alone; we are undertaking further work to better understand this. However, it is clear that, in cases where we've taken statutory action, there is evidence of improvement. Where we have set conditions on approval, follow up visits indicate things have got better. The longer-term impact of statutory action is still unclear. We set conditions on approval for the first time in 2016, and as more data become available we will be better able to track the efficacy of our actions.

Enhanced monitoring does not always result in us taking statutory action; there are a number of examples of the process itself being effective

in raising the profile of education issues and influencing progress and improvement (box 6).

Box 6: University Hospital Southampton

Background

University Hospital Southampton, a large teaching hospital, is the main specialty training hub for the Wessex region. In 2013, the NTS indicated very poor results for this trust, particularly for doctors in training in posts in the trauma and orthopaedics department. An HEE and GMC visit confirmed there were issues affecting doctors in training at all levels across this department. These issues included bullying and undermining, lack of clinical supervision and support for doctors in training, and lack of educational opportunities.

Actions

In 2014, after several subsequent visits and a lack of evidence of improvement, the GMC and the Dean agreed that he should plan to start removing doctors in training from the department. This would have had a significant effect on the ability of the trust to deliver the service. This triggered the trust, including the Board, into extensive action and this department became a priority. All levels of management were aligned in

making improvements. Subsequent visits in 2015 indicated a significant turnaround. The cultural shift within the department has been sustained; it is now a high-performing specialty within the trust.

Challenges

Once the issues were highlighted, the trust was empowered to make the changes required. The trust took the threat of removal of doctors in training very seriously, and the HEE threat was enough to encourage action. Through our enhanced monitoring process, the GMC was able to influence and enable HEE to act, but it was not necessary to take direct statutory measures.

Outcome

The Dean has attributed the turnaround to our presence during visits and input into high-level discussions around the issue. This is a prime example of how enhanced monitoring can work without the GMC taking direct action.

Enabling all groups to reach their potential

Differential attainment (DA) is the gap between the attainment levels of different demographic groups of doctors in training. Differentials that exist because of ability are expected and appropriate. However, differentials connected solely to age, gender, ethnicity, disability etc (ie protected groups)* may be unfair. Our standards require training pathways to be fair for all. The challenges outlined throughout this report demonstrate how important it is that we enable the whole workforce to fulfil its potential – supporting everyone to achieve high standards isn't just the right thing to do for the sake of fairness, it's also the right thing to do to help with workforce pressures.

The cause of the differentials is complex and our understanding is still developing. Research has identified a wide range of contributory factors which are believed to contribute to the differences.⁴⁹

Two factors are previous educational attainment and a sense of belonging, which will be influenced by early access to economic and social capital, such as the level of parental education and support for educational or professional progression and aspiration.

In addition to the above, there are a wide range of contributory factors once someone is in medical education.

Firstly, unconscious bias or discrimination cannot be ruled out, although research suggests that it is unlikely to be the primary driver of the differential.

Secondly, other factors include stereotype threat,[†] increased anxiety arising from perceived bias or discrimination within the system, a lack of role models and champions from diverse backgrounds in senior roles, challenges fitting in or establishing relationships with a diverse network of seniors and peers, as well as increased risk of being placed in training environments that are distant from family and friends.⁵⁰

Each doctor will have a uniquely personal experience of the training pathway. Most will overcome the barriers they face to achieve success and many doctors from protected groups excel throughout their training and career. We want to learn from these experiences to help better support those who are disadvantaged, due to either lower prior attainment or protected characteristics, when they enter training.⁵¹

Holding organisations to account through capacity building and building the evidence base

We have strengthened our regulatory monitoring of how organisations responsible for the design and delivery of medical education are responding to the differentials as required by our standards. We have asked each HEE local office and Deanery, the deaneries in Scotland, Northern Ireland and Wales, and the medical royal colleges to describe how they are responding to the attainment gap.

We recognise that this is a complex area however an understanding of the issues and effective interventions are emerging. In order to support training organisations to meet our standards we are providing a range of support including data that enable them to explore outcomes

* Protected groups are identified in the Equality Act 2010 as sharing a particular characteristic against which it is illegal to discriminate.

† Stereotype threat is a situational predicament in which people are or feel themselves to be at risk of conforming to stereotypes about their social group.

and perceptions broken by demographic characteristics within their region or specialty.

We are providing a platform through our website and a range of events for those organisations that have developed innovative solutions aimed at tackling the factors contributing to DA so they can share their ideas and evidence of impact (See box 7).

Widening and deepening our understanding

We are continuing to move forward our collective understanding of the issues around DA. We will be publishing some new research from the Work Psychology Group⁵² in which they explore other

measures which might provide additional insight into differential experiences and perceptions and DA in the earlier years of medical education. Many of these measures can be collected locally by organisations and some we hope to include in future GMC data publications.

In response to *Fair Training Pathways*,⁴⁹ which found a wide range of local interventions taking place, but little evidence as to their impact or effectiveness, we have published a toolkit which provides practical ideas on how organisations can evaluate the impact of their activities in the short and longer term. We are providing a forum in which their lessons can be shared with others nationally across regional and specialty boundaries.

Box 7: Differential attainment tools and initiatives

- **An early performance indicator tool (i-Tap)** was created by HEE Midlands and East to determine which doctors may need more support to pass exams. It has been rolled out to the 2015 GP intake and an evaluation is being undertaken during 2018–2019.
- **Voluntary support sessions** have been rolled out for students with disabilities on the Gateways to the professions programme⁵³ to support their progression. The initial evaluation of the 2017 trial has been positive.
- **A unique personalised support programme** has been developed by HEE North West, which has enabled more IMG doctors to successfully pass their GP exams. Over two years, the third and fourth attempt pass rates for Clinical Skills

Assessment (CSA) have almost doubled across the North West of England.

- **A peer mentoring service** has been rolled out by HEE Kent, Surrey and Sussex. Feedback has been positive and found that the mentors and mentees enjoyed taking part and found the additional support valuable.
- **Encouraging conversations around DA** through the use of a board game has been effective in HEE North West to support trainers and educators in thinking and talking about the subject. The aim was to build trainers' confidence to talk openly with trainees earlier, and to raise awareness around how attainment can be affected by different experiences and aspects of a doctors in training life.

A common threshold for safe practice

When a doctor applies to join the medical register, we must be sure they are safe to practise. We already confirm this in a number of ways. Now we're developing plans to establish a Medical Licensing Assessment (MLA), which builds on our existing assurance work by setting a common threshold for safe practice.

This means that we and the wider community can be assured that doctors joining the medical register with a licence to practise meet that threshold, which will be the same no matter where they obtained their medical degree.

The MLA will comprise two elements: a computer-based test of applied knowledge; and an assessment of clinical and professional skills.*

The assessment will be taken by UK medical graduates and IMGs from outside the EEA.

We also want to assess medical graduates from the EEA. That would mean nearly all doctors go through a common assessment. At the moment, the law says we cannot do this. The issue is part of the negotiations about Britain leaving the EU. Once we know the outcome of the negotiations, we will be able to plan further.

The GMC's Council has agreed that we will develop the MLA to start in 2022.

Focus on quality for revalidation

Revalidation is an important aspect of maintaining standards with its emphasis on continued learning and professional development. We issued updated guidance in May 2018⁵⁴ to ensure doctors are clear about what is required and, why, for the revalidation process.[†] It provides information on the balance between the quality and quantity of supporting information that a doctor must collect, and explains that the GMC does not set a minimum or maximum amount. Given the pressures discussed in the previous two chapters, it is essential that the activities involved in revalidation are focused carefully on the aspects that will add value for each doctor involved.

New guidance on reflection

We recognise that doctors are feeling concerned about practising reflectively and being open and honest if something goes wrong. We have responded to these concerns on our website.⁵⁵

Doctors' reflections are central to learning and to safe practice and fundamental to medical professionalism. The importance of reflection is built into our guidance on what should be expected of UK medical graduates as well as the guidance we give royal colleges and faculties to help them develop postgraduate curricula. Moreover, reflections are an important requirement for annual appraisals and revalidation.

* For the clinical assessment, all assessments will be quality assured against the same requirements.

† Licensed doctors are expected to collect six types of supporting information: continuing professional development, quality improvement activity, significant events, feedback from colleagues, feedback from patients, and complaints and compliments.

Working with the Academy of Medical Royal Colleges (AoMRC), the Conference of Postgraduate Medical Deans (COPMeD) and the Medical Schools Council, we co-produced and published new guidance on reflective practice, *The Reflective Practitioner*¹¹ in September 2018. The new guidance was in answer to calls from medical students, doctors, responsible officers and appraisers for clearer information on what is meant by reflection and how it can be used within medical practice. The short guide illustrates commitment to supporting an open and honest learning culture and offers clarity in a number of areas, including the following key points:

- Reflective notes don't need to give the full factual details of a case or situation, but should focus on learning and future actions.
- There is no one way of reflecting; how individuals reflect is personal.
- Tutors, supervisors, appraisers and employers should support individual and group reflection. It is important to have time to reflect on both positive and negative experiences, and group reflection often leads to ideas that can improve patient care.

- The GMC does not ask a doctor to provide their reflective notes in order to investigate a concern about them. The doctor can choose to offer them as evidence of insight into their practice, but it is entirely their decision.
- Reflective notes can, however, currently be required by a court if they are considered relevant. We continue to call for doctors' reflections to be protected in law.

Alongside these guidelines, AoMRC and COPMeD have issued a Reflective Practice Toolkit,⁵⁶ which lays out the principles for reflective practice and offers a number of examples and templates to support the writing of reflective notes.

We are currently producing learning materials, including case studies, to support doctors in applying the guidance in practice and being reflective practitioners. These will be published on our website in due course.

Collaborating to improve working environments

We are very concerned to ensure that the environments in which doctors work are as safe and supportive as possible. We therefore need to be fully able to react to any concerns which could have an impact on patients and medical practice raised both internally and externally about organisations across the UK. In order to ensure our responses are coordinated and effective we have established an internal Patient Safety Intelligence Forum (PSIF). This is where senior managers from across the GMC meet to discuss how to respond to specific concerns in the healthcare sector that have been brought to our attention through our liaison and visits teams,* via through other regulators, through the media, or other sources.

Ahead of the meetings, teams are informed about which organisations are of concern. Our field forces and intelligence teams collate relevant and up-to-date information gathered by us about these sites. This information is used to inform decisions at all levels within the GMC, and PSIF provides an opportunity to view all our evidence in one place and gain a high-quality overview of each site. Using this evidence, PSIF makes recommendations which can lead to proactive intervention and provision of support by our field forces. This can mean activity based at the organisation itself, or working with other healthcare bodies, such as other regulators, education deaneries, and local and national governments, to intervene and provide support.

Many of the sites discussed at PSIF have multiple issues, and we aim to support the organisation, where we can, with as many of these as possible.

Some sites are discussed at PSIF regularly, over a long period of time, as different issues emerge or change. As we continue to develop our intelligence gathering and upstream regulation[†] capabilities we are learning from each site that we support. As a result PSIF is increasingly able to look at sites and provide support before those sites become seriously compromised.

In England, we also attend the Joint Strategic Oversight Group (JSOG), which has a similar remit to our internal PSIF, for enabling collaborative working and information sharing. JSOG is an external group convened by NHS Improvement. We have been able to provide helpful intelligence to JSOG, which has been well received. We intend to continue our participation and in doing so, improve on the help we can give so that the whole sector can benefit from our data and expertise.

We also contribute intelligence and data to cross-sector projects in Scotland, Wales and Northern Ireland, including the UK Advisory Forums (UKAF) where issues in each country are discussed with stakeholders. We also work with our regulatory and improvement body partners in each country, including NHS Education for Scotland, Healthcare Improvement Scotland, Healthcare Inspectorate Wales, and The Regulation and Quality Improvement Authority in Northern Ireland, to enhance our collaborative offering and to inform action and conversation in each country. We will be continuing to grow our provision in this area.

* Liaison and visits teams include: our offices in Northern Ireland, Scotland and Wales, and our Regional Liaison Service (RLS) in England, which works with doctors, educators, employers and other regulators to protect patients and support good medical practice, our Employer Liaison Service (ELS), which works with responsible officers, medical directors and medical managers to protect patients and support doctors to meet our standards, and our Education Visits team, who meet medical schools, deaneries and local offices and local education providers.

† Upstream regulation aims to drive improvement rather than taking action only once harm has occurred.

Box 8: North Lincolnshire and Goole NHS Trust

In November 2017 PSIF discussed concerns about appraisal rates at North Lincolnshire and Goole NHS Trust. North Lincolnshire and Goole is a trust with multiple issues relating to recruitment, retention and staffing. This is due to a variety of factors, many linked to its geography as a dispersed trust, with individual sites being some considerable distance from each other and from populous urban areas. In cases like North Lincolnshire and Goole it is very important that all issues that can be addressed are dealt with, as even small improvements in the situation can have a strong impact.

The problems with appraisal were of interest to PSIF as appraisal is an important aspect of a doctor's development and is encouraged by both *Good Medical Practice*⁵⁷ and the revalidation system that the GMC is responsible for. At organisations where there are problems around recruitment and retention of staff it is essential that the staff who are already there feel engaged. These staff must be

allowed to develop their skills and interests, and their existing skills must be kept current and sharp. Lower than expected appraisal rates could be a sign that doctors are not sufficiently engaged or supported and this could lead to a loss of skill or interest, which could negatively affect what the organisation can provide for patients.

In November 2017 the concerns around appraisal rates were discussed, in addition to other educational, staffing and retention concerns. As a result our Employer Liaison Service met the medical director and responsible officer to see if there was any help we could offer, including running workshops for doctors raising awareness of the need for good appraisal and learning cultures. In April 2018 we heard from the trust that they had found this support to have been "very helpful". As of October 2018 there are no outstanding concerns about the appraisal and learning culture at the trust.

Emerging Concerns Protocol

Nine health and social care regulators and other bodies (including ourselves)* signed the Emerging Concerns Protocol (the Protocol), to help us share concerns with each other more effectively.^{58, 59}

The Protocol seeks to provide a clearly defined mechanism for us to share information and intelligence that may indicate risks to users of services, their carers, families, or professionals in England.

We know that sharing concerns at the right time can make it easier to notice that a problem is emerging. We believe that working together more effectively can reduce regulatory burden by encouraging our organisations to come up with joint plans when we share similar concerns. The Protocol will help ensure regulators are transparent with the public, providers and professionals about the way that we work together.

* Protocol signatories: Care Quality Commission; General Dental Council; General Medical Council; General Pharmaceutical Council; Health and Care Professions Council; Health Education England; Local Government and Social Care Ombudsman; Nursing and Midwifery Council; and Parliamentary and Health Service Ombudsman.

We will work together to review and evaluate the process to make sure that it works for providers, professionals and people who use services.

In addition to the signatories NHS England and NHS Improvement have also supported our emerging concerns working group.

The Protocol covers England only. We will continue to work collaboratively with the relevant national organisations in the other countries of the UK to achieve the same objective.

Box 9: Using the Emerging Concerns Protocol

In one of the instances of the Protocol being invoked, a senior doctor approached a GMC regional liaison adviser with concerns about surgical equipment in their workplace which was an urgent patient safety concern. Some of the surgical packs were missing parts and there were surgical instruments which broke during operations. The GMC reported this to the Care Quality Commission (CQC), which agreed that we should use the provisions of the Protocol to initiate a regulatory review panel. The information gathered at this point was shared with the Nursing and Midwifery Council, a co-signatory of the Protocol.

A meeting was held where all sides shared their concerns and discussed what their own

data and intelligence said on the matter. The CQC was able to enhance its ongoing inspection of the organisation, and the Health and Safety Executive and the Medicines and Healthcare products Regulatory Agency were also informed. The dangerous equipment was removed from the site within hours, providing a tangible example of the Protocol having a positive effect on the safety of both patients and staff.

This case also illustrates the joined-up nature of healthcare and how actions in one area can have a positive effect elsewhere. The supplier of the substandard surgical packs was found to have provided packs to other organisations. These packs were also identified and removed.

Collaborative quality assurance of training environments

Organisations that train doctors and medical students must meet our standards.* Through our quality assurance processes, we work with medical schools and postgraduate organisations to check that our standards are being met.

Since 2011 we have gained this assurance partly through a series of regional reviews, which took the form of visiting each postgraduate organisation, each medical school and a sample of LEPs in each region. This schedule of reviews

has now come to an end and we are undertaking a further review to determine how we will seek assurance in the future.

Our proposed approach will give us better, more continuous assurance as we work more closely with medical schools and postgraduate organisations. We will be more flexible and supportive with these bodies, allowing them to provide evidence in a way that fits with their activities. This will in turn enable them and us to spend more time making sure that training environments are safe and provide high-quality training for the doctors of the future.

Raising concerns

Working and learning environments for doctors must be free of bullying and harassment. It is the responsibility of healthcare providers and employers of doctors to ensure that they are operating a positive culture where concerns can be raised with confidence. Doctors at all stages in their career should never hesitate to act openly and honestly if something has gone wrong.

There have been anecdotal reports from our Regional Liaison Service (RLS) and devolved offices that there is an issue with processes of reporting and acting upon concerns. The reports also imply that doctors are 'inoculated' against problems linked to resource shortages, in the sense that they have become 'normal ways of operating' and may not be reporting those concerns as a result. Some strategies reported on in chapter 3 represent this 'normalisation'.¹

Our intelligence data indicate that there is a lack of awareness of Freedom to Speak Up Guardians (existing NHS staff in England with an additional role to facilitate candour, raising of concerns and other openness issues).

There were also a number of issues raised with us at meetings and sessions with doctors about the software used to raise concerns, including problems with the length of forms or problems around the issuing or use of passwords.

Doctors in training raising concerns

The national training survey (NTS) suggests that for doctors in training there is a largely positive picture about the reporting of patient safety and educational concerns but not uniformly. Four out of five (81%) of all doctors in training told us in the NTS, carried out in the spring of 2018, that there is a culture of proactively reporting concerns in their post. However, 4% disagreed or strongly disagreed that there was a culture of reporting concerns, and 15% neither agreed nor disagreed.

We can see from our internal analysis that there is also variation between specialties, with some having a more negative viewpoint than others, both from doctors in training and trainers.

* Our standards for the management and delivery of medical education are laid out in *Promoting Excellence* ⁶⁰

Doctors in training in GP (89%), obstetrics (87%) and paediatrics (87%) posts are more likely to say that they agree or strongly agree that there is a culture of proactively reporting concerns compared with those in surgery (76%), medicine (77%), and occupational medicine (78%) posts. It is true that more than three quarters of doctors in training in these latter specialties are positive about the culture of reporting in their post, but the difference in responses (almost 13 percentage points between GP and surgery) is of note. It is also very worrying that a quarter of trainees in these specialties do not think such a culture exists.

Three quarters (74%) of doctors in training are confident that patient safety concerns are effectively dealt with in their post. Although this is positive for the majority, the fact that a quarter (26%) do not agree that patient safety concerns are adequately dealt with is also potentially worrying. This again varies between specialties with four in five doctors in training in GP posts being confident compared with 64% of doctors in training in psychiatry posts and 62% in surgery posts.²³

Raising educational concerns

In the 2018 NTS, nine out of 10 (90%) doctors in training said that they are confident they know how, or could find out how, to raise a concern about their education or training.

However one out of ten (10.5%) doctors in training are not confident that their concern would be addressed. Only two thirds (66.7%) are confident. Just three in five trainers in occupational medicine (61.2%), obstetrics and gynaecology (61.1%), and medicine (60.3%) feel confident that concerns will be addressed.²³

Raising concerns and leadership

NTS findings show that a substantial minority of doctors in training do not feel confident about raising concerns, nor do they feel that any concerns raised will be dealt with appropriately. In addition, our RLS and devolved offices have picked up significant anecdotal evidence that confidence in raising concerns is not uniform, highlighting the need for leaders to work proactively on ensuring just cultures where concerns can be raised easily, without fear, and appropriate learning or action can happen.

This issue, if not addressed, can have serious consequences for the wellbeing of doctors and the quality of care patients receive. In the many inquiries into patient harm such as Mid Staffordshire, and more recently Gosport, doctors reported that there is a lack of response from senior management and others when they raise concerns.

Jeremy Hunt, then UK health secretary, said Gosport showed there was a blame culture across the health service that made medical staff reluctant to raise the alarm about mistakes.⁶¹

Good leadership is crucial in creating a workplace environment where patients' interests are prioritised and staff are supported in maintaining standards. If the top of the organisation can demonstrate that the good clinician is one who learns from experience, this will help mitigate the fear of blame among staff, which may act as a barrier to reporting errors.

The qualitative data that we capture from the interactions of our staff with doctors on the frontline demonstrate that good leadership in this area can have a positive effect and is therefore worthwhile. We have captured some

instances of a positive mood coming from good leadership and doctors feeling listened to and prepared appropriately.

But our qualitative data also demonstrate that this level of leadership is lacking in some places. Some doctors have explained that they don't raise concerns, or that they feel unwilling to do so, because they worry about personal negative consequences if they do so. This includes being labelled a troublemaker, not being able to get references or other future damage to their careers, and getting other colleagues in trouble.

We also have evidence from our internal intelligence gathering that some consultants are discouraging less senior doctors from exception reporting or rota monitoring. These are the mechanisms for doctors in training across the UK to report concerns they have about the impacts of working in under-resourced environments.

Part of the independent review of gross negligence manslaughter and culpable homicide will address how doctors feel able and better supported to act on their concerns.

Doctors are also concerned that individual clinicians are being held accountable for system pressures. They fear they are getting the blame when things go wrong.

The independent review is also looking to address how accountability is appropriately apportioned between healthcare systems and individual doctors.

GMC response to raising concerns

We are completely committed to playing our part in engendering a speak-up culture across the healthcare sector. We have a pivotal role to play

in making the health service a place for learning, not blaming.

The Emerging Concerns Protocol

As we outlined above, we are one of eight health and social care regulators in England which have signed a new agreement to help them share with each other more effectively concerns that may indicate current or future risks to users of services, their carers, families or professionals.

In particular the Protocol will provide an avenue for raising concerns that might not have triggered other formal information sharing processes. There is significant emphasis on creating and nurturing open cultures where staff can speak up about their concerns.

Exception reporting and rota monitoring

Since the introduction of exception reporting in 2016, organisational cultures, staff engagement and differences in local processes have all impacted on its effectiveness.

We have been pushing for the standardisation of exception reporting across England and are working with the BMA and the wider medical profession to improve how doctors of all grades can register safety concerns about working in an under-resourced environment.⁶²

In June 2018, we, together with NHS Improvement, the AoMRC, the BMA, the CQC, HEE and NHS Employers, agreed a joint approach to improving exception reporting. We are also currently working with partner organisations in Scotland, Wales and Northern Ireland on issues around rota monitoring, in particular the BMA.⁶³

When doctors fail to meet standards

We have systems in place to support doctors who may be struggling to meet our professional standards as set out in *Good Medical Practice*.⁵⁷ When these standards are breached, doctors may become subject to fitness to practise investigations.

In the web annexe we detail our full fitness to practise data. Here we examine certain elements that relate to this chapter's themes of maintaining high standards and fairness.

Complaints about doctors

Most doctors do not have complaints that question their fitness to practise and, as we saw in chapter 3, many doctors are going the extra mile to deliver high-quality care and cope with the current pressures in their work environments. Only a tiny minority are given sanctions or warnings each year.

Complaints continue to decline

Complaints made to the GMC about doctors continue to fall. In the 2017 report we saw that the decline in complaints had slowed but the downward trend continued, with a year-on-year reduction of 8%.

Over the five years from 2012 to 2017 complaints reduced by 13%. Complaints from people acting on behalf of organisations (other than employers)

reduced by 46% between 2012 and 2017 to 869 in 2017, and complaints from members of the public reduced by 10% to 5,005 – the reasons for this reduction are unknown (figure 43, see page 124).

Referrals from employers reduced by 46% (from 604 to 328, between 2012 and 2017), which is in part due to a range of activities, such as our work to encourage more health cases being resolved at a local level where possible, and the Employer Liaison Services (ELS) work with employers to improve their understanding of our referral thresholds, ensuring only relevant cases are referred to us.

The number of complaints referred to employers dropped in 2013–14 (figure 44, see page 125), which may have been due to changes made to our online complaints form. These changes help complainants understand more clearly what types of complaint should be made to the GMC and which could be made locally. We also made changes to our guidance regarding doctors' duty of candour, which has resulted in the 98% increase in doctors self-referring to the GMC. The guidance says doctors must be open and honest with their regulators and raise concerns where it is appropriate.⁶⁴

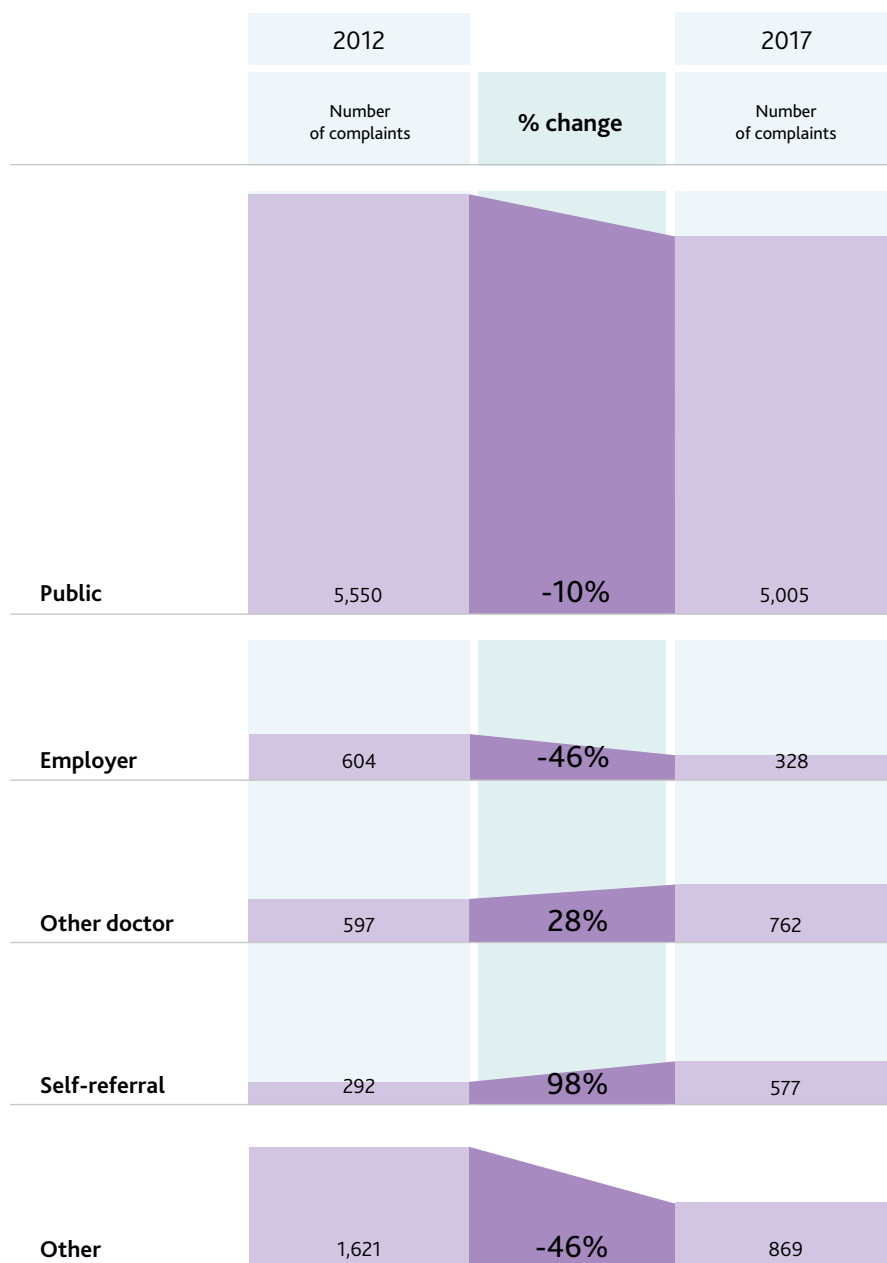
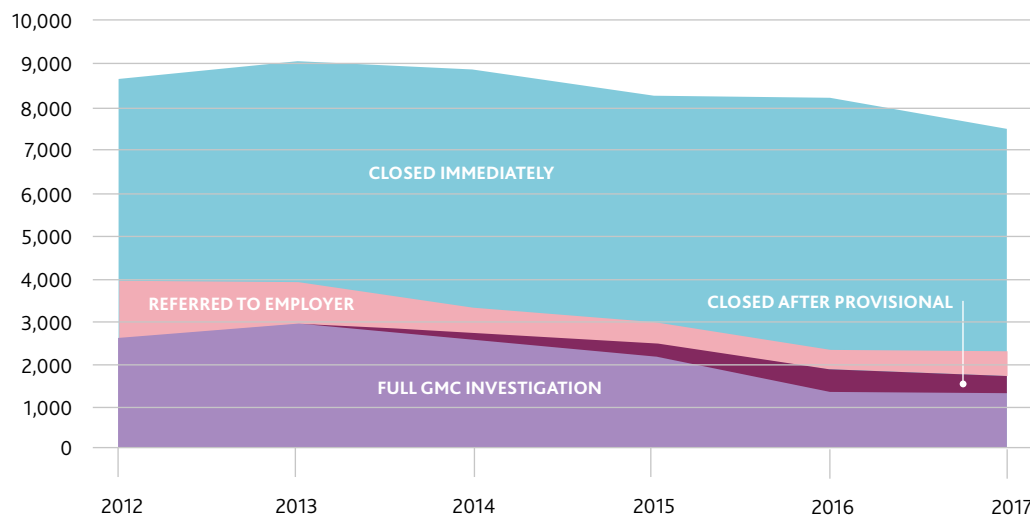
Figure 43: The change in complaints from each source, from 2012 to 2017

Figure 44: Complaints received by outcome,* from 2012 to 2017

Reforms to fitness to practise

Through our fitness to practise reforms, we are developing and implementing a range of actions to ensure high standards while also supporting doctors going through the process.

This includes reducing the number of full investigations, thereby minimising stress for doctors and time spent away from practice. We are also developing a 'Local first' approach (see below).

Provisional enquiries

As figure 44 shows, most complaints about doctors are closed immediately where there are no grounds for further examination of the complaint. Where this is not the case, complaints are sometimes referred back to employers if they are the most appropriate body to handle them. For example some complaints made about behaviour or communication not linked to a wider pattern of behaviour. Prior to 2014,

all the remainder were subject to a full GMC investigation that would often put a significant burden on the doctor involved, even if the case were subsequently closed with no further action. Since then, as part of our efforts to reduce the burden on doctors who become involved in fitness to practise procedures, we have introduced provisional enquiries. This allows for further examination of some complaints to be made to determine whether a full investigation is really a necessary and proportionate response to the complaint.

The roll-out of this new process has meant that, by 2017, 40% of complaints that are not closed immediately or referred back to employers are now subject to provisional enquiries. Of these, 68% have not subsequently required a full investigation. Since being introduced, 951 complaints have been closed after provisional enquiries, reducing considerably the burden on the doctors concerned, compared with what would have been the case had they been subject

* There are 94 complaints still being assessed not included in this chart, data as of 15 May 2018.

to a full GMC investigation. The proportion of complaints which go through to a provisional enquiry has been increasing as the process becomes more embedded (7.8% of complaints in 2017 went through to provisional enquiries compared with 6.9% of complaints in 2016 and 4.5% in 2015).

Details of the provisional enquiry process are described in box 10. The level of risk we are

willing to accept has not changed, nor the thresholds for investigation; we remain confident in the assurances our processes provide. However the success of the provisional enquiry process showcases that some innovation is possible within the restrictions of our current legislation.

Box 10: How we have implemented provisional enquiries

A provisional enquiry is a limited, initial enquiry at the triage stage of our fitness to practise process to help us decide whether to close a complaint or open a full investigation. It is essentially a way of filtering our complaints to minimise the number of full investigations we need to carry out. It helps us to respond more quickly and proportionately to a complaint, and to accurately assess risk and to avoid unnecessary investigations.

We aim to complete provisional enquiries within 63 days compared with six months for a full investigation, helping reduce unnecessary stress and inconvenience to all parties involved, and reduce the time that the complainant spends waiting for a response. It also allows us to put more resources into the most serious cases.

During a provisional enquiry we gather one or two discrete and easily obtainable pieces of information such as medical records and/or a local investigation report. We may also seek an expert medical opinion to inform our decision making.

The introduction of our liaison teams, the ELS and RLS, has strengthened our relationship with the profession and their employers by facilitating closer working. This has enabled us, via the ELS, to gather the easily obtainable evidence which is needed to inform the provisional enquiry process. Through the ELS we are able to increase confidence in local processes and it is often as a result of our confidence in the robustness of local processes that we are able to close enquiries to us and allow them to be dealt with locally. Our ELS, RLS and devolved offices allow us to increase our understanding of what is happening on the ground in an area. The embedding of the revalidation process and enhanced local governance processes have also streamlined the way we can gather the necessary evidence.

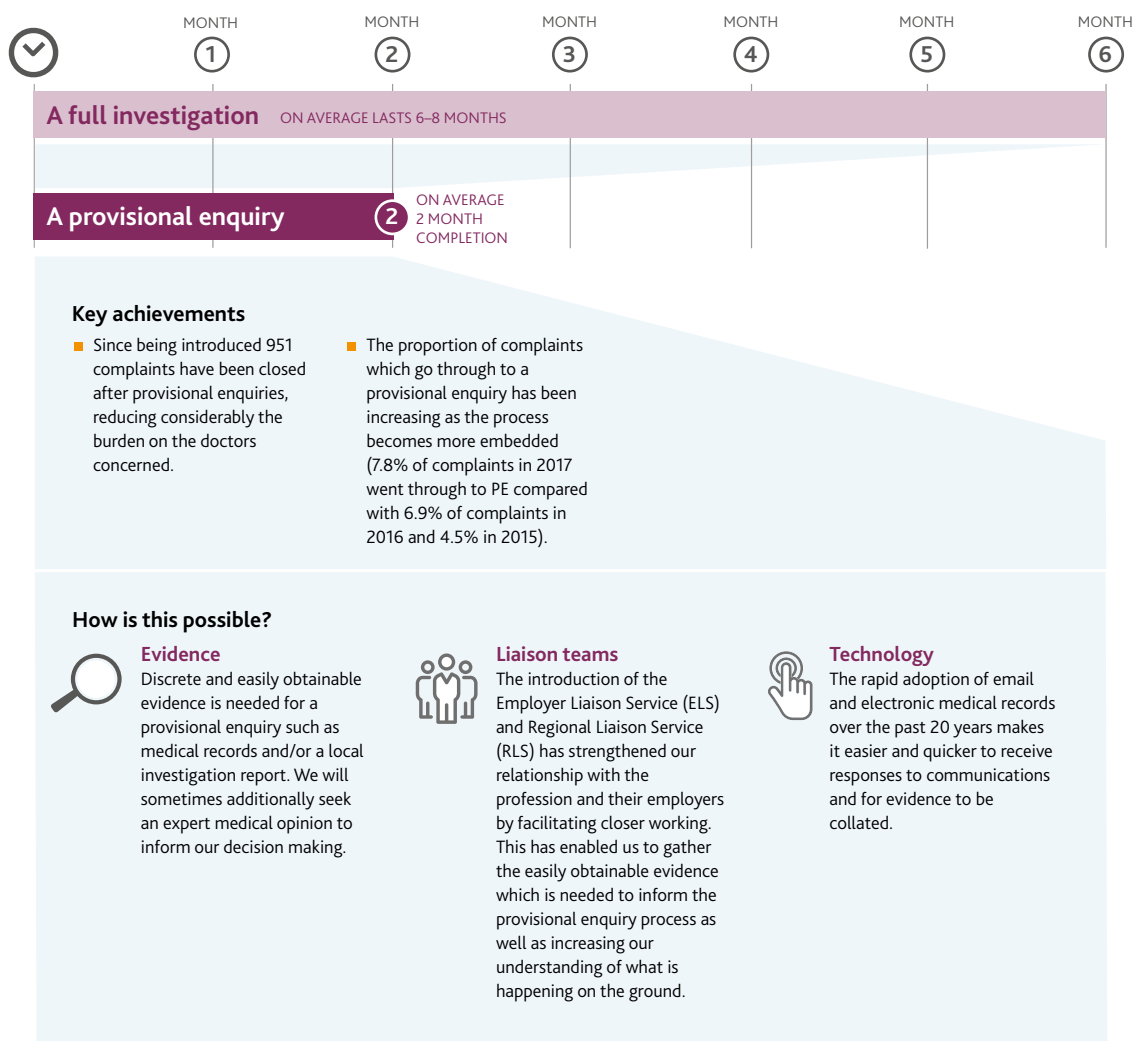
The rapid adoption of email and electronic medical records over the past 20 years makes it easier and quicker to receive responses to communications and for evidence to be collated.

Why did we introduce provisional enquiries?

On reviewing our data, we found that between 2010 and 2013 85% of investigations were closed with no formal action against a doctor. We

therefore acknowledged that our current fitness to practise processes were not proportionate and sought a way we could improve our processes through our current legislative boundaries.

Figure 45: A full investigation compared with a provisional enquiry



Local first

We've come a long way in recent years to improve how we handle complaints about doctors. But there is still much more we want to do to make sure concerns are dealt with as swiftly and efficiently as possible for everyone involved. We still know how stressful the whole complaints process can be.

Our long-term aim (requiring legislative reform) is that all complaints and concerns about doctors should be dealt with at the right level and, where appropriate, concerns should be addressed locally, only involving GMC action where necessary. Resolution at local level is likely to increase the learning from an incident within

the organisation where the incident occurred. This is particularly important as a variety of the strategies identified in chapter 3 are adopted in different places to deal with the pressures we have been reporting on.

Our corporate strategy¹⁶ commits to a pilot of a 'local first' approach by 2020. We are currently carrying out a programme of research to help us understand and map out how this would work, what the challenges, risks and benefits are, and how we can work with our key partners to partially achieve this ambition within our current legislation, while also being clear about where legislative reform is most important.

Box 11: How the GMC takes the context of an incident into account

When we consider a complaint, we look at potential individual or system failings (or a combination of both) and take these into account when considering whether action is needed.

We are now giving all fitness to practise decision makers, case examiners and clinical experts human factors training. Being aware of human factors means considering what people are being asked to do, the skills and competence of the person being asked to do it, and the environment in which they are working. These factors are all relevant to the context in which incidents take place, and we are committed to ensuring that they are always taken into account appropriately.

In cases where a healthcare organisation has referred the doctor to us, we also confirm whether the doctor has previously raised any concerns about patient safety or systems. This helps us understand the context of the case and reduces the risk of doctors being disadvantaged for raising concerns.

Our focus is on whether the concern and the doctor's response suggest that the doctor is likely to pose a risk to patients or to public confidence in doctors in the future, rather than on punishing doctors for what has gone wrong in the past.

The risk will be lower for a doctor who shows insight into what has happened and retracts to make sure that mistake can't happen again.

Fairness in fitness to practise

We take our responsibility to be a fair and transparent regulator very seriously.

There have been claims that we act in a discriminatory way and that our fitness to practise procedures exhibit institutional bias against groups of doctors, such as BME doctors.⁶⁵ However research has indicated that it is the nature and seriousness of allegations that are the primary drivers of the outcome of an investigation.

Our data analysis and audits to date indicate that our processes do not introduce disproportionate outcomes for doctors of particular ethnicities. We continually monitor this issue and improve our methods of data analysis in this area. We are undertaking further analysis of our approaches and will fully publish this in 2019.

Although we have been assured that there is not disproportionality of outcome as a result of our processes once a complaint is received, we know that there is disproportionality in the flow of complaints into the GMC. Some groups are more prone to complaints or concerns from particular sources, such as the police or employers compared with other groups. Successive reports on *The state of medical education and practice in the UK* have found, for example, an overrepresentation of BME doctors being complained about by these two sources.⁶⁶

Research has not yet established deeper reasons behind why certain groups of doctors are referred more often.

So, we have commissioned independent research to better understand this issue.¹²

It will include:

- understanding how clinical leadership influences the way healthcare organisations identify and respond to concerns that might result in referrals
- looking at how the complaints are dealt with locally, for example through disciplinary hearings, before a decision is made to refer to the GMC
- understanding how organisations assure themselves regarding their decision making about fitness to practise concerns and identifying where there is good practice that could be replicated more widely.

The research is being carried out by Roger Kline, Research Fellow at Middlesex University Business School, and Dr Doyin Atewologun, an expert in work psychology, diversity and leadership at Queen Mary University of London's School of Business and Management.

The work will cover all four countries in the UK and cover a broad range of types of employers across the health sector. The results will be published in the first half of 2019.

This will enable us to work more closely with clinical leaders to properly develop supportive and open workplaces. There will be important lessons for employers as well. We aim to work with employers to help us better understand and address the reasons for this, although solutions are unlikely to rest wholly with us.

Box 12: Diversity on our tribunal panels

Of the Medical Practitioner Tribunal Service's 306 members, 46% are female and 19% identify as BME.⁶⁷

This compares favourably with the most recently published figures for courts in England and Wales (28% female and 7% BME) and

tribunals in England and Wales (46% female and 14% BME).⁶⁸

It also compares well with the UK population (51% female and 13% BME).⁶⁹



How we and others can build a sustainable workforce

The GMC can contribute to workforce strategies across the UK to deal with the pressures outlined in previous chapters. We outline some in this chapter



We are working with others to help recruit and retain more doctors, particularly GPs

We have started an independent review of medical student and doctor wellbeing



We are calling for changes to outdated legislation that blocks us from most effectively supporting health systems, doctors and patients in the 21st century

Our programme of 'Welcome to UK practice' inductions for doctors new to the UK is being expanded

We are making post-graduate training more flexible and relevant to meet changing workforce and patient needs



We are exploring with others establishing a national database that more accurately captures doctors' scope of practice so that capabilities and gaps can be better identified

Introduction

As demonstrated in the previous chapters, the health system across the UK is at a critical juncture: a combination of increasing demand on services, changing career expectations from clinical professionals, greater prevalence of multimorbidities in an ageing population, and the challenges of implementing, regulating and paying for new technology collectively creates significant pressures that are putting patients at risk now and in the future.

In our clinically led system, the medical workforce of nearly 245,000 licensed doctors in the UK is at the heart of this storm.

As the body responsible for regulating the medical education and practice of doctors in the UK, we can support the four governments, their health systems, and doctors, bringing ideas, data, insight and our regulatory toolkit to bear as part of a systemic response to a national challenge.

In this chapter we examine what could be done by us and in collaboration with others:

A Improving the supply of doctors:

we believe we can build on our existing work set out in chapter 4. This includes in the short term making it easier for international doctors to work in the UK by reforming legislation to make the route for joining the GP Register and the Specialist Register more proportionate. And in the longer term making training more flexible and more relevant, by reviewing training pathways through allowing a more modular approach to postgraduate training. Finally to ensure relevant skills such as clinical leadership

and risk management in complex systems are included in training, we could promote these through generic professional capabilities or through weighting curricula outcomes.

B Better support to retain and attract doctors:

we are continuing to build on our 'Supporting a profession under pressure' programme⁴⁸ so as to play our part in developing good workplace cultures and supportive environments. This will include acting upon the findings of the UK-wide review of medical students and doctors' wellbeing led by Professor Michael West and Dame Denise Coia. We are also reviewing the way we quality assure education and training whilst continuing to support those in enhanced monitoring and engaging on proposals for introducing credentialing in areas that are not currently regulated or where training opportunities are insufficient or too inflexible to support service delivery.

C Taking a more strategic approach to maintaining and improving standards:

we recognise that we can better support the profession in partnership with other

parts of the health systems in the UK. For example we are working with partners to explore how more data on doctors' scope of practice might be captured to inform strategic workforce planning and reviewing how our front line engagement teams engage with the profession and the health systems in which they work.

Many of the options we present below can be implemented as part of ongoing work programmes, though some will need a willingness to challenge long-held assumptions about medical education and careers. Some

will require flexibility of regulation that can only be delivered through legislative reform to a legislative framework that is over 35 years old and becoming an active block to supporting the health systems and patients.

In the long term, we believe that with legislative reform of the Medical Act,²⁷ we could shift much of the significant resource that the GMC has into oversight of education and training and upholding medical standards whilst reducing pressures on practising doctors, improving their productivity and service to patients.

A: Improving the supply of doctors

In chapter 2, we looked at the medical workforce, highlighting specialisms and localities where there is the risk that there may not be the supply of doctors required to meet growing demand. Multiple approaches are possible to improve supply and here we consider some that we could particularly contribute to alongside others.

General practice

We have been working with NHS England (NHSE), Health Education England and the Royal College of General Practitioners (RCGP) to support the international GP recruitment programme. Part of that programme included mapping the UK GP curriculum against two GP curricula in Australia. This means that GPs trained in Australia under those curricula will be required to provide significantly less evidence as

part of any GP registration application for the UK. We have also supported NHSE and HEE to proactively contact overseas doctors currently training in the UK to encourage them to consider primary care for their specialty training and remain in the UK to work following completion of their certificate of completion of training (CCT).

In addition, we have begun to explore with partners what additional flexibility there could be with the Performers List in England. Work is under way to review these regulations in light of the wider service changes in primary care following the NHS five-year forward view and the establishment of sustainability and transformation partnerships (STPs) and accountable care organisations. Additional flexibility in the Performers List* could include adding the outstanding cohort of defence

* Each country in the UK holds a National Performers List for GPs which is set out in legislation. The list provides an extra layer of reassurance for the public that GPs practising in the NHS are suitably qualified, have up-to-date training, have appropriate English language skills and have passed other relevant checks. The Performers List also includes processes for responding to concerns about GPs and taking local action to restrict or suspend their practice when appropriate.

medical services GPs onto the list so that they can also work in the NHS. Further segmenting the Performers List to include other groups of doctors could support the retention of retiring or returning GPs to work within a limited scope of practice and the development of a specialty doctor cohort where non-GPs could work in limited primary care roles. These changes would expand the primary care workforce, lessen the demand on GPs for some aspects of care and free up capacity.

The GP Register and the Specialist Register

We are seeking legislative reform of the equivalence route for joining the GP Register and Specialist Register (also known as certificate of eligibility for specialist registration (CESR) and certificate of eligibility for general practice registration (CEGPR routes). This reform will provide greater flexibility in the process and support doctors with a wider range of options to demonstrate their knowledge, skills and experience for GP registration. In most cases, this would reduce the time required of doctors to collate the evidence for their applications, which should encourage more doctors to seek registration as well as shorten the amount of time it takes doctors to join the GP Register or Specialist Register.

Enabling IMGs to access PLAB more quickly

In order to obtain UK registration, most overseas doctors must pass the two parts of the Professional and Linguistic Assessment Board (PLAB) test. The numbers of overseas doctors seeking to sit the PLAB assessment test has

increased significantly in the past 12 months with around a 45% increase in PLAB1 candidates and more than 75% increase in doctors sitting PLAB2. To support this demand we have run more PLAB2 testing days than ever. We have also opened and/or expanded our existing PLAB1 assessment centres in numerous countries to make it easier for doctors to book onto a test. This included, for the first time this year, offering PLAB1 in our office in Scotland following discussions with the Scottish Government. In summer 2019 we will also open a new two-circuit clinical assessment centre in Manchester for the PLAB 2 assessment, which will reduce waiting times and support doctors to obtain registration more quickly.

Making training more flexible and relevant

We will continue reviewing training pathways, in particular looking at how postgraduate training can have a more modular approach to ensure doctors in training learn the relevant skills, such as clinical leadership. This review will also explore the legal possibilities for recognising experience gained outside approved training. This work would be undertaken with Royal Colleges, The Academy of Medical Royal Colleges, and Health Education England (HEE), NHS Education for Scotland (NES), the Northern Ireland Medical & Dental Training Agency (NIMDTA) and Health Education and Improvement Wales (HEIW). In addition, we want to explore the legal possibilities around recognising more of the experience gained outside approved training, as part of the overall educational approach.

Medical associate professions

We believe there's a strong case for one regulator to have oversight of both the medical profession we currently regulate and the medical associate professions (MAPs) and their training systems. We would be willing to take this responsibility if the government selects us.

Legislative reform will be required once the Department of Health and Social Care has made its decision on MAPs regulation.

Internationally based doctors treating patients in the UK

With advances and developments in technology and telemedicine, we are exploring how to maximise the longer-term potential for internationally based doctors to treat UK patients, with the same assurance on standards as when the care is provided by UK based doctors. Some developments in this area may require legislative reform.

Strengthening oversight of the training environment

We are seeking stakeholder support in all four countries for new and more proportionate powers that strengthen oversight of the training environment. This would allow a gradation of powers to intervene when necessary to provide support, which will make improvement possible. These are required particularly for foundation training and new initiatives such as trust fellowship* programmes.

Medical Licensing Assessment

In the medium term, the introduction of the Medical Licensing Assessment from 2022 means that UK medical students and IMGs will have to demonstrate that they meet a common threshold for safe practice in the UK before we register and license them. This will give greater assurance to patients, employers and educators that doctors entering the UK workplace have the knowledge and clinical and professional skills for safe practice.

Supporting doctors who are not on the GP Register or the Specialist Register and not in training

We will be surveying doctors on neither register and not in training in 2019 to seek greater insight into their motivations, experiences and challenges. By getting a better understanding of this group we will be able to identify the best ways to support and develop this part of the workforce.

Incentivising good workforce culture and employment practice

We will explore how we can incentivise good workforce culture and employment practice in partnership with regulatory colleagues within the health systems of the UK.

* Trust Fellowship Programmes are a new approach to training which some individual trusts choose to offer. They offer an alternative to formal postgraduate medical training. Non-consultant grade doctors are able to work permanently for a trust and receive additional training. Doctors are able to continue to develop their careers, specialise, and gain experience so that they can apply for a CESR in the future, rather than using formal postgraduate training to obtain a CCT.

B: Better support to retain and attract doctors

We have looked, particularly in chapter 3, at the pressures encountered by doctors and the support that they value. We have also shown in chapter 4 how we work with employers and educators to support doctors, particularly those in training. We are continuing to build on this through our 'supporting a profession under pressure' programme,⁴⁸ and the following proposals look at how we can do more by working with others to ensure we retain the workforce we have.

Supporting good workplace culture and wellbeing

We've started a UK-wide review of medical students and doctors' wellbeing, led by Professor Michael West and Dame Denise Coia. This review will identify the factors that impact on the wellbeing of medical students and doctors across the four countries of the UK.

The findings from this review will be published in 2019 and will enable us to work together with organisations across the UK to agree priority areas for collaborative action to help tackle the causes of poor wellbeing.

Enhancing support to doctors who are new to practice in the UK

Our 2018–20 corporate strategy¹⁶ is committed to enhancing support to doctors who are new to practice in the UK by encouraging them to attend our Welcome to UK Practice sessions.

Offering greater support to providers in enhanced monitoring

We currently have a review of our quality assurance processes in education and training underway. Additionally, we will also continue to support postgraduate bodies in their work with local education providers who are in enhanced monitoring.

Credentialing

We are engaging on a draft framework for credentials, which we plan to launch in 2019. This will address areas that are not currently regulated and enable greater flexibility to meet patient and service needs. This will recognise the experience and knowledge that has previously gone unrecognised.

C: Strategic approach - taking a more systemic approach to maintaining and improving standards

We recognise that no single organisation can deliver on reducing the pressures that threaten standards or develop the most optimal framework for understanding risk and thereby more effectively maintain and improve standards. A coordinated approach is necessary involving government, arm's-length bodies, professional regulators, regional leaders, providers, patients and the public, and, of course, the professions. This may require a strategic alignment of all these organisations.

Enhancing insight into distribution of doctors across the UK

We are undertaking work with partners to explore how more data on the scope of practice of doctors could be captured. A database of this information, identifying who is providing what practice and where, would enhance and better support workforce planning and the identification of gaps and capabilities across the UK. We have much data and insight to support this, so it could be developed with minimum burden to inform strategic workforce planning and to help target our support to maintain and improve standards.

Strategic approach to front-line engagement on continuing professional development

We are currently reviewing our field forces – those parts of the GMC that engage directly with doctors and the health care systems in which they work – in order to ensure we are engaging in the most effective way with regulatory partners in supporting providers and clinicians and protecting patients at a national, regional and local level.

Conclusion

We will be following up the research findings and issues reported in this year's report, looking at what we can contribute to address areas of concern. We will report back on progress in next year's report.

Glossary

AoMRC	Academy of Medical Royal Colleges
BMA	British Medical Association
BME	Black and minority ethnic
CAC	Clinical Assessment Centre
CBT	Cognitive behavioural therapy
CCT	Certificate of completion training
CEGPR	Certificate of eligibility for general practice registration
CESR	Certificate of eligibility for specialist registration
COPMeD	Conference of Postgraduate Medical Deans
CPD	Continuing Professional Development
CQC	Care Quality Commission
CSA	Clinical Skills Assessment
DA	Differential attainment
EEA	European Economic Area
ELS	Employer Liaison Service
EU	European Union
GMC	General Medical Council
HEE	Health Education England
HEIW	Health Education and Improvement Wales
HIS	Healthcare Improvement Scotland
HIW	Healthcare Inspectorate Wales
IMGs	International medical graduates
JSOG	Joint Strategic Oversight Group
MAPs	Medical associate professions
MLA	Medical Licensing Assessment
MRPQ	Mutual Recognition of Professional Qualifications
NES	NHS for Education for Scotland
NHSE	NHS England
NIMDTA	Northern Ireland Medical and Dental Training Agency
NTS	National training surveys
PLAB	Professional and Linguistic Assessments Board
PMQ	Primary medical qualification
PSIF	Patient Safety Intelligence Forum
RCGP	Royal College of General Practitioners
RLS	Regional Liaison Service
RQIA	Regulation and Quality Improvement Authority
SAS	Staff grade, specialty, and associate specialist doctors
STPs	Sustainability and transformation partnerships
UKAF	UK Advisory Forums

A note on research and data

The analysis and data in this report have been drawn from primary research, and from the information we collect when registering doctors, assuring the quality of medical education and training, and assessing doctors' fitness to practise.

Commissioned primary research

We commissioned* three research projects exploring the experiences of doctors in the UK. The research methods of each of these are outlined below.

What it means to be a doctor

This research, carried out by independent research consultancy ComRes,[†] explores themes such as the motivations, morale, and working pressures experienced by doctors over the last three years. This project aimed to gain an in-depth understanding of the professional experiences and perceptions of doctors that impact on the ways they practice and develop their careers. Understanding the challenges that doctors encounter across their professional lives, and what shapes their approach to practice, can help us to become a more effective regulator by targeting our support and other interventions appropriately.

This project used a mixed methods approach. An initial scoping phase used a literature review and 25 interviews with stakeholders across the UK, including representatives of doctors, educators, trainers and employers, to determine the themes to be explored throughout.

2,602 of the UK's registered doctors then completed an online survey. A representative sample of the medical profession was drawn from

the GMC register, applying quotas by nation, age, gender, ethnicity, registration status, and where the doctor's primary medical qualification (PMQ) was achieved. Participants responded to a range of open and closed questions, offering rich data both qualitative and quantitative.

Use of net values in the *What it means to be a doctor* survey data

Net values have been used in reporting the data from the *What it means to be a doctor* survey.

- **'at least once a week'** includes all those respondents who chose 'every day/ almost every day' as their response in the survey
- **'at least once a month'** includes all those respondents who chose: 'every day/ almost every day', 'several times a week', 'weekly' or 'monthly' as their response in the survey
- **'less than monthly'** includes all those respondents who chose: 'every few months', 'once or twice a year' or 'never/ almost never' as their response
- **'overall increased'** includes all those respondents who chose: 'increased a great deal', 'increased' or 'somewhat increased' as their response in the survey
- **'overall decreased'** includes all those respondents who chose: 'decreased a great deal', 'decreased', or 'somewhat decreased' as their response in the survey.

* Each of the research organisations undertaking the research had been selected through a competitive tendering procurement process.

† ComRes is a member of the British Polling Council and abides by its rules.

Having completed the online questionnaire, participants were asked by ComRes if they would be willing to take part in a follow-up depth interview. A number of those who gave consent were contacted to provide a purposive sample. The interviews allowed for elaboration on some of the key themes emerging from the online questionnaire, and have added depth and nuance to the findings.

Adapting, coping, compromising – qualitative study

Knowing as we do that pressures in the UK health system are mounting, we commissioned Community Research* to conduct research exploring how doctors are practicing in this system 'under pressure'. We were interested to explore whether doctors are adapting their individual practice to mitigate pressures and what forms this takes, and consider the sustainability of working under pressure, and of the approaches taken in response.

The initial qualitative phase of this project comprised 40 in-depth interviews with doctors across the UK. Participants were representative of the UK's medical workforce across a range of factors including; the country of the UK in which doctors primarily practice, the main setting in which roles are carried out, career stage/seniority, and specialism. All interview participants were invited to complete a follow-up activity which saw them keeping an app-based diary of situations in which they had to make adaptations or compromises in order to cope with their workload or system pressures. A total of 15 doctors participated in the follow-up activity.

Adapting, coping, comprising – quantitative study

The quantitative phase of this research saw 700 doctors take part in a rapid survey, with sampling carried out by independent research consultancy medeconnect.† Their sample included 100 of each of the following groups of doctor: GPs aged 45 or under; GPs aged over 45; specialists aged 45 or under; specialists aged over 45; doctors on neither register and not in training aged 45 or under; doctors on neither register and not in training aged over 45; doctors in training (mixture of secondary and primary care trainees).

The responses to the survey used throughout this report are unweighted. Weighting samples of this size can reduce the accuracy of the statistics used, so in the interests of good practice and transparency we have used unweighted data – ie the actual responses without a further statistical transformation. However, we have checked that weighting the results on the basis of the relative size of each surveyed group on the register in 2018 makes a negligible difference to the results for 'all surveyed doctors' responses (of 0–3 percentage points per question). None of the conclusions or expressions of relative scale used in the text, such as 'two-thirds' or 'one in 10' would be different if the weighted percentages had been used instead of unweighted data.

Participants answered 12 closed questions in a short online questionnaire. The questions were based on emerging findings from the qualitative interviews and extended the scope of the project by increasing the sample size, and quantitatively testing a number of key themes.

* Community Research are a Company Partner of the Market Research Society.

† medeConnect are a member of the British Healthcare Business Intelligence Association and the European Pharmaceutical Market Research Association.

Use of net values in the *Adapting, coping, compromising* survey data

Net values have been used in reporting the data from the *Adapting, coping, compromising* survey.

- **'overall agree'** includes all those respondents who chose 'agree strongly' or 'agree somewhat' as their response in the survey
- **'overall disagree'** includes all those respondents who chose 'disagree strongly' or 'disagree somewhat' as their response in the survey
- **'overall decreased'** includes all those respondents who chose 'increased substantially' or 'increased somewhat' as their response in the survey
- **'overall increased'** includes all those respondents who chose 'decreased substantially' or 'decreased somewhat' as their response in the survey
- **'overall deteriorated'** includes all those respondents who chose 'deteriorated significantly' or 'deteriorated somewhat' as their response in the survey
- **'overall improved'** includes all those respondents who chose 'improved significantly' or 'improved somewhat' as their response in the survey

National training survey (NTS)

As with previous editions of *The state of medical education and practice in the UK*, we have drawn insights from this year's national training survey (NTS) – our annual survey of 70,000 doctors in training and the doctors who act as trainers. By gathering the views of these doctors we are able to make sure doctors in training receive high quality training in a safe and effective clinical environment, and trainers are well supported in their role.

Consistency in classifying doctors area of practice in primary research surveys

To make sure we are consistent in the way we have reported the data from both *What it means to be a doctor* and *Adapting, coping, compromising*, we have used the following terms in the data reported in *The state of medical education and practice in the UK*:

- doctors who classified themselves as 'consultants' are referred to as 'specialists'
- doctors who classified themselves as 'specialty doctor / staff grade / associate specialist' are referred to as 'doctors on neither register and not in training'

Our data

Our in-house data in this report were primarily drawn from the information we collect when registering doctors, assuring the quality of medical education and training, and assessing doctors' fitness to practise.

Where comparative differences are reported in the text, these are large enough to be robust to the occasional proportional changes that have previously been observed in our data due to on-going GMC processes.

Percentages in all tables are rounded and may not add up to 100%.

Data for the analysis of the profession in 2018 refer to the the List of Registered Medical Practitioners (LRMP) known as the medical register, the GP Register and the Specialist Register on 30 June 2018. Data for the analysis of the change between 2012 and 2018 refer to the state of the registers on 30 June of each year between 2012 and 2018. Where data are aggregated over 2012–18, the number of doctors are taken as being the count of doctors over those years. In figures or tables showing GPs and specialists separately, the very small number of

doctors who are on both the GP Register and the Specialist Register are excluded unless stated otherwise.

Fitness to practise data

Fitness to practise data for 2012–17 was for enquiries either received or closed between 1 January 2012 and 31 December 2017. The data were drawn from the GMC's database on 15 May 2018. For data referring to specific years, we used enquiries received between 1 January and 31 December of that year, except where we label an enquiry as being closed in that year.

Data for cases closed in each year were for enquiries closed between 1 January and 31 December of that year at the point of a decision being made – either the case examiner giving a decision, or the Medical Practitioner Tribunal Service hearing ending. 41% of complaints that originated in 2017 and were investigated did not yet have an outcome (674 complaints) when the data were drawn from the GMC database.

Data on medical students and doctors in training

Data about medical students by academic year between 2011 and 2017 came from the medical schools' annual reports to us.

The number of doctors in postgraduate training programmes is from data that HEE local teams in England and deaneries in Northern Ireland, Scotland and Wales provided in the 2018 national training surveys – it was accurate on 20 March 2018.

The 2017 national training survey was open from 20 March to 09 May 2018. Doctors in training were asked about the post they were in on 20 March 2018. The results were calculated using all valid responses.

Areas of practice

Some doctors have multiple specialties recorded on the Specialist Register. For the analysis, we have used their primary specialty. We separate out GPs and do not include them in tables of specialties.

For the analysis of doctors' specialties, primary specialties were grouped into 13 specialty groups according to the current list of specialties and subspecialties by approved curriculum. All older terms were matched to the specialty group that was the best fit; where that was not possible, they were assigned to the 'other specialty or multiple specialty' group – 163 doctors were in this group in 2018.

Data relating to the age of a doctor

There is a small group of doctors on the register with no date of birth recorded (1.6% in 2012 and 1.1% in 2018). In these cases, we subtract 24 years from the full date that they passed their primary medical qualification (PMQ). This is a minor improvement in precision from previous editions that subtracted 24 years from the year, and not full date, of passing a PMQ.

Data relating to the ethnicity of a doctor

For the purpose of analysis, white ethnicity is defined as white British, white Irish and other white. Black and minority ethnic (BME) includes Asian or Asian British, black or black British, other ethnic groups and mixed ethnic groups. We did not know the ethnicity of 12% of licensed doctors on the register in 2018.

Data relating to the nationality of a doctor

At the time a doctor applies for registration, up to two nationalities may be recorded. For the

purpose of analysis, British nationality is where at least one of their nationalities is British, or derives from a country that qualifies them for British citizenship. EEA nationality are considered doctors who are not British and where at least one of their nationalities is from a country within the EEA. For the purposes of registration, the EEA is the 28 countries of the EU, together with Norway, Switzerland, Iceland and Liechtenstein. Doctors with all of their nationalities from countries outside the EEA are placed in Non-EEA nationality group. In 2018 we had no nationality information for almost 60,000 doctors (25% of all licensed doctors).

Regional and country data

The index of doctors per population given in chapter 2 figure was derived using a denominator based on mid-2018 population estimates from the Office for National Statistics in the UK. The regions of England are grouped according to regions defined by the Office for National Statistics, which were formerly called government office regions.

Countries are grouped into regions using the following groups

Africa: Algeria, Angola, Burundi, Cameroon, Democratic Republic of the Congo, Côte D'Ivoire, Ethiopia, Gabon, Gambia, Ghana, Guinea, Kenya, Liberia, Libya, Malawi, Mali, Mauritius, Morocco, Mozambique, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, Somalia, South Africa, Sudan, Tanzania, Togo, Tunisia, Uganda, Zambia and Zimbabwe.

Central Europe, eastern Europe and Baltic countries (EEA): Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Romania and Slovakia.

Northwestern Europe (EEA): Austria, Belgium, Denmark, Finland, France, Germany, Iceland, Ireland, Netherlands, Norway, Sweden and Switzerland.

Southern Europe (EEA): Bulgaria, Croatia, Greece, Italy, Malta, Portugal, Slovenia and Spain.

Non-EEA Europe: Albania, Belarus, Bosnia and Herzegovina, Kosovo, Macedonia, Moldova, Montenegro, Russia, Serbia and Ukraine

Middle East: Bahrain, Egypt, Iran, Iraq, Israel, Jordan, Kuwait, Lebanon, Oman, Palestinian Territories, Qatar, Saudi Arabia, Syria, Turkey, United Arab Emirates and Yemen.

South Asia: Bangladesh, India, Nepal, Pakistan and Sri Lanka.

Rest of Asia: Afghanistan, Armenia, Azerbaijan, China, Georgia, Hong Kong, Indonesia, Japan, Kazakhstan, Kyrgyzstan, Malaysia, Mongolia, Myanmar, Philippines, Singapore, South Korea, Taiwan, Tajikistan, Thailand, Turkmenistan, Uzbekistan and Vietnam.

Northern America: Canada and USA.

South, Central and Latin Americas and the Caribbean: Antigua and Barbuda, Argentina, Barbados, Belize, Bolivia, Brazil, Cayman Islands, Chile, Colombia, Costa Rica, Cuba, Curacao, Dominica, Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Montserrat, Nicaragua, Panama, Paraguay, Peru, Saba, Saint Kitts and Nevis, Saint Lucia, Saint Martin, South Netherlands Antilles, Suriname, Trinidad and Tobago, Uruguay and Venezuela.

Oceania: Australia, Cook Islands, Fiji, New Zealand and Papua New Guinea.

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