Contents

Foreword 03

An information resource 05

Executive summary 07
  Chapter 1 – Working during the pandemic 08
  Chapter 2 – Experiences and challenges in postgraduate medical education 09
  Chapter 3 – Workforce 10
  Chapter 4 – Building towards a positive future 11

Introduction 12
  Facing a new peak of pressure 12
  Forming the foundations for future healthcare 13
  Emerging into a new world 14

Chapter 1: Working during the pandemic 17
  Summary 18
  Introduction 19
  Working practices during 2021 20
  The impact on doctors 27
  Variation of experiences across the workforce 35
  Patient care 40
  Conclusion 45
## Chapter 2: Experiences and challenges in postgraduate medical education

Summary 47
Introduction 48
Training quality and supportive environments in 2021 49
Pandemic and recovery pressures on workloads and wellbeing 54
Implications of pandemic pressures for training opportunities and career progression 62
Wider trends and positive developments within postgraduate medical education 68
Conclusion 74

## Chapter 3: Workforce

Summary 76
Introduction 77
The number of doctors with a licence to practise 78
Doctors joining the UK workforce 81
Doctors in the UK training pipeline 86
Doctors leaving the UK workforce 90
Doctors’ future career intentions 93
Conclusion 96

## Chapter 4: Building towards a positive future

Summary 98
The opportunity to retain positive changes is now 99
Compassionate cultures help retain the positive changes made during the pandemic 103
Supporting workloads and efficient ways of working 104
Conclusion 108

## Glossary

110

## A note on research and data

111

## References

120

## Acknowledgements

124
Foreword

It’s nearly two years since the pandemic began, and today we find ourselves in a new, but no less critical, stage.

Against the ongoing backdrop of coronavirus, the health service is now contending with significant care backlogs, continuous high demand and the stark reality of the health needs of the population not being met.

Patients are facing crippling uncertainty as they wait for examinations, operations and treatment. The skill and professionalism of practitioners are required more than ever as the call to meet this deficit in care grows louder.

Doctors have performed with distinction, but now exhaustion and disillusionment are setting in.

Our research this year paints a worrying picture of rising burnout, declining job satisfaction and growing workloads against 2020 levels.

Doctors reporting an intention to leave UK practice is not new, but this year we see harder evidence of them taking steps towards this end, especially within the GP population.

Meanwhile, there is increasing pessimism around the ability to sustain the gains that were made early in the pandemic.

These imperatives – the recovery of services, the recovery of healthcare staff and the reduction in patient harm – go hand in hand, and balancing them will be central to success in the months ahead.

There is cause for hope.

Despite the difficulties, doctors still feel that the pandemic has led to positive changes, particularly in relation to teamwork and the sharing of knowledge across the profession. But we continue to see a range of different experiences. As a group, Asian and British Asian doctors, for example, were less likely than White doctors to agree that they were part of a supportive team.

At an organisational level, the continued focus on inclusive and compassionate cultures signals a system-wide consensus around the fundamental importance of practitioner wellbeing, another hugely encouraging sign.

It is absolutely crucial that we embed and build on these benefits in the months ahead. We all have a part to play in ensuring the stresses on the system do not harm the health and wellbeing of the workforce, or the patients they serve.

For us at the GMC, that means reassuring doctors that we recognise the severity of the present situation and want to support them as we move through the next few months. For employers, it means putting initiatives to improve working environments front and centre of their plans.

We know that culture and leadership are material to outcomes – both in shaping the care that doctors provide and in motivating them to stay in the workforce. Our research shows that the negative impact on wellbeing is the most common reason that doctors plan to leave the profession before their retirement.
The focus on retention must be matched by a commitment to sustainable recruitment. This includes both developing the next generation of UK-trained talent and giving overseas doctors, who continue to be an essential part of the workforce mix, the tools they need to thrive. Physician Associates and Anaesthesia Associates, due to come under GMC regulation, are also a vital piece of the puzzle.

This two-pronged approach – improving workplace experiences coupled with sustaining workforce supply – must be the shared agenda of all of us in the health system. First-class patient care demands it.

The challenges we set out in this report are large and long-standing, magnified by the pandemic but not created by it. To tackle them we must come together with a focus and determination proportionate to the scale of the task.

We know the solutions – now let’s work together to implement them.

Professor Dame Carrie MacEwen
Acting Chair

Charlie Massey
Chief Executive and Registrar
Alongside this report, we publish a range of data and information resources which underpin many of the analyses and findings that follow. This includes a set of reference tables, GMC Data Explorer, and GMC education data reporting tool.

**Reference tables**

The five areas these data cover are:

1. Who is on the medical register? Who is on the temporary emergency register (TER)?
2. How does the make-up of the register differ by country and region?
3. Who are doctors in training and what are their training programmes?
4. Who are trainers?
5. Fitness to practise data.

You can find the reference tables on our website: [www.gmc-uk.org/somep](http://www.gmc-uk.org/somep)

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**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.

It provides access to data on:

- the current location of registered doctors, where they graduated from and their deanery or local education providers
- education
- the number of doctors with open cases and active sanctions at each designated body
- what allegations are made about doctors over time.

You can find GMC Data Explorer here: [https://data.gmc-uk.org/gmcdata/home/#/](https://data.gmc-uk.org/gmcdata/home/#/)
The GMC education data reporting tool

Our education data reporting tool allows the public to access a wide range of information regarding medical education in the UK. The tool is commonly used by deaneries, royal colleges, trusts, and local education providers to quality-assure medical education.

The tool contains:

- Our national training survey (NTS) results, viewable at different organisation, programme, and specialty levels, including:
  - individual question-level results from the 2021 trainee and trainer surveys, as tables or graphs
  - comparisons between full-time and less than full-time trainees
  - results of burnout questions

- an enhanced monitoring dashboard, displaying the number of current cases in each UK country or region.

- progression reports on key stages in doctors’ training, such as:
  - specialty examinations
  - annual review of competence progression (ARCP)
  - application and entry into specialty training
  - foundation doctors’ preparedness for postgraduate training

- a summary dashboard showing a snapshot of data for any geographic location.

You can find the GMC education data reporting tool here:
The 2021 edition of ‘The state of medical education and practice in the UK’ reflects on the extensive and ongoing toll of the coronavirus (COVID-19) pandemic, but also highlights learning to build on.

Doctors, and their colleagues in the health system, have worked with dedication, resilience, and innovation. The recovery of healthcare professionals is now vital, and a fundamental part of the recovery of services.

This report examines the evidence from our latest research, giving important insights into doctors’ thoughts and experiences over this challenging period, and their intentions and concerns for the future.

**A worsening picture on workload, welfare, and burnout, challenging patient safety and retention**

Our data and research show rising clinical pressures are exacerbating chronic challenges to doctors’ welfare, patient safety, and workforce retention. The situation is worse than in the summer of 2020, with many doctors feeling dissatisfied, reporting negative effects on mental health and wellbeing, being at high risk of burnout, and dealing with a high-intensity workload most of the time. Over two-thirds of doctors told us workload pressure was a barrier to patient care.

A high overall quality of training and supportive training environments have been sustained. But trainees and trainers both report high workloads, and our research shows some of the worst indications of burnout since 2018, when we began asking about it. These pressures impact the opportunities and progression of many doctors in training; education quality and ability to progress must be maintained as part of healthcare recovery.

The advent of the pandemic saw innovations and developments in the delivery of healthcare at rapid pace. Most of these were improvements, and were considered positive changes that could shape the future of healthcare. But there are signs of waning confidence that these positive changes will be sustained and built upon.

**Building a positive future**

Despite these challenges, the opportunity to retain and build on the positive changes seen over the pandemic must not be lost. Improved teamworking was reported as one of the positive changes, and it is important that the newly regulated medical associate professions are able to work effectively to help support these developments. We will continue to support the recovery and evolution of the health system as part of ensuring the safety of patients and the wellbeing of doctors.
Executive summary

Chapter 1 – Working during the pandemic

Medical practice has continued to evolve rapidly over the past year in response to changes and challenges in the healthcare environment caused by the coronavirus pandemic. A growing backlog of patient care and further pandemic waves have put many doctors under intense pressure. There is concern and uncertainty in the profession about how we will emerge from the pandemic.

Doctors continue to face significant changes in both their professional and personal lives as a result of the pandemic. More doctors are once again struggling with workload, after our data in 2020 indicated a temporary decrease in workload for some. More doctors are at a high risk of burnout, with a return to levels similar to those seen before the pandemic. There is a strong relationship between burnout, workload pressures, and levels of support.

Our research found GPs are once again reporting much greater pressure than any other group. On average, GPs described the workload on three quarters of their days as ‘high intensity’, and around a third were at high risk of burnout. There is concerning evidence of differences in experiences between doctors that belong to particular groups, such as:

- Disabled doctors were almost twice as likely as non-disabled doctors to be dissatisfied, at a high risk of burnout, struggling with workload, and taking hard steps towards leaving the profession.

- Doctors from a Black and minority ethnic (BME) background, particularly Asian/Asian British doctors, are less likely to agree that they are supported by their immediate colleagues or are part of a supportive team, echoing our 2019 ‘Fair to refer?’ research, which found doctors from BME backgrounds are often treated as ‘outsiders’ in the workplace, receiving poorer support.

There is growing recognition that the pandemic has created unprecedented workplace conditions that have placed healthcare professionals at risk of moral injury: psychological distress resulting from actions, or lack of action, violating a person’s moral or ethical code.

Workload pressures emerged as the factor that most often contributed to compromised patient care and safety. Delays to patient care and long waiting lists are key concerns for doctors. The shift to providing more care remotely has many benefits, but remote care is not always suitable and can carry a risk of interfering with the effective delivery of patient care. The full effect of the pandemic on patient care and the doctor-patient relationship is not yet clear.

There are encouraging examples of changes during the pandemic period, particularly relating to teamwork and sharing knowledge and experiences across the medical profession. Doctors feel that some changes have helped deal with increased patient demand and relieve workloads. However, in the face of current healthcare pressures – 30% of doctors said they often feel unable to cope with their workload, up from 19% in 2020 – there is a very real risk that the opportunity to sustain positive changes could be lost.
Chapter 2 – Experiences and challenges in postgraduate medical education

Postgraduate medical trainees are an integral part of the medical workforce, developing skills, knowledge, and experience while providing patient care. Most then advance into UK practice on the specialist or GP registers. We monitor the experiences and progress of these doctors through the national training survey (NTS), the largest annual survey of doctors in the UK.

It is reassuring that the overall quality of training being delivered remains high, and most trainees and trainers continue to feel supported and valued at work. Some recent improvements have been sustained, including an improvement in managing the effect of rota gaps on training opportunities, as well as the successful use of virtual learning environments and remote consultations to develop trainees’ skills.

However, the impact of the pandemic is evident: a greater proportion of trainees and trainers are at high risk of burnout than ever before, and workloads in several specialties are increasing, especially in general practice.

Furthermore, trainees are facing challenges around meeting curricula requirements and finding opportunities to backfill missed training. Some trainees are struggling to gain required competencies and experiences, often exacerbated by the need to catch up on missed opportunities while working in the wider context of the ongoing pandemic and recovery. Trainees in medicine, surgery, and obstetrics and gynaecology programmes are finding it particularly tough.

Service recovery must not be prioritised at the expense of recovery in training; training is a vital aspect of service recovery, improvement, and future workforce supply. The pandemic continues to affect many trainees negatively, with risks to both morale and the development and progression of doctors. These pressures could have long-term consequences for staff wellbeing, workforce capacity, and, ultimately, patient care and service delivery.
Chapter 3 – Workforce

The ongoing coronavirus pandemic continues to affect doctors’ career intentions and the medical workforce. In 2021, 23% of doctors said they were planning to leave the profession, up from 19% in 2020. This year 7% of all doctors said they had taken ‘hard steps’ towards leaving the profession, up from 4% in 2020 and 3% in 2019.

Over a third of doctors (35%) said they were considering reducing their contracted hours in 2021. Though less than the 41% who were considering doing so in 2019, before the pandemic, this rise indicates a return to the concerning level seen at that time. Some doctors felt it was not realistic to reduce their hours in the current climate, though they may have wanted to.

The pandemic has affected the movement of international medical graduates (IMGs), reducing both the number that joined and the number that left the UK workforce. Overall, the total number of licensed IMGs in the workforce increased by 6%, to over 77,000 in 2021. Around 7,000 IMGs joined the workforce in 2021, a 33% decrease from the over 10,000 that joined in 2020, but comparable with 2019 (when just over 7,000 joined). It is currently unclear what the longer-term effect of the pandemic will be on doctor migration.

There has been an unprecedented increase in the number of students accepted into UK medical schools, with the number of students commencing in 2021/22 up 21% compared with 2020/21.
Chapter 4 – Building towards a positive future

The coronavirus pandemic continues to affect the UK’s health system adversely, in terms of treatment backlogs and access for patients, as well as taking a toll on the wellbeing of doctors. Our ‘Caring for doctors, Caring for patients’ research highlighted the direct relationship between workplace stress and quality of care for patients. Evaluating and learning from the range of new innovative approaches and adaptations implemented throughout the pandemic will be vital in ensuring best practice approaches are retained.

It is also important to reflect on the positive changes and opportunities that have emerged in response to the huge challenges doctors and their healthcare colleagues continue to face. Positive changes in communication and teamwork have largely been maintained. Interdisciplinary teamworking has been a vital element of effective working practices during the pandemic, supporting more inclusive, compassionate workplaces that focus on workforce wellbeing. Additionally, greater visible support from leadership figures has further aided a more compassionate working culture that plays a central role in ensuring patient safety.

Our ‘Fair to refer?’ research recommended senior leaders engage with staff, particularly to support ‘out groups’ of doctors, such as those in ethnic minority groups. Leadership is critical in ensuring cultural shifts are maintained, as well as learning from the flexible and adaptable approaches to delivering patient care that accelerated during the pandemic, such as the use of remote consultations, triaging cases to the most appropriate healthcare professional, and sharing knowledge across teams. Multidisciplinary team working, engaging Physician Associates and Anaesthesia Associates, must also be part of long-term recovery.

The strategic plans in place across the health services of England, Scotland, Wales, and Northern Ireland are a promising signal of future improvements across the UK’s health services. These plans represent a combined will and commitment to improve health and wellbeing support; tackle discrimination and improve a sense of belonging; evolve new ways of working and delivering care effectively; and grow workforces for the future to ensure patient safety and high-quality clinical services are maintained. We, along with other organisations, are working with the national bodies to help deliver these plans, either directly where it is within our remit or by providing support and evidence.

We have a specific role in enabling the supply of doctors and in supporting medical education and training. We will continue to do this through:

- Setting standards and effectively monitoring new UK medical schools and new overseas programmes.
- Ensuring that education and training capacity is protected and quality assured, while encouraging flexibility in training that could also contribute to meeting service needs and equality, diversity, and inclusion goals.
- Working with others across the system to build on the lessons from the pandemic around preparedness, training progression, and support for doctors in training.
- Working towards achieving our equality, diversity, and inclusion targets and eliminating ethnicity-based differentials in the doctors referred to us by employers, and tackling differential attainment in medical education through our ‘fairer training cultures’ programme of work.
Introduction

The 2021 edition of ‘The state of medical education and practice in the UK’ provides an important opportunity to acknowledge and reflect on the extensive and relentless toll of the coronavirus (COVID-19) pandemic, but also highlights learning for us all to build on as the health system recovers.

Since early 2020, doctors in the UK have shown dedication, resilience, and innovation in working with colleagues from across the health service to respond to the biggest healthcare challenge in generations. Throughout this crisis, doctors have stepped up to mitigate the devastating effects of the coronavirus pandemic – from treating patients with COVID-19, to leading the roll-out of the vaccination programme – while still meeting the general health needs of the public.

In 2020, we reported that alongside mounting pressures brought on by the pandemic, some positive responses had also emerged. These included strengthened team working, an increase in knowledge sharing, and the better visibility of leaders. Doctors have worked hard since March 2020 to develop new ways of working, ensuring that the health system continues to function and adapt at pace to the ever-changing challenges of the pandemic. We have the opportunity to retain and build on these positives to improve doctors’ experiences and patient care, especially now – when doctors who expected to be emerging from the crisis are facing record waiting lists, huge demand, and surges in COVID-19 cases.

Doctors are already pushed to their limits. Getting the balance right between recovery of services and recovery for healthcare professionals is vital. Doctors need the opportunity to recharge, reflect, and reset. Without this, the restoration of healthcare more generally will be seriously compromised.

This report uses data and research unique to the GMC, including the results of the 2021 national training surveys (NTS) and the 2021 Barometer survey, as well as commissioned in-depth interviews and focus groups with doctors, and the GMC’s register and fitness to practise data. Our analyses of these uncover priorities, progress, and potential improvements, to lend support to the health service beyond this period of recovery. Increasing demands on the profession make it essential that decision makers draw on the findings that follow to tackle pervading issues, and to make the most of opportunities.

Facing a new peak of pressure

Our analysis of 2021’s NTS and Barometer surveys contains stark warning signs. They highlight how rising pressures are exacerbating chronic challenges to doctors’ welfare, patient safety, and workforce retention.

In 2021, 22% of doctors reported feeling dissatisfied with their role, while 42% said that the pandemic had a negative effect on their mental health and wellbeing. 17% of doctors were at high risk of burnout and they described their workload on nearly two-thirds of their days as being ‘high intensity’. This demonstrates a worsening situation compared with the one in summer 2020.
Doctors’ day-to-day experiences and environments affect the quality of patient care. So it’s unsurprising that 69% of doctors cited workload pressures as a barrier to patient care, while 65% of doctors who had witnessed compromised patient safety or care said that pressure on workloads was a contributing factor. An increasing proportion of doctors are taking ‘hard steps’ towards leaving UK medical practice – up from 3% in 2019 and 4% in 2020, to 7% in 2021. This is much more likely among doctors who reported a high risk of burnout (19%) and dissatisfaction (17%). It’s therefore vital that these inherently linked issues are considered together. In chapter 1, we explore the effects of current working environments on doctors and patients in more detail. We highlight the importance of exploring the key roles of both teamwork and the ability to develop expertise while working to support satisfaction and retention.

Several positive themes have emerged over the past year, including the continuing high quality and supportive nature of training environments, which have been sustained throughout the pandemic. Despite this, trainees and trainers are reporting the highest levels of burnout risk since 2018. As explored in chapter 2, clinical pressures have affected both training opportunities and pathway progression for many doctors in training. Ensuring that training progression is sustained is key to recovery as 2022 approaches. This could, however, be compromised by pressure on workforce capacities at local levels, as health services continue to face high demand and a mounting patient backlog. The evidence in chapter 2 demonstrates that both education quality and progression must be maintained as healthcare recovers from the coronavirus pandemic.

The continuing shortage of healthcare professionals in the UK, particularly in some locations and specialties, poses a further threat to patient care, as well as to professionals’ wellbeing and progression.

**Forming the foundations for future healthcare**

The emergence of COVID-19 saw healthcare teams adapt and transform at rapid pace. With so much having changed so quickly, it’s easy to lose sight of the significance of innovations and improvements such as interdisciplinary teamwork and improved use of technology, which have formed such solid foundations for the future of healthcare.

However, in the face of the current pressures under which doctors are working, the positive aspects that have emerged from the pandemic response may be lost. Early signs indicate that some are already disappearing. For example, the number of doctors who feel unable to cope with their workload weekly has increased from 19% in 2020 to 30% in 2021. Whereas in 2020, 24% of doctors said that the pandemic response had positively impacted the volume of administrative tasks demanded of them, this dropped to only 10% in 2021. 70% of doctors reported being satisfied in 2021, down from 75% in 2020. Although some of these changes are relatively small, they collectively paint a concerning picture. They also highlight the importance of sustaining positive changes for the workforce, even at a time of increased pressure on resources.
The analysis in chapter 3 highlights the perceived threats and opportunities associated with positive working practices and cultures. This chapter demonstrates that workload pressures and doctors’ wellbeing and welfare are vital considerations in supporting staff retention as the UK health services recover from the coronavirus pandemic.

Emerging into a new world

As 2022 approaches, recovery must be prioritised. This does not imply a ‘back to normal’ approach. Instead, we and other healthcare regulators are advocating improved ways of working that build on the positive adaptations that have taken place during the pandemic. Now is an opportunity to build on the innovations and the pace of change we have seen, and to increase the use of new systems and technologies that have proved their worth in care provision. We do not believe there is a case for a return to the status quo.

The positive changes that have emerged during the pandemic must be retained. In chapter 4 we capture some of those positives – both overarching and doctor-specific – recognising those that might be valuable in the future. For example, the remote consultation service ‘Attend Anywhere’, first trialled in Scotland in 2016, became vital in providing care to patients during the coronavirus pandemic. In 2020, Wales and England adopted the platform to allow patients to access primary care without leaving their homes. Patients and clinicians alike have said that the service provides many advantages that will persist after the pandemic subsides.³

Doctors’ overall satisfaction and manageable workloads are crucial in underpinning good, safe patient care and in workforce retention. Compassionate working cultures and supportive, visible leadership also play roles in this. The future supply of doctors must be prioritised to reduce workload issues and the risk of burnout. At the same time, the current workforce must be supported by using the newly regulated medical associate professions effectively. It is vital to recognise that healthcare workers will need personal time and space to recover from the pandemic. They will also require support from their employers, the UK governments, and from multidisciplinary colleagues to allow them to meet the challenges ahead, to reduce their risk of burnout, and to learn from the pandemic.

We can be proud of the diversity of the UK’s medical workforce. However, we must continue to work together to ensure that all healthcare environments are inclusive and fair as some groups of doctors report different working experiences than others (Box 1).
Box 1: Importance of inclusive, diverse, and compassionate environments

Throughout 2021’s report we review the range of evidence about doctors’ experiences and how these can affect patient care and safety. The evidence highlights the benefit of good support systems provided to practitioners by their colleagues at all levels, ensuring doctors’ satisfaction, reducing risk of burnout, and supporting retention in the UK workforce. It also highlights the importance of inclusive working environments, in helping doctors work effectively through multidisciplinary team working and by sharing information and ideas. This evidence is supported by the 2019 ‘Fair to refer?’ research that found that certain groups of doctors are often treated as ‘outsiders’ in the workplace and receive poorer support than their colleagues. It amplifies the importance of ensuring autonomy, belonging and competence as highlighted in ‘Caring for doctors, Caring for patients’.

The evidence in the following chapters includes:

- Findings from 2021’s Barometer survey that show that disabled doctors were almost twice as likely as non-disabled colleagues to report feeling dissatisfied. Additionally, they were at a higher risk of burnout, more likely to be struggling with workload, and were more likely to be taking hard steps towards leaving the profession.

- Further analysis of the Barometer data shows that overall, White UK graduates and UK graduates from Black and minority ethnic backgrounds reported similar levels of burnout and satisfaction. It is notable that Asian/Asian British doctors as a group were less likely to agree that they were supported by their immediate colleagues (80% compared to 87% of White doctors) and were less likely to agree that they were part of a supportive team (73% compared to 82%).

- Findings from the NTS show that most trainees agreed that their workplace provided a supportive environment for everyone regardless of background, belief, or identity. However, trainee responses varied by ethnicity. 84% of trainees from a Black and Black British background gave a positive response, compared with 91% of White trainees.
The pandemic has created unprecedented workplace situations for healthcare professionals that have placed them at risk of suffering moral injury. Moral injury is psychological distress that results from actions, or the lack of them, which violate someone’s moral or ethical code. In chapter 1, we look at how often doctors feel that they were unable to provide the level of care they wanted and how this relates to doctors’ workplace experiences. Ensuring that the risk of moral injury for the healthcare workforce is recognised and mitigated against will be an important aspect of recovery. The Welsh Technical Advisory Group report reaffirms the importance of prioritising wellbeing and makes multiple recommendations for the recovery and future protection of healthcare workers. These include time and space to reflect, safe spaces to rest, peer support mechanisms, and resilience training.

We are supporting the recovery phase in many ways, given that patient safety and supporting doctors’ wellbeing lie at the heart of our work. A sustainable workforce supply and the protection of education and training capacity are issues that this report will examine in detail. We support and welcome longer-term solutions to the workforce supply, such as the opening of the new school of medicine at Ulster University, which accepted its first students in 2021.

Based on the evidence in this report, and the innovation evident across the healthcare system, there is hope that we can find a way to support the recovery of healthcare professionals and health services, while also securing patient safety and care.
Working during the pandemic
Summary

- Doctors reported struggling with heavier workloads during 2021, with six out of ten (59%) working beyond rostered hours at least once a week, and three out of ten (30%) feeling unable to cope with their workload weekly.

- The proportion of doctors at a high risk of burnout has increased from 10% in 2020, to 17% in 2021. There is a strong relationship between burnout, workload and levels of support, and GPs continue to report being under the greatest pressure.

- Delays to patient care and the need to deal with resultant waiting lists are key areas of concern for doctors.

- Almost half of doctors (46%) have been providing more care remotely than face to face. While remote care has allowed patients to continue to access care during periods of lockdown and social distancing restrictions, remote care is not always suitable, and in some circumstances has had a detrimental impact on patient care.

- There is evidence that adaptations to working practices during the pandemic are continuing to lead to improvements in some areas, with 60% of doctors reporting that it has had a positive impact on teamwork.
Introduction

Medical practice has had to continue to evolve in the past 12 months, in response to rapid changes in the healthcare environment during the coronavirus (COVID-19) pandemic. A growing backlog of patient care and further waves of COVID-19 have put many doctors under intense pressure. There is concern and uncertainty in the profession about how we’ll emerge from the pandemic.

The pandemic has, however, also shone a spotlight on longstanding issues, leading to new ways of working that are having a positive effect on both doctors and patients. Although there is growing concern around the ability to sustain gains that were made early in the pandemic, there is still optimism that we can build on what has been learned to help tackle the long-term pressures doctors are facing.

There is some light at the end of the tunnel and things are easing. Right from the early stage, we kept saying ‘when all this is sort of blown over, we’ll sit down and properly go through what’s happening’. We haven’t reached that point yet.”

Case studies, Cardiology Consultant

Box 2: Evidence sources used in chapter 1

3,386 doctors completed the 2021 Barometer survey – a representative sample of the UK medical register. The survey was carried out in June and July 2021. The questions explored the ongoing experiences of doctors working during the COVID-19 pandemic, along with wider aspects of their work and future career plans.

When analysing the data from the Barometer survey, we consider the experiences of different groups of doctors. Most often, the patterns we see relate to a doctor’s registration type or specialty, but we have also highlighted some notable differences by doctors’ demographic characteristics. When reporting differences by doctors’ ethnicity, where possible we try to present the data on individual ethnic groups. However, due to limited sample size we are sometimes required to report on doctors from a Black and minority ethnic (BME) background as a collective group.

This chapter also includes insights from commissioned qualitative research exploring the implications of changes to doctors’ working practices that are emerging following the pandemic. This involved eight focus groups with frontline doctors followed by 19 in-depth interviews with clinical and non-clinical managers.

You will find further information on the evidence sources in A note on research and data on page 111.
Chapter 1: Working during the pandemic

Working practices during 2021

The pandemic continues to drive changes to doctors’ practice

The pandemic continues to have a major impact on the day-to-day work of doctors. They have been required to alter and adapt their practice in response to large-scale and rapid changes in how healthcare services are delivered and used. While some measures introduced in the early stages of the pandemic have proved to be temporary, many new ways of working look set to become embedded in doctors’ future practice.

Our evidence sources point to various areas where doctors’ practice has changed during the pandemic:

- increased working from home
- virtual meetings and training
- remote consultation and ongoing management of care
- rota changes and redeployment
- shifts in roles and responsibilities within the multi-disciplinary team
- reconfiguration of patient care pathways.

Levels of redeployment are lower than in the early stages of the pandemic, but more than a third of doctors (35%) were still redeployed in the last year – one out of ten (10%) into a different area of practice, and a further quarter (25%) in the same area of practice. Rates of redeployment were highest among trainees (56%) as well as among doctors working in anaesthetics or intensive care (66%), medicine (60%), and in surgery (51%).
Almost half of doctors are providing more care remotely than face to face

The unprecedented shift towards remote working since the start of the pandemic continues, with the majority of doctors (64%) providing more remote care now than they were before the pandemic. In 2021, almost half of doctors (46%) have been providing more care remotely than face to face. GPs were most likely to be providing the greater proportion of their care remotely (77%), while half of specialists (50%) still provide most, or all, care face to face (Figure 1). It is important to highlight that these data were collected in Summer 2021, and the model of remote care provision will continue to evolve.

The rapid shift to remote care has been delivered effectively across the system, at different points along the care pathway. This has included digitally-supported total triage,* remote GP consultations, virtual clinics, and remote management of ongoing patient care. The impact of the shift towards remote care on both doctors and patients is examined in more detail later in this chapter.

Figure 1: Proportion of patient care provided remotely during the last year by registration type

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

<table>
<thead>
<tr>
<th>Registration Type</th>
<th>All, or nearly all, face to face</th>
<th>Mostly face to face with a small amount remote</th>
<th>Mostly remote with a small amount of face to face</th>
<th>Roughly even mix</th>
<th>All, or nearly all, remote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total doctors</td>
<td>16%</td>
<td>15%</td>
<td>21%</td>
<td>37%</td>
<td>9%</td>
</tr>
<tr>
<td>GPs</td>
<td>20%</td>
<td></td>
<td>74%</td>
<td>4%</td>
<td></td>
</tr>
<tr>
<td>SAS and LE doctors</td>
<td>15%</td>
<td>13%</td>
<td>25%</td>
<td>33%</td>
<td>13%</td>
</tr>
<tr>
<td>Doctors in training</td>
<td>22%</td>
<td>17%</td>
<td>18%</td>
<td>27%</td>
<td>15%</td>
</tr>
<tr>
<td>Specialists</td>
<td>23%</td>
<td>27%</td>
<td>23%</td>
<td>19%</td>
<td>6%</td>
</tr>
</tbody>
</table>

* Total triage means that every patient contacting a practice first provides some information on the reasons for contact and is triaged before making an appointment.
Increased workload pressures

After a temporary decrease in workload for some doctors during the early stages of the pandemic, the 2021 Barometer survey indicates that more doctors are again struggling with workload. Six out of ten doctors (59%) reported working beyond rostered hours at least once a week, while three out of ten (30%) felt unable to cope with their workload weekly. On average, doctors described the workload on 60% of their days as ‘high intensity’ (Figure 2).

Since 2019, we have analysed the relationship between working hours and feeling able to cope, to classify doctors into four distinct groups:

- **Managing** – not regularly working beyond rostered hours and coping with workload.
- **Normalised** – regularly working beyond rostered hours, but not regularly feeling unable to cope with workload. Long hours are a normal part of their working life that they have learnt to cope with.
- **Issues unrelated to working extra hours** – not regularly working beyond rostered hours, but not coping with workload, because of other factors.
- **Struggling** – regularly working beyond rostered hours and not coping with workload.

In 2020, we reported on a substantial drop in the number of doctors struggling with their workload. However, as paused services restarted against a growing backlog of patient care and further COVID-19 waves, we expected workload pressures to increase once again for many doctors. The 2021 data confirmed this, as a quarter of doctors (26%) fell into the ‘struggling’ group (an increase from 15% in 2020), and around a third (35%) were in the ‘managing’ group (a decrease from 51% in 2020) (Figures 3–4).

![Figure 2: Intensity of doctors’ workload on each working day](image)

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

- High: 10%
- Moderate: 30%
- Low: 60%

*n = 3,386 (all doctors), the Barometer survey 2021, QCB*
Figure 3: Quadrant analysis of doctors working beyond rostered hours weekly and feeling unable to cope with workloads weekly

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

- Rarely/never worked beyond rostered hours
- Feel unable to cope at least weekly
- Managing
- Normalised
- Issues unrelated to working extra hours
- Struggling

n = 3,386 (all doctors), the Barometer survey 2021, QC1_1/2

Figure 4: Quadrant analysis of doctors’ workload 2019–21

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

n = 3,386 (all doctors), the Barometer survey 2021, QC1_1/2
n = 3,693 (all doctors), the Barometer survey 2020, QC1_1/2
n = 3,876 (all doctors), the Barometer survey 2019, QC1
Differences in workload between registration types

Stark differences in the experiences of each registration type have re-emerged in the 2021 Barometer survey data (Figure 5). GPs are once again reporting much greater pressure than any other group. On average, GPs described the workload on 76% of their days as ‘high intensity’, a significantly higher proportion than specialists (55% of days), trainees (52% of days), and SAS and LE doctors (57% of days).

The proportion of GPs and specialists struggling with their workload doubled in 2021, with more than half of GPs (54%) and almost three out of ten specialists (28%) now falling into this group. While the proportion of trainees struggling (11%) has also risen in 2021, the increase has not been as marked in this group and is still below pre-pandemic levels. SAS and LE doctors made up the only group where there has not been an increase in the number of doctors struggling with their workload. For GPs and specialists, the number struggling has returned to the worrying proportions of 2019.

Figure 5: Proportion of doctors ‘struggling’ with their workload by registration type 2019–21

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

Percentage ‘struggling’ (%)
New ways of working can help relieve workloads

Despite the data painting a broadly negative picture in terms of workload pressures, it has been encouraging to hear examples of innovative practice that have helped deal with increased patient demand and relieve workloads. These new ways of working look set to play an important role in helping the UK emerge from the pandemic. Three areas highlighted as making a particular difference were remote working, co-operation with community services, and reconfiguration of care pathways.

Although not always the case, the shift towards remote working has offered some doctors greater efficiency and flexibility to manage their workload.

“People aren’t in neat ten-minute packages, some are going to take longer. So this flexibility is such a plus because [I] can spend time on a patient who needs it [and I] can get the sick notes done quicker, without feeling every ten minutes [I’m] running behind. From a wellbeing perspective, mentally I’ve been feeling a lot less pressure on that time aspect.”

Changes to working practices,
GP focus group

Flexibility and maximising capability across the healthcare workforce have played a key role in managing workloads. Where available, improved co-operation with community services has made a difference to workloads – particularly in general practice.

“Previously we didn’t rely on the community services, like the community matron, district nurses. We tried to deal with everything ourselves. During the past year we had to use the community services, and that’s been a learning [point] for us - that actually we don’t need to go see every single patient, there are other services that can go and see these people”

Changes to working practices,
GP focus group

Reconfiguration of patient pathways – particularly, deflecting traffic from GPs and emergency departments – has also helped to deal with increased patient demand more efficiently.

“Previously a mental health patient would have come in and waited in the emergency department. The service has now been moved to a bigger area so [that] when the patient comes in and is assessed they’re sent directly over. We no longer spend five or six hours with this type of patient in the emergency department.”

Changes to working practices,
NHS manager interview
Levels of support remain stable

The vast majority of doctors continue to feel well supported by their ‘immediate colleagues’, but less so by ‘senior medical staff’ and ‘non-clinical management’. More than four out of five (84%) respondents agreed that they are supported by their immediate colleagues, two-thirds (66%) felt supported by senior medical staff, with just half (50%) agreeing that they are supported by non-clinical management. This is consistent with responses to these statements in the 2020 Barometer survey.

Specialists and GPs continue to report feeling less supported by senior medical staff, with specialists particularly unlikely to agree that they are supported by non-clinical management. However, the data suggest a stronger feeling of support among SAS and LE doctors compared with last year. (Table 1).

Table 1: Agreement with statements concerning workplace support by registration type 2020–21

To what extent do you agree with the following statements?

<table>
<thead>
<tr>
<th></th>
<th>GPs</th>
<th>Specialists</th>
<th>Doctors in training</th>
<th>SAS and LE doctors</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020</td>
<td>2021</td>
<td>2020</td>
<td>2021</td>
<td>2020</td>
</tr>
<tr>
<td>I am supported by immediate colleagues</td>
<td>86%</td>
<td>82%</td>
<td>84%</td>
<td>83%</td>
</tr>
<tr>
<td>I am supported by senior medical staff</td>
<td>61%</td>
<td>50%</td>
<td>61%</td>
<td>57%</td>
</tr>
<tr>
<td>I am supported by non-clinical management</td>
<td>70%</td>
<td>62%</td>
<td>45%</td>
<td>39%</td>
</tr>
</tbody>
</table>

2021 data: n = 3,386 (all doctors), the Barometer survey 2021, QD3_1-3
2020 data: n = 3,693 (all doctors), the Barometer survey 2020, QD3_1-3
The impact on doctors

Better teamwork is being maintained

In the 2021 Barometer survey, we once again asked doctors about the impact of the pandemic on various aspects of their working lives (Figure 6). Overall, nine out of ten (88%) doctors felt that at least one area had been positively affected, while seven out of ten (69%) felt that at least one area had been negatively affected.

![Figure 6: Impact of the pandemic on aspects of doctors' working lives](image)

Thinking about your day-to-day work during the COVID-19 pandemic, do you feel there has been a positive, mixed or negative impact on the following areas?

<table>
<thead>
<tr>
<th>Area</th>
<th>Positive or mostly positive (%)</th>
<th>Mixed (%)</th>
<th>Negative or mostly negative (%)</th>
<th>No impact (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sharing knowledge and experiences across the medical profession</td>
<td>60</td>
<td>27</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Teamwork between doctors</td>
<td>60</td>
<td>27</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Teamwork between multidisciplinary healthcare professionals</td>
<td>49</td>
<td>32</td>
<td>11</td>
<td>6</td>
</tr>
<tr>
<td>Speed of implementing change</td>
<td>46</td>
<td>35</td>
<td>14</td>
<td>3</td>
</tr>
<tr>
<td>Visibility of senior leaders within healthcare settings</td>
<td>40</td>
<td>25</td>
<td>17</td>
<td>12</td>
</tr>
<tr>
<td>Co-operation between different parts of the healthcare system</td>
<td>37</td>
<td>38</td>
<td>18</td>
<td>5</td>
</tr>
<tr>
<td>Clarity of roles and responsibilities with teams delivering care</td>
<td>33</td>
<td>38</td>
<td>14</td>
<td>13</td>
</tr>
<tr>
<td>Access to development or learning opportunities</td>
<td>30</td>
<td>30</td>
<td>36</td>
<td>3</td>
</tr>
<tr>
<td>Care provided to patients</td>
<td>29</td>
<td>42</td>
<td>24</td>
<td>3</td>
</tr>
<tr>
<td>The doctor-patient relationship</td>
<td>28</td>
<td>41</td>
<td>23</td>
<td>6</td>
</tr>
<tr>
<td>The volume of administrative tasks or procedures</td>
<td>10</td>
<td>31</td>
<td>44</td>
<td>13</td>
</tr>
<tr>
<td>My mental health and wellbeing</td>
<td>9</td>
<td>39</td>
<td>42</td>
<td>8</td>
</tr>
</tbody>
</table>

n = 3,386 (all doctors), the Barometer survey 2021, Q13_1-12
Some doctors have expressed concern that the ‘all in this together’ attitude present during the early stages of the pandemic may have become less prevalent, resulting in the loss of some of the positive changes in ways of working.

“[the pandemic] gave a chance for everyone to pull together. It was fantastic, I think it opened my eyes to what could and should be possible all the time. As we sank more back to normality, it was like I’d had a vision of how it could be.”

*Case studies, SAS doctor*

However, doctors still feel that the pandemic has led to improvements in certain aspects of their work, particularly with respect to teamwork and the sharing of knowledge and experiences across the medical profession. Six out of ten (60%) doctors felt that there had been a mostly positive impact on teamwork between doctors and around half (49%) felt the same applied to teamwork between multidisciplinary healthcare professionals.

There are many examples of the pandemic accelerating a shift towards more effective joined-up care across multidisciplinary teams, facilitated by more visible and transparent leadership. Better teamwork, alongside strong leadership, has also provided the foundation for other positive changes to occur. This has involved breaking down long-standing silos and creating cultures that promote collaboration.

“"To me that was phenomenal, truly. We managed to move the whole team and service, but more significantly we got through a culture of barriers and ‘Team A versus Team B’ and that has continued ever since. They have a great relationship now and are working together really well.”

*Changes to working practices, NHS manager interview*

Across most of these aspects of doctors’ work, a similar proportion of doctors reported a positive impact this year compared with the 2020 survey (Figure 7). This suggests that improved ways of working in several areas are currently being sustained. One area highlighted by doctors as much more negative is the growing volume of administrative tasks or procedures. More than four out of ten (44%) doctors felt that this had been negatively affected during the pandemic – substantially higher than a year ago (26%). This was particularly the case among GPs (75% reporting a ‘negative or mostly negative impact’), suggesting that this is one of the factors contributing to the higher workloads within this group in 2021.

“"Days full of frustration [about the] amount of time doing admin tasks.”

*2021 Barometer survey, open text response*
Thinking about your day-to-day work during the COVID-19 pandemic, do you feel there has been a positive, mixed or negative impact on the following areas?

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Positive Impact</th>
<th>Mostly Positive</th>
<th>Mixed</th>
<th>Negative Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sharing of knowledge and experiences</td>
<td>60%</td>
<td>54%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teamwork between doctors</td>
<td>60%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teamwork between multidisciplinary</td>
<td>49%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>healthcare professionals</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speed of implementing change</td>
<td>46%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visibility of senior leaders within patient</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>care settings</td>
<td>40%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clarity of roles and responsibilities within</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>teams delivering care</td>
<td>33%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access to development or learning opportunities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The volume of administrative tasks or</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>procedures</td>
<td>10%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My mental health and wellbeing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Positive or mostly positive impact

\[n = 3,386 \text{ (all doctors), the Barometer survey 2021, Q13, 1–5, 7–10}\]

\[n = 3,693 \text{ (all doctors), the Barometer survey 2020, Q13, 1–4, 6–10}\]
**Burnout has increased since 2020**

More than two out of five doctors (42%) felt that working during the pandemic has had a negative impact on their mental health and wellbeing – an increase from around a third (32%) in 2020.

A greater proportion of doctors are also at risk of burnout. A third of doctors (33%) are at a moderate or high risk of burnout, while around seven out of ten (67%) are at a low or very low risk (Figure 8). The number of doctors at a high risk of burnout (17%) has increased substantially since 2020 (10%), and levels are now similar to those seen pre-pandemic in 2019 (16%).

There is a strong relationship in the data between burnout, workload pressures and levels of support (Figure 9). Doctors at a high risk of burnout were most likely to be struggling with their workload (70%), and least likely to agree that they are part of a supportive team (56%).

* Information on the categorisation of burnout risk can be found in *A note on research and data* on page 111.

† This number does not match exactly with Figure 8 due to rounding.

---

**Figure 8: Doctors’ risk of burnout by registration type**

<table>
<thead>
<tr>
<th>Registration Type</th>
<th>Very Low Risk</th>
<th>Low Risk</th>
<th>Moderate Risk</th>
<th>High Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total doctors</td>
<td>46%</td>
<td>22%</td>
<td>15%</td>
<td>17%</td>
</tr>
<tr>
<td>GPs</td>
<td>22%</td>
<td>24%</td>
<td>22%</td>
<td>32%</td>
</tr>
<tr>
<td>Specialists</td>
<td>46%</td>
<td>21%</td>
<td>15%</td>
<td>18%</td>
</tr>
<tr>
<td>Doctors in training</td>
<td>57%</td>
<td>20%</td>
<td>12%</td>
<td>11%</td>
</tr>
<tr>
<td>SAS and LE doctors</td>
<td>59%</td>
<td>22%</td>
<td>11%</td>
<td>7%</td>
</tr>
</tbody>
</table>

n = 3,386 (all doctors), the Barometer survey 2021, QD1/D2

**Figure 9: Proportion of doctors struggling with workload and agreement with support statements by risk of burnout**

<table>
<thead>
<tr>
<th>Risk of Burnout</th>
<th>Struggling with Workload</th>
<th>Agree that they are part of a supportive team</th>
</tr>
</thead>
<tbody>
<tr>
<td>High risk of burnout</td>
<td>70%</td>
<td>56%</td>
</tr>
<tr>
<td>Moderate risk of burnout</td>
<td>40%</td>
<td>69%</td>
</tr>
<tr>
<td>Low risk of burnout</td>
<td>24%</td>
<td>81%</td>
</tr>
<tr>
<td>Very low risk of burnout</td>
<td>6%</td>
<td>88%</td>
</tr>
</tbody>
</table>

n = 3,386 (all doctors), the Barometer survey 2021, QC1_1/2/D1/D2/D3-4
As with workload pressures, GPs were the most likely to be at a high risk of burnout (32%), compared with specialists (18%), doctors in training (11%) and SAS and LE doctors (7%) (further analysis of burnout among doctors in training is presented in chapter 2).

Almost one out of five doctors (17%) have taken time off due to stress during the last year. Doctors at the highest risk of burnout were most likely to have taken time off (23%). However, despite being more at risk of burnout, fewer GPs and specialists took a leave of absence (9% and 8% respectively), suggesting that some groups feel less able to take this action.

“ When you’re off, either you can’t fully relax because you’re keeping one eye on what’s going on at work or you feel guilty that you’re leaving everyone else to it.”

Case Studies, Cardiology consultant

New initiatives to support wellbeing may not be enough

New initiatives to support doctors’ wellbeing have been introduced during the pandemic, such as better support services and wellbeing spaces.

“ Our directorate has built a wellbeing room, a comfortable place to reflect, have a cup of tea, [and] sit in peace and quiet. We’ve got wellbeing champions/officers from various specialisms trained as support workers overseeing wellbeing.”

Changes to working practices,
Secondary care lead interview

Although doctors welcome a greater recognition of wellbeing issues, many highlighted that improving staffing levels and reducing workload are the actions most likely to make a positive difference. The 2021 Barometer survey indicated that more than a quarter of doctors (27%) found it difficult to take breaks every single day due to the intensity of their workload. This suggests that many doctors will struggle to access support when they need it.

The ‘Caring for doctors, Caring for patients’ 2019 report’ identified three core needs for the maintenance of doctors’ wellbeing and motivation at work:

■ Autonomy - the need for doctors to have control over their work lives, and to act consistently with their work and life values.

■ Belonging - the need for doctors to be connected to, cared for, and caring of, others in the workplace.

■ Competence - the need for doctors to experience effectiveness and deliver valued outcomes, such as high-quality care.

To be effective, interventions to support doctors’ wellbeing must recognise these core needs and ensure that each of them is met. Tackling burnout in the medical profession will be explored further in chapter 4.
High levels of burnout could lead to more gaps in the workforce

Burnout may ultimately contribute to pushing more doctors away from full-time practice or out of the profession completely, putting further pressure on an already stretched workforce. In the 2021 Barometer survey, doctors at a higher risk of burnout were more likely to be considering reducing their hours in clinical practice, taking a break or leaving the profession permanently (Figure 10). Half (50%) of doctors at a high risk of burnout said they are ‘fairly/very likely’ to leave the UK profession in the next year. The most common reasons respondents gave for considering these career changes related to the desire for a better work-life balance and the excessive demands of the role affecting their wellbeing.

The 2021 Barometer survey indicates that 7% of doctors have taken ‘hard steps’ towards leaving the medical profession.” This is almost twice the proportion in 2020 (4%), although it is likely to be in part explained by a backlog of doctors who were prevented from leaving due to pandemic restrictions. The trends in the number of doctors leaving the register and reasons for this are explored further in chapter 3.

People are overwhelmed, experiencing anxiety and depression and going off sick. A lot of people are frustrated and burnt out, and hand in their resignation.”

Changes to working practices,
NHS hospital manager interview

Figure 10: Proportion of doctors likely to make career changes by risk of burnout

* Hard steps towards leaving include: contacting a recruiter; applying for or attending training to prepare for a new role, applying for another role outside of medicine.
The majority of doctors remain satisfied in their day-to-day work

Workload pressures, support and experiences of the workplace ultimately drive doctors’ overall satisfaction. In the 2021 Barometer survey, seven out of ten doctors (70%) reported that they are at least ‘somewhat satisfied’ in their day-to-day work, with 43% being in the most satisfied group (either ‘satisfied’ or ‘very satisfied’). By contrast, only two out of ten (22%) reported being overall dissatisfied (Figure 11). While satisfaction levels have dropped since 2020 (75% overall satisfied), they are still higher than they were in 2019 (63% overall satisfied).

However, the picture is not consistent across registration types. In the 2020 survey, satisfaction levels were fairly consistent. But this year, satisfaction among specialists and particularly GPs has once again dropped significantly, while both trainees and SAS and LE doctors are reporting being more satisfied (Figure 12).

Figure 11: Satisfaction with day-to-day work as a doctor

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

<table>
<thead>
<tr>
<th>Percentage (%)</th>
<th>Very satisfied</th>
<th>Satisfied</th>
<th>Somewhat satisfied</th>
<th>Neither satisfied or dissatisfied</th>
<th>Somewhat dissatisfied</th>
<th>Dissatisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>70% overall satisfied</td>
<td>8%</td>
<td>35%</td>
<td>27%</td>
<td>7%</td>
<td>10%</td>
<td>8%</td>
</tr>
</tbody>
</table>

n = 3,386 (all doctors), the Barometer survey 2021, QA1

Figure 12: Proportion of doctors overall satisfied by registration type 2019–21

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

<table>
<thead>
<tr>
<th>Percentage ‘overall satisfied’ (%)</th>
<th>GPs</th>
<th>Specialists</th>
<th>Doctors in training</th>
<th>SAS and LE doctors</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>62</td>
<td>60</td>
<td>61</td>
<td>52</td>
</tr>
<tr>
<td>2020</td>
<td>67</td>
<td>65</td>
<td>70</td>
<td>58</td>
</tr>
<tr>
<td>2021</td>
<td>70</td>
<td>70</td>
<td>73</td>
<td>67</td>
</tr>
</tbody>
</table>

n = 3,386 (all doctors), the Barometer survey 2021, QA1
n = 3,693 (all doctors), the Barometer survey 2020, QA1
n = 3,876 (all doctors), the Barometer survey 2019, QA1
Doctors are concerned about lasting effects of redeployment

Focus group discussions suggest that many trainees and SAS and LE doctors are feeling jaded by redeployment. While there is an acknowledgement that flexibility within the workforce will be important in dealing with the backlog of patient care, redeployed doctors expressed concerns that they are becoming de-skilled and that their career progression will be impeded.

“I feel like I’m getting de-skilled in things that are bread and butter. I’m just purely on the ward running around like a glorified Senior House Officer.”

*Changes to working practices, SAS and LE doctors focus group*

“I’m fed up with dealing with COVID-19 patients, I want to get back to endo-crinology which is what I hope to specialise in.”

*Changes to working practices, Trainee focus group*

‘Lack of opportunity for progression and training’ was the most common area of concern expressed by trainees for the coming year, identified by 1 out of 5 (20%). SAS/LE doctors and doctors in training – the two groups most likely to find themselves redeployed – were also most likely to report concerns about the pandemic continuing (14% and 18% respectively).

Despite this, the data do not suggest that the experiences of redeployed doctors were worse, with overall levels of satisfaction actually higher among those who have been redeployed (75% compared with 68% non-redeployed) (Figure 13). It is important to note that while there is no indication from the 2021 Barometer survey data that redeployed doctors have been disproportionately affected, respondents were not being asked to reflect directly on their redeployment.

<table>
<thead>
<tr>
<th>Figure 13: Workplace experiences of redeployed and non-redeployed doctors</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hard steps towards leaving</strong></td>
</tr>
<tr>
<td>Non-redeployed: 7%</td>
</tr>
<tr>
<td>Redeployed: 8%</td>
</tr>
<tr>
<td><strong>Overall satisfied</strong></td>
</tr>
<tr>
<td>Non-redeployed: 68%</td>
</tr>
<tr>
<td>Redeployed: 75%</td>
</tr>
<tr>
<td><strong>High risk of burnout</strong></td>
</tr>
<tr>
<td>Non-redeployed: 18%</td>
</tr>
<tr>
<td>Redeployed: 16%</td>
</tr>
</tbody>
</table>

*n = 3,386 (all doctors), the Barometer survey 2021, Q12/D1/D2/A1/B1/B3*
Variation of experiences across the workforce

As well as differences associated with a doctor’s area of practice, the 2021 Barometer survey data indicate there may be some variation in experiences based on other factors including disability, ethnicity, and where a doctor gained their primary medical qualification (PMQ). It is particularly important that we identify where experiences vary based on a protected characteristic, as this may be indicative of issues around equality, diversity, and inclusion.

A widening gap between disabled and non-disabled doctors

Disabled doctors were almost twice as likely as non-disabled colleagues to report feeling dissatisfied, being at a high risk of burnout, struggling with workload and taking hard steps towards leaving the profession (Figure 14). This concerning pattern has been evident in the Barometer data since 2019, but the gap between the experiences of disabled and non-disabled doctors has widened substantially over recent years.

“From my point of view as a junior on a London Covid ward, I found senior support was better. More consultants were around. I felt really well supported. It was really helpful.”

Changes to working practices,
Trainee focus group

Doctors in the focus groups with a more positive experience of redeployment usually attributed it to having better support from senior doctors. In the 2021 Barometer survey, doctors who had been redeployed were more likely to agree that they are supported by senior medical staff (70% compared with 64% non-redeployed).
Figure 14: Workplace experiences of disabled and non-disabled doctors 2019–21

Percentage (%)

- 'Struggling' workload quadrant
- High risk of burnout
- Overall dissatisfied
- Hard steps towards leaving

Disabled Non-disabled

n = 3,386 (all doctors), the Barometer survey 2021, QF3/C1_1/2/D1/D2/A1/B1/B3
n = 3,693 (all doctors), the Barometer survey 2020, QF3/C1_1/2/D1/D2/A1/B1/B3
n = 3,876 (all doctors), the Barometer survey 2019, QF3/C1_1/2/D1/D2/A1/B1/B3
It is worrying that disabled doctors feel less supported – whether that is by immediate colleagues, senior doctors, or non-clinical management (Figure 15). They were also more likely to identify lack of support from management as a reason for dissatisfaction (24% compared with 16% of non-disabled doctors).

**Figure 15: Agreement with statements on support by disability**

*To what extent do you agree with the following statements?*

<table>
<thead>
<tr>
<th>Statement</th>
<th>Disabled</th>
<th>Non-disabled</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am supported by non-clinical management</td>
<td>52%</td>
<td>41%</td>
</tr>
<tr>
<td>I am supported by senior medical staff</td>
<td>68%</td>
<td>55%</td>
</tr>
<tr>
<td>I am supported by immediate colleagues</td>
<td>85%</td>
<td>73%</td>
</tr>
</tbody>
</table>

*n = 3,386 (all doctors), the Barometer survey 2021, QF3/D3_1-3*
UK graduate doctors are reporting more negative workplace experiences

UK graduate doctors reported a more negative experience than doctors with a non-UK PMQ on a number of key indicators (Table 2). UK graduate doctors were more likely to be dissatisfied, struggling with workload, and at a high risk of burnout. Doctors who graduated outside of the European Economic Area (international medical graduates) were the most positive group. This pattern is broadly evident across GPs, specialists, and trainees – but for SAS and LE doctors the picture is more mixed.

Despite this, doctors who obtained their PMQ outside the UK were more likely to have taken hard steps towards leaving the UK medical profession, suggesting that other factors may be driving future career intentions in this group.

Table 2: Workplace experiences by primary medical qualification (PMQ)

<table>
<thead>
<tr>
<th></th>
<th>UK</th>
<th>EEA</th>
<th>IMG (outside of EEA)</th>
<th>Non-UK PMQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Struggling’ workload quadrant</td>
<td>31%</td>
<td>19%</td>
<td>18%</td>
<td>18%</td>
</tr>
<tr>
<td>High risk of burnout</td>
<td>21%</td>
<td>14%</td>
<td>11%</td>
<td>12%</td>
</tr>
<tr>
<td>Overall dissatisfied</td>
<td>25%</td>
<td>20%</td>
<td>16%</td>
<td>17%</td>
</tr>
<tr>
<td>Hard steps towards leaving</td>
<td>6%</td>
<td>9%</td>
<td>10%</td>
<td>10%</td>
</tr>
</tbody>
</table>

\(n = 3,386\) (all doctors), the Barometer survey 2021, QF2/C1_1/2/D1/D2/A1
Asian doctors feel less supported by their immediate colleagues

While there were also notable differences in workplace experiences by ethnicity, these appear to be largely driven by PMQ, with White UK graduates and UK graduates from other ethnic backgrounds reporting similar levels of burnout and satisfaction.

However, doctors from a Black and minority ethnic (BME) background, particularly Asian/Asian British doctors, are less likely to agree that they are supported by their immediate colleagues or that they are part of a supportive team (Table 3). This echoes the 2019 ‘Fair to refer?’ research which found that doctors from a BME background are often treated as ‘outsiders’ in the workplace, receiving poorer support.

Doctors from a BME background, independent of whether they obtained their PMQ inside or outside the UK, were also more likely to have taken hard steps towards leaving the UK medical profession (10% compared with 5% of White doctors).

Table 3: Agreement with statements on support by ethnicity

<table>
<thead>
<tr>
<th></th>
<th>White</th>
<th>BME</th>
<th>Asian/Asian British</th>
<th>Black/Black British</th>
<th>Mixed or multiple ethnic groups</th>
<th>Other ethnic group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supported by</td>
<td>87%</td>
<td>82%</td>
<td>80%</td>
<td>85%</td>
<td>82%</td>
<td>86%</td>
</tr>
<tr>
<td>immediate colleagues</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Part of a supportive</td>
<td>82%</td>
<td>75%</td>
<td>73%</td>
<td>83%</td>
<td>72%</td>
<td>79%</td>
</tr>
<tr>
<td>team</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

n = 3,386 (all doctors), the Barometer survey 2021, QF2/D3_1-3
Patient care

Delays in patient care are a key concern for doctors

The pandemic has resulted in a growing backlog in patient care, driven by later patient presentation of health concerns alongside delays in screenings, tests and treatments.

‘High patient numbers and long waiting lists’ was the biggest area of concern for both GPs (21%) and specialists (21%). Delays in treatments and the backlog of patient care have also led to a higher degree of overlap and some tension between primary and secondary care settings.

‘Primary care around the country is being hammered, and it’s difficult for people to get to the GPs because they’ve got such a backlog. So there is probably more shared care with GPs of pregnant patients, and GPs are monitoring less.’

Changes to working practices, Specialist focus group

We had to take over the management for example of rheumatoid patients with flare-ups and [it] wasn’t uncommon for us to be giving steroid injections – we took on a lot of [the secondary care] workload.”

Changes to working practices, GP focus group

A quarter of doctors regularly find it difficult to provide patients with a sufficient level of care

Two-thirds of doctors (64%) have found it difficult at some point over the last year to provide a patient with the ‘sufficient level of care’ they need, and a quarter (25%) experience this on a weekly basis (Figure 16). This is consistent with the 2020 survey (25% at least weekly), but encouragingly remains some way below pre-pandemic levels (34% at least weekly).

Figure 16: Frequency found it difficult to provide sufficient patient care by registration type

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

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Occasionally</th>
<th>At least once a month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total doctors</td>
<td>33%</td>
<td>28%</td>
<td>11%</td>
</tr>
<tr>
<td>GPs</td>
<td>10%</td>
<td>32%</td>
<td>11%</td>
</tr>
<tr>
<td>Specialists</td>
<td>18%</td>
<td>36%</td>
<td>13%</td>
</tr>
<tr>
<td>Doctors in training</td>
<td>48%</td>
<td>24%</td>
<td>14%</td>
</tr>
<tr>
<td>SAS and LE doctors</td>
<td>62%</td>
<td>20%</td>
<td>6%</td>
</tr>
</tbody>
</table>

n = 3,386 (all doctors), the Barometer survey 2021, QC1_4
Three out of ten doctors (29%) have witnessed a situation in which they believed that a patient’s safety of care was being compromised when being treated by a doctor over the last year. The factors most often identified as contributing to these situations were ‘pressures on workload’ (65%), and ‘delays to providing care, treatment or screenings’ (54%).

It was again GPs who most often reported difficulties providing patients with a sufficient level of care. This may be being exacerbated by increasingly high patient expectations in primary care, as GPs were much more likely to identify ‘difficulties dealing with patient expectation and dissatisfaction’ as a key concern for the coming year (21% compared with 3–5% across other registration types).

**Figure 17: Main barriers to providing good patient care**

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

- Pressure on workloads: 69%
- Time spent on bureaucracy/admin: 57%
- Delays to providing care, treatment and screenings: 54%
- Rota gaps: 42%
- Lack of access to necessary equipment or services: 41%
- Lack of appropriately qualified staff: 39%
- Providing patient care remotely: 38%
- Inadequate communication between healthcare professionals: 31%
- Inadequate communication with patients: 25%
- Inadequate training or preparation: 18%
- Insufficient support from senior colleagues: 16%

*Pressure on workloads is negatively affecting patient care*

In the 2021 Barometer survey we asked doctors what they considered to be the main barriers to providing good patient care. The top three reported barriers were ‘pressure on workloads’ (69%), ‘time spent on bureaucracy or admin’ (57%) and ‘delays to providing care, treatment or screenings’ (54%) (Figure 17). Pressure on workloads was also identified as a contributing factor in almost two-thirds (65%) of situations where patient safety or care had been compromised.

*n = 3,386 (all doctors), the Barometer survey 2021, QC9*
Doctors in the focus groups indicated that additional workload has had significant implications for quality of care, particularly in intensive care and palliative care. 

For many patients with advanced cancers, whose symptoms we would normally treat with palliative care to improve quality of life, and often prolong their life for more than one year, we were instructed not to go ahead with treatments, because we had [to prioritise other patients]. It was not the same quality of service because we were not able to provide it.”

*Changes to working practices, Specialist focus group*

Doctors who are ‘struggling’ with their workload were ten times more likely to find it difficult to provide a patient with sufficient care on a regular basis compared with doctors in the ‘managing’ group (Figure 18).

Overloaded with non-clinical work, and not enough time in the day to fulfil my patient and clinical responsibilities as much as I would like to. I don’t feel my patients are getting the best service currently.”

2021 Barometer survey, open text response

The ‘Caring for doctors, Caring for patients’ report highlighted the strong relationship between doctors’ wellbeing, burnout and patient care. In the 2021 Barometer survey, more than half of those at high risk of burnout (56%) found it difficult, on at least one occasion a week, to provide a patient with sufficient care. Doctors who regularly find themselves unable to provide patients with the best care due to factors outside their control can experience psychological harm (known as moral injury). A vicious cycle exists where this in turn leaves them less able to provide safe, high-quality care.

**Figure 18: Proportion of doctors who found it difficult to provide sufficient patient care weekly by workload quadrant**

<table>
<thead>
<tr>
<th>Workload Quadrant</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Struggling</td>
<td>60%</td>
</tr>
<tr>
<td>Issues unrelated to workload</td>
<td>35%</td>
</tr>
<tr>
<td>Normalised</td>
<td>18%</td>
</tr>
<tr>
<td>Managing</td>
<td>6%</td>
</tr>
</tbody>
</table>

At least once a week

*n = 3,386 (all doctors), the Barometer survey 2021, QC1_1/2/C1_4*
Changes to working practices have had both positive and negative effects on patient care

When doctors were asked how patient care had been affected during the pandemic, by far the most common response was that the impact had been both positive and negative (42%). COVID-19 continues to have a devastating impact on patients and their families, but these data suggest that some of the changes in ways of working to have emerged during the pandemic have improved patient care.

Where services have been reconfigured to offer more direct access to patient care, this has not only helped ease pressure on emergency departments but can also result in improved patient experiences.

“40% of patients were discharged from hospital [on] their first visit and didn’t need to come back. The patient only has to come into hospital once rather than two or three times.”

Changes to working practices,
NHS hospital manager interview

Many doctors feel that working more closely with community care services during the pandemic has accelerated a shift towards more holistic patient-centred care. Digital innovations have also empowered patients to take a more active role in managing their own care.

“Previously having a [blood pressure] machine at home was the exception. Now more than half the people I speak to do. So they can take readings for me without having to come in. And it then really informs the consultation, even if it’s a remote consultation. It provides me with really useful information which might mean they don’t need to come in. That’s empowering the patient to self-manage.”

Changes to working practices,
GP Focus Group
Remote care offers benefits and risks for patient care

The shift towards remote care during the pandemic has been driven by necessity. There are clear benefits in terms of flexibility and greater efficiencies, meaning patients can often access treatment more quickly and conveniently. However, remote care is not always suitable, and doctors have expressed concerns that the current model may exclude sections of society and in some cases compromise the quality of care being delivered – for example, through increased risk of missed diagnosis.

Electronic and telephone [consultations] in reality are going to miss things more – how is that managed?"

*Changes to working practices, GP interview*

Of those doctors who provide care remotely, a third (33%) reported doing so when they felt face to face would be more suitable at least once a week (Figure 19). Specialists and GPs reported this occurring more frequently than trainees or SAS and LE doctors.

Findings from the focus groups indicate that while doctors across healthcare settings have valued an increased capacity to provide care remotely, assessing the suitability of patients for remote consultation has felt to have been challenging at times – particularly for those working in secondary care.

“We’ve been finding them challenging because at the start of the pandemic there was a lot of confusion about who should be coming in face to face. We now spend a lot of time going through the clinical list to inform the clerical staff who should be going coming into clinic and who should not.”

*Changes to working practices, Specialist focus group*

![Figure 19: Frequency providing remote care when face to face was felt to be more suitable by registration type](image-url)

*How frequently, if at all, over the last year have you had to provide remote care when you felt face to face care would have been more suitable?*

<table>
<thead>
<tr>
<th>Total doctors</th>
<th>9%</th>
<th>42%</th>
<th>14%</th>
<th>21%</th>
<th>13%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialists</td>
<td>9%</td>
<td>29%</td>
<td>15%</td>
<td>33%</td>
<td>12%</td>
</tr>
<tr>
<td>GPs</td>
<td>15%</td>
<td>39%</td>
<td>6%</td>
<td>15%</td>
<td>24%</td>
</tr>
<tr>
<td>Doctors in training</td>
<td>4%</td>
<td>52%</td>
<td>18%</td>
<td>20%</td>
<td>5%</td>
</tr>
<tr>
<td>SAS and LE doctors</td>
<td>6%</td>
<td>53%</td>
<td>16%</td>
<td>15%</td>
<td>8%</td>
</tr>
</tbody>
</table>

- Never
- Occasionally
- At least once a month
- At least once a week
- At least once a day

*n = 2,800 (those that provided remote care), the Barometer survey 2021, Q18*
Although doctors may find it is easier to assess the suitability of remote care in general practice, the data suggest that it is within this setting where it could be most often compromising patient safety and care. More than half (54%) of GPs who have witnessed a situation where a patient’s safety or care was compromised reported that providing care remotely was one of the contributing factors (compared with 13-34% across the other registration types).

The GMC has provided support on remote consultations through our online ethical hub, and this year we updated our guidance on prescribing remotely.

**Conclusion**

- The pandemic continues to have a major impact on the day-to-day work of doctors. During the past 12 months, a substantial level of redeployment has remained, and most doctors are still providing more care remotely.

- Doctors’ workload and risk of burnout have risen over the last year, returning to similar levels reported before the onset of the pandemic. Doctors are concerned about growing waiting lists and many are reporting that the increased pressure on workloads is affecting patient care.

- Experiences are not uniform across the medical workforce. GPs again report being under the greatest pressure, and the gap between disabled and non-disabled doctors has continued to grow.

- It is encouraging that high numbers of doctors still feel that the pandemic has led to improvements in some aspects of their work, particularly in relation to teamwork. These new ways of working will play an important role in supporting the pandemic recovery – something that will be explored further in the final chapter of this report.

- Having examined the situation for doctors across the profession in chapter 1, the next chapter will focus on postgraduate training and how doctors’ training experiences have been affected by the pandemic.
Experiences and challenges in postgraduate medical education
Summary

■ The quality of training has remained high during the pandemic. 76% of trainees rated the quality of teaching as good or very good. And 85% said they had a ‘good’ or ‘very good’ experience in their post – up by three percentage points since 2019.

■ Four out of five trainees (81%) and secondary care trainers (78%) felt their working environment was fully supportive. Almost all GP trainers (96%) said the same.

■ Trainees in some specialties, including public health and general practice, have experienced heavier workloads over the past year. And a higher proportion of trainees are at high risk of burnout – 15% compared with 10% in the pre-pandemic national training surveys.

■ The pandemic and operational recovery continue to present challenges for many trainees and trainers around lost training opportunities, exam preparation, completing workplace-based assessments, ‘backfilling’ training, and access to practical procedures.

■ There have been some positive trends in the past year, including an improvement in managing the effect of rota gaps on training opportunities, as well as the successful use of virtual learning environments and remote consultations to develop trainees’ skills.
Introduction

This year’s national training survey (NTS) data allow us to present a clearer snapshot of postgraduate education, both of where we are, and what we are emerging into. 2020’s ‘State of medical education and practice in the UK’ report emphasised the different and sometimes contradictory experiences reported by trainees during the first wave of the pandemic. Several factors underpinned this, such as doctors’ specialties, their stage of training or seniority level, and where in the UK they were practising. Even within these variables, diverse experiences abounded, and coherent patterns were difficult to discern.

But in 2021, the extreme regional variation we saw last year has largely disappeared. And we’re now able to identify certain ‘crunch points’ in programme specialties where trainees are facing challenges, especially around meeting curricula requirements and finding opportunities to ‘backfill’ missed training.

Postgraduate trainees are an integral part of the overall medical workforce we’ve reported on in chapter 1. They develop skills, knowledge, and experience on the training pathway to progress their careers, all while providing patient care and sustaining the wider healthcare system. Most of these doctors will advance into UK practice on the specialist or GP registers. As such, we pay careful attention to their experiences and progression along the pathway.

We do so through the NTS, the largest annual survey of doctors in the UK. In 2021, almost 50,000 trainees gave us their views on their training and the environments where they work. More than 16,000 trainers reported their experience, from their perspective as clinical and/or educational supervisors.

The survey results help us assess whether education is being provided in safe, effective, and appropriately supportive training environments that meet our standards. If there are concerns about a training site where our standards aren’t being met, we work with the postgraduate dean and employer to resolve the problem. We also use the results to identify trends in postgraduate education, which helps us drive improvements.

It is reassuring to find that the overall quality of training being delivered remains high, thanks to the skill and dedication of trainers. Most trainees and trainers continue to feel supported and valued at work, and some recent improvements, such as rota gaps, have been sustained. Virtual Learning Environments (VLE) have proved their worth as an effective and widely embraced means of delivering some aspects of training.

However, the impact of the pandemic on the workforce is becoming evident. A greater proportion of trainees and trainers are at high risk of burnout than ever before. And workloads in several specialties are increasing, especially in general practice.
This is compounded by the difficulties some trainees face in gaining required competencies and experiences, and by the need to catch up on missed opportunities – while also working in the wider context of recovery from the ongoing pandemic. Trainees in medicine, surgery, and obstetrics and gynaecology programmes are finding it particularly tough. Although most trainees remain confident that they will progress, a system and workforce under pressure may lead to longer-term consequences for staff wellbeing and training. This will in turn compromise patient care and service delivery.

It is important that service recovery is not prioritised at the expense of training. As our data show, the pandemic continues to compromise the training of a significant proportion of trainees, with a subsequent risk to trainee morale, development, and career progression. If future problems of workforce capacity are to be avoided, the system needs to protect trainees’ wellbeing and progression throughout its ongoing recovery and renewal.

This chapter will draw on high-level NTS findings and census data to consider doctors’ experiences of their everyday training environments. We then use our programme-specific questions to explore the continued effects of the pandemic on the delivery and provision of training, including the need to compensate for or backfill missed opportunities. The chapter concludes by looking at some of the wider trends and positive developments emerging from our data.

Training quality and supportive environments in 2021

The quality of training remains high

In the 2021 NTS, most trainees said they were satisfied with the quality of training they received in their current post. Positive responses to questions on teaching, supervision and overall experience remain similar to, or slightly above, pre-pandemic levels. This is broadly true across all post specialties, regions, and countries of the UK.

Overall, 76% of trainees rated the quality of teaching as good or very good, and almost nine out of ten (88%) gave the same rating to clinical supervision. 85% said they had a ‘good’ or ‘very good’ experience in their post – up by three percentage points since 2019.

Some variation exists between specialties (Figure 20). Whereas trainees in general practice, occupational medicine, and anaesthetics posts responded most positively, those in medicine, surgery, and obstetrics and gynaecology posts were less positive. This difference was consistent across all three measures – teaching, clinical supervision, and experience. These variations are consistent with pre-pandemic findings. In other words, they reflect longer-term differences of experience, rather than more recent pandemic pressures.
Figure 20: Proportion of trainees who rated the quality of their teaching, supervision, and experience as ‘good’ or ‘very good’, split by post specialty

- Anaesthetics
  - Quality of teaching: 82%
  - Quality of supervision: 95%
  - Quality of experience: 90%

- Emergency medicine
  - Quality of teaching: 74%
  - Quality of supervision: 89%
  - Quality of experience: 86%

- General practice
  - Quality of teaching: 69%
  - Quality of supervision: 86%
  - Quality of experience: 94%

- Medicine
  - Quality of teaching: 69%
  - Quality of supervision: 85%
  - Quality of experience: 81%

- Obstetrics and gynaecology
  - Quality of teaching: 69%
  - Quality of supervision: 84%
  - Quality of experience: 78%

- Occupational medicine
  - Quality of teaching: 69%
  - Quality of supervision: 87%
  - Quality of experience: 90%

- Ophthalmology
  - Quality of teaching: 85%
  - Quality of supervision: 90%
  - Quality of experience: 86%

- Paediatrics and child health
  - Quality of teaching: 82%
  - Quality of supervision: 91%
  - Quality of experience: 88%

- Pathology
  - Quality of teaching: 84%
  - Quality of supervision: 92%
  - Quality of experience: 87%

- Psychiatry
  - Quality of teaching: 83%
  - Quality of supervision: 89%
  - Quality of experience: 86%

- Public health
  - Quality of teaching: 70%
  - Quality of supervision: 88%
  - Quality of experience: 88%

- Radiology
  - Quality of teaching: 83%
  - Quality of supervision: 89%
  - Quality of experience: 87%

- Surgery
  - Quality of teaching: 70%
  - Quality of supervision: 83%
  - Quality of experience: 78%

- All trainees
  - Quality of teaching: 76%
  - Quality of supervision: 88%
  - Quality of experience: 85%

*n = 46,793 (all trainees), NTS 2021*
Chapter 2: Experiences and challenges in postgraduate medical education

Trainers enjoy their role, but protecting time to train can be challenging

Trainers themselves continue to tell us they enjoy their role supporting the training of the next generation of doctors – nine out of ten (91%) agreed with this. This is consistent across all specialties.

However, while almost half (47%) of trainers told us they were always able to use time allocated to them to train, 29% said this was not the case. As usual, there was large variation between specialties for this question – although most specialties reported very small improvements compared with 2019’s results. Around three out of five trainers in anaesthetics (63%) responded positively compared with just over a third of those in medicine (36%) and radiology (33%). 61% of trainers in general practice responded positively, but this has declined by five percentage points since 2019 – a much larger negative swing than any other specialty.

It’s extremely pleasing to see that the overall quality of teaching and supervision has been maintained throughout the pandemic. That’s thanks to the skill and dedication of trainers, trainees, and education bodies. We recognise, however, that these positives are part of a bigger picture of challenge. As this report later discusses, the pandemic has brought significant disruption to training and more broadly, sustained pressure on the healthcare systems and those who work in them.

Most trainees and trainers across the UK feel supported and valued at work, but there’s some variation by specialty and ethnicity

Four out of five trainees (81%) agreed that their working environment was fully supportive (Figure 21), but a greater proportion of those in obstetrics and gynaecology (10%), surgery (9%), and ophthalmology (8%) disagreed. These variations are broadly in line with pre-pandemic specialty differences.

Seven out of ten trainees (70%) reported that staff were always treated fairly. However, one out of ten (12%) disagreed. Four-fifths of trainees said staff were always treated with respect (79%), and that they felt valued members of the team (79%).

Most trainees (89%) agreed that their workplace provided a supportive environment for everyone regardless of background, belief, or identity – up by four percentage points since the 2020 survey, when we introduced this question. Trainee responses varied by ethnicity and primary medical qualification (PMQ).

- 91% of White trainees regarded their working environment as supportive for everyone, compared with 84% of trainees from a Black and Black British background. This difference is similar to that between the two groups in 2020.
- 86% of trainees from a mixed ethnic group and 88% of trainees from an Asian or British Asian background gave a positive response to this question.
- 90% of trainees with a UK PMQ responded positively, compared with 85% of those with a non-UK PMQ.
### Figure 21: Positive and negative responses to questions on supportive environment

<table>
<thead>
<tr>
<th>Question</th>
<th>Trainees</th>
<th>Secondary care trainers</th>
<th>GP trainers</th>
</tr>
</thead>
<tbody>
<tr>
<td>The working environment is fully supportive</td>
<td>81%</td>
<td>78%</td>
<td>96%</td>
</tr>
<tr>
<td>Staff are always treated fairly</td>
<td>70%</td>
<td>68%</td>
<td>97%</td>
</tr>
<tr>
<td>Staff always treat each other with respect</td>
<td>79%</td>
<td>63%</td>
<td>94%</td>
</tr>
<tr>
<td>I feel I am a valued team member (trainees) / valued by my trust/board/practice (trainers)</td>
<td>79%</td>
<td>63%</td>
<td>94%</td>
</tr>
<tr>
<td>My department/unit/practice provides a supportive environment for everyone, regardless of background, beliefs, or identity</td>
<td>89%</td>
<td>77%</td>
<td>99%</td>
</tr>
<tr>
<td>Incident(s) of rudeness and incivility among doctors/healthcare staff are negatively affecting my experience in my role</td>
<td>14%</td>
<td>20%</td>
<td>7%</td>
</tr>
</tbody>
</table>

---

*Disagree with statement*  
*Agree with statement*

---

\[ n = 46,793 \text{ (all trainees); 14,075 (secondary care trainers); 2,339 (GP trainers), NTS 2021} \]
One out of seven (14%) trainees had experienced incidents of rudeness and incivility among doctors/healthcare staff, which were negatively affecting their training experience. A higher proportion (17%) from Asian or British Asian backgrounds reported this, compared with those from a White (12%) or Black/Black British (13%) background. Only 37% of trainees said they’d not experienced any rudeness or incivility in their post, a picture consistent across all ethnicities and PMQs. This question was new to the survey in 2021.

As in our pre-pandemic surveys, GP trainers were overwhelmingly satisfied (96%) that their working environment was fully supportive. Almost all agreed that this was the case, regardless of background, belief, or identity (99%)*, and that they were valued in their workplace (94%). More than half (55%) hadn’t experienced any rudeness or incivility in their role, and only seven percent said such instances were negatively affecting them.

Trainers in secondary care specialties were slightly less positive, although the results remain exactly in line with our pre-pandemic data. Nearly four-fifths (78%) said their trust, board or practice was fully supportive. As among trainees, there is some variation between specialties – a smaller proportion of trainers working in surgery (72%) and ophthalmology (73%) agreed with this statement.

Fewer than two-thirds of secondary care trainers (63%) felt valued by their trust/board. Around one out of seven (14%) did not feel valued – rising to around one out of five trainers in ophthalmology (18%) and surgery (19%).

Finally, around four-fifths of trainers in secondary care (77%) thought their trust/board provided a supportive environment for everyone regardless of background, beliefs, or identity – up by three percentage points compared with 2020. A fifth felt that incidents of rudeness and incivility were negatively affecting them in their role – a much higher proportion than of GP trainers or trainees.

**Year-on-year improvements in managing the impact of rota gaps have continued**

The 2021 NTS suggests that improvements in the management of the effect of rota gaps on training have continued, despite the pandemic. Since we first asked doctors how common it was for educational and training opportunities to be lost due to rota gaps in 2017, trainees have reported annual improvements of two to three percentage points. While we do not have comparable data for 2020, this year’s NTS suggests the trend has continued unaffected by the pandemic.

Over half of all trainees (55%) said that, in their post, education or training opportunities were rarely lost due to gaps in the rota, compared with 49% in 2019. A quarter of trainees (25%) responded negatively, an improvement on 2019 (29%) – although this still accounts for more than 10,000 trainees in the survey.

Rota gaps concern trainees to significantly different extents according to their post specialty. A much smaller proportion of doctors working in obstetrics and gynaecology (34%), medicine (42%), and surgery (48%) posts said that ‘gaps rarely affected’ their training, compared with those in occupational medicine (94%), public

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* In 2020, GP trainers were asked a similar question relating to their trust/board rather than practice. 70% responded positively, although just 4% explicitly disagreed with the statement.
health (87%), and general practice (82%). These variations between specialties are broadly in line with pre-pandemic differences, except for emergency medicine and paediatrics, which have seen modest improvements since 2019 (by eight percentage points and nine percentage points respectively), and occupational medicine, which reported a 19-percentage point improvement (albeit from a smaller sample size).

Three-quarters (75%) of trainees agreed that in their current post, there were enough staff to ensure that patients were always treated by someone with an appropriate level of clinical experience – slightly more than in 2019 (72%). However, around one out of eight (12%) disagreed.

Pandemic and recovery pressures on workloads and wellbeing

While overall trainee workloads remain at 2019 levels, some specialties have reported sizeable changes towards or away from heavier workloads

Two-fifths (39%) of trainees described the intensity of their workload through the day in their current post as heavy or very heavy; slightly more than half (55%) said it was about right. This is exactly in line with our pre-pandemic results.*

As Figure 22 shows, there is significant variation between specialties. Two-thirds (65%) of trainees working in emergency medicine posts reported heavy or very heavy workloads during the day, compared with less than a fifth of those in anaesthetics (19%) and occupational medicine (13%, albeit with a much smaller sample size).

However, compared with our pre-pandemic findings, trainees working in some specialty posts have reported larger swings towards heavier workloads – notably in public health (a 10-percentage point increase) and general practice (nine percentage points).

Conversely, trainees in occupational medicine and public health posts reported an increase in working beyond rostered hours at least once a month (by 21 and 20 percentage points respectively).

GP trainers are reporting increasing workloads

Three-fifths (60%) of secondary care trainers described the intensity of their workload as heavy or very heavy – a six-percentage point improvement compared to our pre-pandemic surveys (66% in 2019). However, GP trainers reported a more negative picture. 87% said their workload was heavy or very heavy, six percentage points more than in 2019.

Two-thirds (66%) of secondary care trainers worked beyond their rostered hours at least once a week, and 85% at least once a month. This represents a small improvement compared with 2019 (70% and 88% respectively). Once again, GP trainers fared worse, with 90% reporting having worked beyond their hours at least once a week – an increase of two percentage points since 2019.

* We did not ask this question (‘by day’) in our 2021 pandemic-focused NTS.
Figure 22: Change in proportion of trainees who reported ‘heavy’ or ‘very heavy’ workloads by day, split by post specialty, 2019 vs 2021

<table>
<thead>
<tr>
<th>Post Specialty</th>
<th>2019</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paediatrics and child health</td>
<td>45%</td>
<td>36%</td>
</tr>
<tr>
<td>Emergency medicine</td>
<td>71%</td>
<td>65%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>37%</td>
<td>33%</td>
</tr>
<tr>
<td>Surgery</td>
<td>41%</td>
<td>41%</td>
</tr>
<tr>
<td>Medicine</td>
<td>46%</td>
<td>46%</td>
</tr>
<tr>
<td>Occupational medicine</td>
<td>12%</td>
<td>13%</td>
</tr>
<tr>
<td>Anaesthetics</td>
<td>18%</td>
<td>19%</td>
</tr>
<tr>
<td>Radiology</td>
<td>19%</td>
<td>21%</td>
</tr>
<tr>
<td>Pathology</td>
<td>19%</td>
<td>22%</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>19%</td>
<td>24%</td>
</tr>
<tr>
<td>Obstetrics and gynaecology</td>
<td>47%</td>
<td>54%</td>
</tr>
<tr>
<td>General practice</td>
<td>30%</td>
<td>39%</td>
</tr>
<tr>
<td>Public health</td>
<td>14%</td>
<td>24%</td>
</tr>
<tr>
<td><strong>All specialties</strong></td>
<td><strong>39%</strong></td>
<td><strong>39%</strong></td>
</tr>
</tbody>
</table>

\[n = 46,793\] (all trainees), NTS 2021
A greater proportion of the trainee and trainer workforce is at high risk of burnout than ever

The pandemic has had a marked impact on trainee wellbeing. This has been the most negative set of responses to our questions on burnout since we introduced them in 2018.

The NTS asks trainers and trainees seven work-related questions taken from the validated Copenhagen Burnout Inventory* to help us better understand the extent of burnout among doctors. In 2021, more than 40,000 doctors chose to answer these voluntary questions.

We have seen a swing towards more negative responses for each of our seven burnout questions, for trainees across all specialties (see Figure 23). In some cases, this difference has been by as many as eight percentage points.

A third of trainees who responded (33%) said they felt burnt out to a high/very high degree because of their work – up from around a quarter in previous years. Three out of five said they always or often felt worn out at the end of the working day. And 44% felt their work was emotionally exhausting to a high/very high degree.

Figure 23: Change in negative trainee responses to burnout questions, from 2018–21

* In the NTS, we measure burnout using the seven work-related questions from the established and widely used Copenhagen Burnout Inventory (CBI). The questions are scored using the established NTS scoring system on a scale from 0–100. The respondents’ mean scores across all seven questions are categorised into one of three levels of burnout: www.gmc-uk.org/help/education-data-reporting-tool-help/burnout-report
Figure 24: Change in negative trainer responses (secondary care and GP) to burnout questions, from 2018–21

Percentage (%)

Secondary care

- I always/often feel worn out at the end of the working day.
- My work is emotionally exhausting to a high/very high degree.
- My work frustrates me to a high/very high degree.
- I feel burnt out because of my work to a high/very high degree.
- I am always/often exhausted in the morning at the thought of another day at work.
- I seldom or never have enough energy for family and friends during leisure time.
- Every working hour is always/often tiring for me.

GP

- I always/often feel worn out at the end of the working day.
- My work is emotionally exhausting to a high/very high degree.
- My work frustrates me to a high/very high degree.
- I am always/often exhausted in the morning at the thought of another day at work.
- Every working hour is always/often tiring for me.
- I feel burnt out because of my work to a high/very high degree.
- I seldom or never have enough energy for family and friends during leisure time.

Year

NTS 2018–21

n = 10,555 (2021 secondary care trainers); 9,257 (2020); 14,738 (2019); 12,632 (2018)

n = 1,854 (2021 GP trainers); 1,528 (2020); 2,477 (2019); 2,274 (2018), NTS 2018–21
Trainers also gave more negative answers to our burnout questions than in 2020 (see Figure 24). A quarter (25%) of secondary care trainers felt burnt out to a high/very high degree because of their work, an increase of two percentage points since 2019. However, this increase is even more marked in general practice, where 22% of GP trainers reported feeling burnt out to a high/very high degree – up by five percentage points since 2019.

In addition, seven out of ten GP trainers (71%, up seven percentage points), and half of secondary care trainers (49%, a decrease of one percentage point) said they always or often felt worn out at the end of the day. And around three out of ten secondary care trainers (29%, down one percentage point since 2019) and GP trainers (30%, up five percentage points) felt frustrated by their work to a high/very high degree.

Each year we use these seven questions to create an indicator measuring overall risk of burnout. As with the individual questions, this indicator also shows a clear swing towards negative responses (Figure 25). 15% of trainees are at high risk of burnout, compared with 10% in our pre-pandemic surveys. 11% of trainers are at high risk, a two-percentage point increase from 2019.
The difference between 2020 and 2021 is even more stark, especially in terms of the proportion of trainees and trainers at moderate and low risk of burnout. The 2020 levels of burnout may have been lower in part because many doctors reported significantly reduced workloads during the spring peak of the pandemic. There was also a lower NTS response rate.

Although trainees across all specialties are showing an increase in the proportion of doctors at high risk of burnout (Figure 26), there are different scales of increase for different post specialties. Emergency medicine continues to be the specialty with the highest proportion of doctors at high risk, but there have been bigger increases since 2019 for almost all other specialties.

**Figure 26: Post specialty variation in trainees at high risk of burnout, 2021 vs 2019**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>2021</th>
<th>2019</th>
<th>Percentage point change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency medicine</td>
<td>21%</td>
<td>17%</td>
<td>1%</td>
</tr>
<tr>
<td>Medicine</td>
<td>16%</td>
<td>13%</td>
<td>5%</td>
</tr>
<tr>
<td>Obstetrics and gynaecology</td>
<td>16%</td>
<td>13%</td>
<td>5%</td>
</tr>
<tr>
<td>Surgery</td>
<td>16%</td>
<td>13%</td>
<td>5%</td>
</tr>
<tr>
<td>General practice</td>
<td>13%</td>
<td>10%</td>
<td>6%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>13%</td>
<td>10%</td>
<td>8%</td>
</tr>
<tr>
<td>Anaesthetics</td>
<td>13%</td>
<td>10%</td>
<td>5%</td>
</tr>
<tr>
<td>Paediatrics and child health</td>
<td>11%</td>
<td>8%</td>
<td>1%</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>10%</td>
<td>7%</td>
<td>4%</td>
</tr>
<tr>
<td>Radiology</td>
<td>9%</td>
<td>6%</td>
<td>3%</td>
</tr>
<tr>
<td>Public health</td>
<td>5%</td>
<td>5%</td>
<td>3%</td>
</tr>
<tr>
<td>Pathology</td>
<td>5%</td>
<td>5%</td>
<td>2%</td>
</tr>
</tbody>
</table>

All trainees                  | 15%  | 13%  | 5%                      |

n = 28,310 (2021 trainees), 35,736 (2019), NTS 2019–21
Occupational medicine not shown due to smaller sample size, but included within ‘All trainees’
The proportion of trainees at high risk of burnout working in emergency posts has only increased by one percentage point since 2019. But for trainees in anaesthetics, medicine, obstetrics and gynaecology, surgery, and general practice posts, it increased by at least five percentage points. The only specialty group to report an improvement was trainers in emergency medicine, with a two-percentage point decrease in the number of doctors at high risk (Figure 27).

Trainees in ophthalmology and general practice posts recorded the largest swing towards negative responses since 2019 (up eight and six percentage points respectively). The same was true of trainers in public health and general practice (up nine and four percentage points respectively) – although there was a smaller sample size for these cohorts.

As in previous years, around two-thirds of trainees (68%) said they knew who to contact in their trust/board (or equivalent) to discuss matters relating to occupational health and wellbeing. However, that figure dropped to just 52% among those in the high risk of burnout category – compared with 62% and 73% for those in the moderate and low risk categories. This variation is consistent with the survey in 2019, when we first introduced this question.

![Figure 27: Post specialty variation in trainers at high risk of burnout, 2021 vs 2019](image)

- Emergency medicine: 17% (2021) vs 17% (2019) with a decrease of 2% change.
- Public health: 17% (2021) vs 17% (2019) with a change of 0%.
- Obstetrics and gynaecology: 13% (2021) vs 13% (2019) with a change of 0%.
- General practice: 13% (2021) vs 13% (2019) with a change of 0%.
- Psychiatry: 11% (2021) vs 11% (2019) with a change of 0%.
- Ophthalmology: 10% (2021) vs 9% (2019) with a change of 1%.
- Surgery: 10% (2021) vs 10% (2019) with a change of 0%.
- Anaesthetics: 10% (2021) vs 10% (2019) with a change of 0%.
- Radiology: 10% (2021) vs 10% (2019) with a change of 0%.
- Medicine: 10% (2021) vs 10% (2019) with a change of 0%.
- Paediatrics and child health: 8% (2021) vs 7% (2019) with a change of 1%.
- Pathology: 7% (2021) vs 7% (2019) with a change of 0%.
- All trainers: 11% (2021) vs 11% (2019) with a change of 0.2%.

Box 3: Burnout and heavy workloads are increasing issues in general practice

Workloads and burnout are increasing at a faster rate for trainers and trainees in GP posts compared with most other specialties. Trainees in GP posts reported the second-highest increase in heavy workloads. Among trainers, GPs too had the highest increase in workload, and the biggest decrease in protected time to train.

Both groups also saw notable increases in burnout – the second-highest among trainees and the third-highest among trainers. This is in line with the Barometer Survey’s burnout findings for GPs, as discussed in chapter 1.

Trainees and trainers in emergency medicine and paediatrics posts stand out as being in a better position than other specialties, compared with 2019. They have seen the biggest improvements in workload and the smallest negative change in burnout of all specialties – and even a small positive change in burnout for emergency medicine trainers.

However, it is important to note that while emergency medicine may have seen a sizeable year-on-year improvement, their baseline scores for both workload and burnout were – and remain – far worse than all other specialties. To illustrate, trainees working in emergency medicine posts reported the second-biggest decrease in heavy workload (five percentage points; after paediatrics’ nine percentage points). But this still leaves 65% of trainees in emergency medicine posts reporting heavy workloads – considerably more than any other specialty (Figure 22).
Chapter 2: Experiences and challenges in postgraduate medical education

The pandemic significantly disrupted training in 2020, particularly opportunities to gain required curriculum competencies

The 2020 NTS uncovered the substantial upheaval to training brought about by the pandemic. Three-quarters of trainees and trainers reported that training had been disrupted. And more than four-fifths said that opportunities to gain required curriculum competencies had been slightly or significantly reduced. Exams and assessments were also affected.

Temporary changes to the Annual Review of Competency Progression (ARCP) process were introduced in early 2020. These allowed trainees to progress to the next level of their programme, but with a requirement to catch up on any missed competencies during the subsequent training year (2020/21). It was an important adjustment in supporting trainees, and in seeking to minimise future disruption to the medical education pipeline. We wanted to reassure trainees and their trainers that their progression would not be held back because of factors beyond their control.

In our 2020 ‘State of medical education and practice in the UK’ report, we made it clear that any recovery of missing training opportunities must prioritise patient safety, and that trainees and trainers must be supported throughout. We knew that training, and healthcare more generally, were likely to remain deeply affected by the pandemic – whether in the form of continuing restrictions, new waves, or variants, or because of increased demand on healthcare systems as staff work through the patient care backlog. So, we, our survey advisory group, and royal colleges felt it was important to track training recovery and the efficacy of new practices and processes through the 2021 trainee survey.

In 2021, many trainees remain anxious about gaining or replacing opportunities

Each year in the NTS, we ask trainees questions developed with the royal colleges reflecting on their programme, rather than their current post. In 2021, this section incorporated questions focused on the continued effects of the pandemic on the delivery and provision of training, including the need to compensate for, or ‘backfill’, missed opportunities.

Many trainees are confident that their current working arrangements are providing opportunities for them to fulfil their training requirements and progress to the next stage of the training pathway. However, for others the picture is less clear:

- Two out of five (41%) trainees said they had been able to compensate for loss of training or opportunities through transferable skills from other aspects of training. But almost a third (31%) disagreed.

- Half of all trainees (49%) reported they had not been provided with effective alternatives to replace missed opportunities through simulation facilities and/or exercises.
More than half of trainees (55%) expected to acquire enough training opportunities to prepare them for their next relevant professional exam. A fifth (20%) disagreed with this.

Most trainees (73%) had been able to participate in the expected number of workplace-based or local assessments. A quarter (25%) had not.

**Trainees on some specialty programmes are facing greater challenges to gain or replace opportunities**

The pandemic and the resulting recovery continue to present challenges for many trainees in the UK, at all levels and specialty programmes. However, trainees in medicine, surgery, and obstetrics and gynaecology programmes are consistently faring much worse on several measures:

- Between 17% and 25% of trainees in these three specialty programmes felt they were not on course to meet curricula competencies and outcomes (compared with 10% across all trainees).

- Around 50% said they had not been able to compensate for lost opportunities through transferable skills from other aspects of training (compared with 31% across all trainees).

- Between 32% and 40% reported they had not taken part in the expected number of workplace-based assessments (compared with 26% across all trainees).

- 28% of trainees in medicine specialty programmes felt they did not have enough opportunities to prepare for next exams (compared with 20% across all trainees).

This variation by programme specialty group is also evident in the questions asked to trainees about ‘backfilling’ training and access to practical procedures. Within the ‘craft’ specialties (broadly defined as programmes where, at the time of the survey, trainees had to meet an indicative number of operative or practical procedures to progress), medicine, surgery, and ophthalmology performed worse than other programmes. Within ‘medicine/other’ specialties, obstetrics and gynaecology and medicine were negative outliers.

This chapter will now provide more detail to support these key findings.

Most trainees are confident about progression, but those in surgery and obstetrics and gynaecology programmes are more pessimistic

Eight out of ten trainees (81%) think they are on course to meet their curriculum competencies and outcomes for their stage of training, while one out of ten (10%) do not. This question was new to the 2021 survey, so we have no historical benchmark. It’s also important to note that trainees can progress with different outcome levels, whereas the question didn’t address that nuance. For example, a respondent may be pessimistic about achieving an Outcome One, but still expect to progress with an Outcome Two (some competencies still required, but no additional training time needed).
There was substantial variation by specialty for this question (Figure 28). A higher proportion of doctors in broad based training (93%) and Foundation (94%) programmes were optimistic – probably because of the nature of competencies they need to acquire. However, a quarter of trainees in surgery and in obstetrics and gynaecology (25% and 24% respectively) felt they were not on course to progress. Just under a fifth of those in ophthalmology, pathology and medicine said the same (19%, 18% and 17% respectively).

**Figure 28: Trainees’ progress towards curriculum competencies and outcomes, split by programme specialty**

I’m on course to meet my curriculum competencies/outcomes for this stage of my training.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Strongly agree/agree</th>
<th>Neither agree nor disagree</th>
<th>I don’t know</th>
<th>Disagree/strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute care common stem</td>
<td>75%</td>
<td>11%</td>
<td>14%</td>
<td></td>
</tr>
<tr>
<td>Anaesthetics</td>
<td>76%</td>
<td>9%</td>
<td>1%</td>
<td>13%</td>
</tr>
<tr>
<td>Broad based training</td>
<td>93%</td>
<td>7%</td>
<td>4%</td>
<td></td>
</tr>
<tr>
<td>Emergency medicine</td>
<td>80%</td>
<td>10%</td>
<td>9%</td>
<td></td>
</tr>
<tr>
<td>Foundation</td>
<td>94%</td>
<td>4%</td>
<td>6%</td>
<td></td>
</tr>
<tr>
<td>General practice</td>
<td>86%</td>
<td>9%</td>
<td>5%</td>
<td></td>
</tr>
<tr>
<td>Medicine</td>
<td>70%</td>
<td>12%</td>
<td>17%</td>
<td></td>
</tr>
<tr>
<td>Obstetrics and gynaecology</td>
<td>61%</td>
<td>13%</td>
<td>24%</td>
<td></td>
</tr>
<tr>
<td>Occupational medicine</td>
<td>84%</td>
<td>5%</td>
<td>2%</td>
<td>9%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>70%</td>
<td>10%</td>
<td>19%</td>
<td></td>
</tr>
<tr>
<td>Paediatrics and child health</td>
<td>86%</td>
<td>8%</td>
<td>5%</td>
<td></td>
</tr>
<tr>
<td>Pathology</td>
<td>66%</td>
<td>14%</td>
<td>2%</td>
<td>18%</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>85%</td>
<td>8%</td>
<td>6%</td>
<td>6%</td>
</tr>
<tr>
<td>Public health</td>
<td>85%</td>
<td>6%</td>
<td>3%</td>
<td>6%</td>
</tr>
<tr>
<td>Radiology</td>
<td>82%</td>
<td>10%</td>
<td>7%</td>
<td></td>
</tr>
<tr>
<td>Surgery</td>
<td>59%</td>
<td>15%</td>
<td>2%</td>
<td>25%</td>
</tr>
<tr>
<td>All trainees</td>
<td>81%</td>
<td>9%</td>
<td>10%</td>
<td></td>
</tr>
</tbody>
</table>

$n = 46,793$ (all trainees), NTS 2021
Trainees on surgery programmes are struggling to replace missed training opportunities

Trainees gave mixed responses to questions on replacing training opportunities. Two out of five (41%) said they had been able to compensate through transferable skills from other aspects of training. But almost a third (31%) felt this wasn’t the case. Again, the situation varies greatly according to specialty. More than half of trainees on surgery (53%), obstetrics and gynaecology (52%), and ophthalmology (50%) programmes felt they hadn’t been able to compensate through transferable skills.

Nearly half of all trainees (49%) said they had not been provided with effective alternatives through simulation facilities and/or exercises. But this rises to almost three-quarters (72%) among trainees on surgery programmes. Trainees in obstetrics and gynaecology (59%), acute care common stem (58%), medicine (57%), and anaesthetics (56%) were also negative outliers.

’Craft’ programme trainees in medicine and surgery are most concerned about backfilling missed training practical procedures

The 2021 NTS asked questions specific to trainees on a ‘craft’ specialty programme.* These are broadly defined as programmes where, at the time of the survey, trainees had to meet an indicative number of operative or practical procedures to progress.

Around three-fifths of ‘craft’ trainees (57%) agreed that they were on course to undertake the expected number of operative/practical procedures. However, there were still more than two-fifths (43%) who said this was not the case – with 14% stating they were significantly below the required amount.

Trainees on craft medicine and surgery programmes were the most negative about their opportunities to undertake operative/practical procedures. 56% of those on a craft medicine programme and 54% on a surgery programme thought they wouldn’t meet the expected number for the year, with around a fifth in each group stating they were significantly below the target (21% and 20% respectively).

Nearly two-fifths (39%) of trainees on craft specialty programmes had not been given opportunities to backfill competencies missed due to the pandemic (either in the NHS or the independent sector). Again, trainees on craft surgery (52%) and medicine (50%) programmes were negative outliers, along with those in ophthalmology (53%).

* Craft programmes = Acute Care Common Stem, Anaesthetics, Cardiology, Clinical Radiology, Gastroenterology, General Surgery, Intensive Care Medicine, Core surgical training, Neurosurgery, Oral and maxillo-facial surgery, Trauma and orthopaedic surgery, Urology, Vascular surgery, Cardiothoracic surgery, Otolaryngology, Paediatric surgery, Plastic surgery, Ophthalmology.
Among trainees on a ‘medicine/other’ programme, those in medicine and obstetrics and gynaecology were the most concerned about gaining practical experience and backfilling missed training

The 2021 NTS also asked questions specific to trainees on a ‘medicine/other physician’ specialty programme. These are broadly defined as programmes where trainees are required to gain a sufficient level of experience in practical procedures, but not tied to a set quantity.

Two-thirds of trainees on a ‘medicine or other physician’ specialty programme (66%) said they were on course to gain enough experience in the practical procedures needed for their stage of training. One out of seven (14%) disagreed. This was especially the case for trainees on programmes in obstetrics and gynaecology and (non-craft) medicine, where 30% and 20% respectively did not think they would gain the required experience.

Two-fifths of trainees on a ‘medicine or other physician’ programme (38%) said they’d been given enough opportunities to backfill missed training, with a fifth (22%) stating this was not the case. A further fifth (17%) felt they had no training to catch up on. A greater proportion of trainees on obstetrics and gynaecology (41%) and medicine (30%) programmes said they hadn’t been given enough opportunities to catch up.

A higher proportion of trainees at the start of the pathway are concerned about preparation for exams and the efficacy of adapted work-place assessments

More than half of respondents (55%) felt they had sufficient experience to prepare them for their next relevant professional exams, with trainees on a public health programme especially confident (82%). However, a fifth of doctors (20%) reported they hadn’t had enough training opportunities in preparation for these exams. Doctors at the start of the postgraduate training pathway (23% in Foundation, 28% and 29% respectively in CT1 and 2) and on medicine programmes (28%) were the most pessimistic (see Figure 29).

Whereas most trainees (73%) had been able to participate in the expected number of workplace-based (or local) assessments, a quarter (26%) had not. This figure rose to 40% of those on the broad based training programme, and to around a third of those on obstetrics and gynaecology (36%), medicine (35%), paediatrics (32%), and surgery (32%) programmes.

* Medicine/Other programmes = Emergency medicine, Audiology medicine, Allergy, Clinical genetics, Clinical pharmacology and therapeutics, Combined infection training, Dermatology, Endocrinology and diabetes mellitus, Genito-urinary medicine, Geriatric medicine, Haematology, Immunology, Infectious diseases, Internal medicine training, Medical oncology, Medical ophthalmology, Neurology, Nuclear medicine, Palliative medicine, Rehabilitation medicine, Respiratory medicine, Rheumatology, Sport and exercise medicine, Obstetrics and gynaecology, Core psychiatry, General psychiatry, Child and adolescent psychiatry, Forensic psychiatry, Old age psychiatry, Psychiatry of learning disability, Medical psychotherapy, Community sexual and reproductive health, Occupational medicine, Chemical pathology, Medical microbiology, Virology, Clinical oncology, Clinical neurophysiology, Renal medicine, Paediatrics.
Figure 29: Trainees’ preparedness for exams, split by training level

I have (or expect to have) had enough training opportunities to adequately prepare me for my next relevant professional exam(s).

- **F1**: 45% Strongly agree/agree, 32% Neither agree nor disagree, 23% Disagree/strongly disagree
- **F2**: 49% Strongly agree/agree, 28% Neither agree nor disagree, 23% Disagree/strongly disagree
- **CT1**: 44% Strongly agree/agree, 28% Neither agree nor disagree, 28% Disagree/strongly disagree
- **ST1**: 56% Strongly agree/agree, 27% Neither agree nor disagree, 17% Disagree/strongly disagree
- **CT2**: 45% Strongly agree/agree, 26% Neither agree nor disagree, 29% Disagree/strongly disagree
- **ST2**: 59% Strongly agree/agree, 26% Neither agree nor disagree, 15% Disagree/strongly disagree
- **CT3**: 67% Strongly agree/agree, 20% Neither agree nor disagree, 14% Disagree/strongly disagree
- **ST3**: 62% Strongly agree/agree, 22% Neither agree nor disagree, 16% Disagree/strongly disagree
- **ST4**: 55% Strongly agree/agree, 25% Neither agree nor disagree, 21% Disagree/strongly disagree
- **ST5**: 56% Strongly agree/agree, 26% Neither agree nor disagree, 19% Disagree/strongly disagree
- **ST6**: 63% Strongly agree/agree, 22% Neither agree nor disagree, 15% Disagree/strongly disagree
- **ST7**: 67% Strongly agree/agree, 20% Neither agree nor disagree, 13% Disagree/strongly disagree
- **ST8**: 70% Strongly agree/agree, 18% Neither agree nor disagree, 12% Disagree/strongly disagree

All trainees: 55% Strongly agree/agree, 26% Neither agree nor disagree, 20% Disagree/strongly disagree

\[ n = 46,793 \text{ (all trainees), NTS 2021} \]
Assessments have had to be adapted to avoid direct patient contact and account for remote working arrangements. However, there were mixed views about the efficacy of these adjustments. Although 42% of trainees thought they offered the same or improved opportunities as pre-pandemic assessments, 25% felt they were worse. This negative view was especially common among trainees in Foundation (32-33%), CT1 (39%), and CT2 (33%) training levels, whereas trainees in the later stages of specialty training were much more positive.

Temporary changes to support trainee progression will continue while pandemic disruption remains

In September 2021 we agreed to continue some of the changes (derogations) to training and progression for medical education and training, following discussions with statutory education bodies, royal colleges, and trainee representatives.

These amendments include changes to postgraduate curricula and assessment, and changes to the ARCP. This decision will allow trainees to progress to the next year of their pathway without having gained the expected capabilities or competences, provided it is safe for them to do so. They will however be required to backfill these aspects of their training.

These adaptations will remain in place during the period of disruption to training caused by the pandemic. We will continue to monitor and review these measures and will only remove them following full discussions with our partners in the wider system.

Wider trends and positive developments within postgraduate medical education

Trainees are broadly positive about the role of virtual learning environments in training delivery

Three-quarters of trainees (74%) said that virtual learning environments (VLEs) are being used effectively to support training. Those on psychiatry, broad based training, medicine, and paediatrics specialty programmes were especially positive (87%, 87%, 86% and 86% respectively).

A greater proportion of doctors on Acute Care Common Stem, Foundation, and surgery programmes said VLEs weren’t being used effectively – 16% to 17%, compared with 10% across all trainees. Trainees at the start of the pathway, in Foundation (16%) and core (15%) levels, were also pessimistic.
Trainees from a Black or Black British background had more favourable views of VLEs compared with other ethnicities. 85% agreed they were being used effectively, 11 percentage points more than the average for all trainees, and 14 percentage points more than White trainees.

Our focus groups also found that the ease and flexibility of virtual training (including the ability to catch up) has had positive effects on attendance and inclusivity within sessions. However, some doctors felt this had come at the expense of networking opportunities beneficial to wider communication and relationship building, especially across specialties.

Virtual training has been good but unfortunately social and networking opportunities can’t occur. You can’t create professional networks, those little bridges. It’s a completely different conversation calling a consultant at 2am and saying, ‘You’ve not met me before’, compared with being able to say, ‘We met at the cardiology day’. They’re superficial but personal relationships.”

The proportion of Foundation trainees who felt adequately prepared for their first post continues to decline, but those who undertook Foundation interim year 1 (FiY1) placements buck the trend

The proportion of F1s feeling prepared for their first post has undergone a small but sustained year-on-year decline from 2015 to 2019. The introduction of Foundation interim year 1 (FiY1) placements in 2020 has complicated that trend.

In 2020, to enable final-year medical students to offer support to health services, we processed applications for provisional registration at an earlier point in the year than usual. This meant that final-year students graduated by their medical school were given a provisional licence to practise, and so could work in a newly-created FiY1 role from late April – rather than August, when they would normally have joined the workforce.

At first glance, the proportion of 2021’s F1s who felt prepared (71%) has increased for the first time in years (66% in 2019). However, this effect is driven by trainees who undertook a FiY1 placement in the summer of 2020. In fact, trainees who didn’t experience FiY1 reported a nine-percentage point decline in their perceived preparedness, compared with the 2019 data.

The contrast in perceived preparedness between doctors who did and didn’t experience FiY1 is marked. 79% of F1s who undertook FiY1 felt adequately prepared upon starting their postgraduate training, compared with 57% of those who didn’t. In addition, only 10% of doctors who worked in an FiY1 post said they did not feel prepared for their first F1 post, compared with 23% of those who did not work in an FiY1 post.

Trainees on the GP programme think remote consultation has helped develop their skills

Three-quarters of GP trainees (74%) said remote consultation was enabling them to develop effective consultation skills. The same proportion (75%) said they had received appropriate feedback from their clinical supervisors to develop remote consultation skills. Most (66%) had been offered specific training on this, but a third (33%) had not.

* This question was only asked to trainees on the GP programme.
Completing an interim role may also have had a small positive or protective effect on wellbeing (Figure 30) as 15% of F1s who had undertaken FiY1 were at high risk of burnout, compared with 18% of those who had not.

These findings support those of our report, ‘2020 Medical Graduates: The work and wellbeing of interim Foundation Year 1 (FiY1) doctors’ during COVID-19.” This research evaluated the experience and impact of FiY1 posts on new doctors, in terms of their work, their wellbeing, and perceptions of practice. The report concluded that:

■ FiY1 was a largely valuable experience which eased the transition to practice.

■ Medical students were attracted to the FiY1 role for their own learning, to contribute to the NHS in a time of need, or through a sense of obligation.

■ FiY1s’ work was similar to the work of F1s.

■ Those who had worked as FiY1s felt more prepared for starting F1 than those who had not been working since April 2020 or those who had worked in non-FiY1 clinical roles.

Participants faced challenging experiences during their FiY1 posts, but these were not necessarily negative if accompanied by support from colleagues.

It is important to note that the creation of the FiY1 programme was a specific and temporary response to the UK’s pandemic response. The greater preparedness of FiY1s could have been due to longer practical experience prior to starting training, as well as the higher support/visibility of senior doctors reported in general during this period.

To establish a similar permanent role in future would require careful workforce planning and support, as well as consideration of cost implications and different national contexts and approaches. However, we recognise that the role brought many benefits and positive experiences for trainees – especially in easing the transition to practice and encouraging supported autonomy. We will work with partners across the profession to share learnings from the scheme widely and build upon positive practices.
More trainees are choosing to work on a less than full time basis

Since we first asked trainees in 2017, the numbers working less than full time (LTFT) has increased steadily from 11% to 15% in 2021, with a further 2% having considered doing so but who have not yet applied. Together, these groups represent more than 8,200 doctors. Just 0.1% (55 doctors) had applied but had their applications rejected.

Gender and ethnicity are both significant factors. Almost a quarter (23%) of women said they worked LTFT, compared with only 5% of men. With respect to ethnic background, 17% of White doctors work LTFT, compared with 8% of those from a Black or Black British background. 14% of those of mixed ethnicity and 13% from an Asian or British Asian background said the same.

A greater proportion of doctors in the later stages of the training pathway work LTFT (Figure 31).

There’s also considerable variation by programme specialty (Figure 32). Nearly two-fifths of trainees in paediatrics (39%) and public health (38%) said they worked LTFT, by contrast with only 6% on a surgery programme. This variation may be linked to the greater proportion of female trainees enrolled in these specialties.

We know doctors’ circumstances vary widely, and that many need more flexibility while they are training, with potential benefits for wellbeing and work-life balance. We work with other organisations to maximise the options for doctors to adapt their training to their personal circumstances, while at the same time ensuring more flexible systems work for patients and service providers as well as for doctors. The conditions for LTFT training should ensure doctors maintain current competences and continue to develop capabilities to progress, maintain an appropriate presence in the training environment and cover the required aspects of the curriculum.
Figure 31: Less than full time working, split by training level

Are you formally working on a less than full time basis, which has been approved by your deanery/ HEE local team?

<table>
<thead>
<tr>
<th>Training level</th>
<th>98%</th>
<th>96%</th>
<th>93%</th>
<th>87%</th>
<th>90%</th>
<th>79%</th>
<th>79%</th>
<th>76%</th>
<th>71%</th>
<th>67%</th>
<th>69%</th>
<th>69%</th>
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<tbody>
<tr>
<td>F1</td>
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<td></td>
<td>7%</td>
<td></td>
<td>17%</td>
<td>18%</td>
<td>23%</td>
<td>21%</td>
<td>27%</td>
<td>31%</td>
</tr>
<tr>
<td>F2</td>
<td></td>
<td>3%</td>
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<td></td>
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<td>CT1</td>
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<tr>
<td>ST2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3%</td>
<td>4%</td>
<td>3%</td>
<td>3%</td>
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<td>3%</td>
<td>3%</td>
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<td>ST7</td>
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<td>3%</td>
<td>4%</td>
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<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td>ST8</td>
<td></td>
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<td></td>
<td></td>
<td>3%</td>
<td>4%</td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td>All trainees</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Yes | I considered working LTFT, but I did not apply | I applied to work LTFT, but it was not approved | No

n = 46,793 (all trainees), NTS 2021
Figure 32: Less than full time working, split by programme specialty

Are you formally working on a less than full time basis, which has been approved by your deanery/HEE local team?

<table>
<thead>
<tr>
<th>Programme specialty</th>
<th>Yes</th>
<th>I considered working LTFT, but I did not apply</th>
<th>I applied to work LTFT, but it was not approved</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute care common stem</td>
<td>89%</td>
<td>7%</td>
<td>4%</td>
<td>7%</td>
</tr>
<tr>
<td>Anaesthetics</td>
<td>77%</td>
<td>20%</td>
<td>3%</td>
<td>7%</td>
</tr>
<tr>
<td>Broad based training</td>
<td>87%</td>
<td>7%</td>
<td>7%</td>
<td>7%</td>
</tr>
<tr>
<td>Emergency medicine</td>
<td>69%</td>
<td>27%</td>
<td>4%</td>
<td>7%</td>
</tr>
<tr>
<td>Foundation</td>
<td>97%</td>
<td>2%</td>
<td>4%</td>
<td>7%</td>
</tr>
<tr>
<td>General practice</td>
<td>75%</td>
<td>22%</td>
<td>3%</td>
<td>7%</td>
</tr>
<tr>
<td>Medicine</td>
<td>84%</td>
<td>14%</td>
<td>3%</td>
<td>7%</td>
</tr>
<tr>
<td>Obstetrics and gynaecology</td>
<td>67%</td>
<td>30%</td>
<td>3%</td>
<td>7%</td>
</tr>
<tr>
<td>Occupational medicine</td>
<td>69%</td>
<td>29%</td>
<td>2%</td>
<td>7%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>89%</td>
<td>9%</td>
<td>2%</td>
<td>7%</td>
</tr>
<tr>
<td>Paediatrics and child health</td>
<td>57%</td>
<td>39%</td>
<td>4%</td>
<td>7%</td>
</tr>
<tr>
<td>Pathology</td>
<td>73%</td>
<td>25%</td>
<td>2%</td>
<td>7%</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>77%</td>
<td>20%</td>
<td>3%</td>
<td>7%</td>
</tr>
<tr>
<td>Public health</td>
<td>61%</td>
<td>38%</td>
<td>2%</td>
<td>7%</td>
</tr>
<tr>
<td>Radiology</td>
<td>82%</td>
<td>16%</td>
<td>2%</td>
<td>7%</td>
</tr>
<tr>
<td>Surgery</td>
<td>92%</td>
<td>6%</td>
<td>3%</td>
<td>7%</td>
</tr>
</tbody>
</table>

| All trainees                 | 82% | 15%                                           | 2%                                            | 7% |

n = 46,793 (all trainees). NTS 2021
Conclusion

In 2021, the overall quality of postgraduate training – where it has gone ahead – has been sustained, and working environments remain supportive. Many trainees have responded positively to virtual learning environments and remote consultation. FiY1 posts have had a positive impact on trainees’ preparedness for starting postgraduate training. And longer-term improvements to the management of the effect of rota gaps on training have continued.

However, the pandemic and recovery continue to put pressure on trainees and trainers. There have been marked changes in workload for many, and a greater proportion of the workforce is at high risk of burnout than ever. These working pressures have implications for training opportunities and career progression. Many trainees remain anxious about gaining or replacing opportunities they need, especially those in medicine, surgery, and obstetrics and gynaecology specialty programmes.

That’s why we have agreed to continue changes to postgraduate curricula and assessment, and to the ARCP. This will allow trainees to progress to the next year of their pathway without having gained the expected capabilities or competences, provided it is safe for them to do so. They will however be required to ‘backfill’ these aspects of their training. These adaptations will remain in place during the period of disruption to training caused by the pandemic.

There are several policy implications of these findings, and wider lessons to be learnt from the pandemic. These include:

- The need to build on lessons from the pandemic to promote flexibility in training delivery and curricula, to support service delivery and recovery in turbulent times.
- How the system can embed lessons from the FiY1 experience, especially around preparedness, autonomy, and support for new trainees.
- The need to encourage virtual learning (where feasible) and look to hybrid models of teaching delivery in the longer term.
- Our work in reviewing guidance and processes in medical education to identify areas where we can do more to support improvements around equality, diversity, and inclusion.

We’re also working with our education partners to take stock of changes which have emerged during the pandemic. Those involved in planning and delivering training have had to adapt quickly. It’s important that we make sure new approaches continue to be fair and inclusive, and that they haven’t created any unintended consequences for particular groups. For example, we’re working with the Academy of Medical Royal Colleges to carry out equality, diversity, and inclusion impact assessments of online exams and assessments across all specialties.

Postgraduate trainees are an integral part of current service delivery in the healthcare system, but also key to the future supply of doctors. As such, it is vital that service recovery is not prioritised at the expense of training and wellbeing. Chapter 3 now turns to the supply and retention of doctors within the wider medical workforce.
Workforce
Summary

- There was a short-term reduction in the number of international medical graduates (IMGs) taking up a licence due to a range of pandemic-related issues limiting travel and access to assessments.

- The volume of IMGs joining by mid-2021 is comparable to the same point in 2019, which was a record year. This is encouraging given the disruption created by the pandemic.

- The pandemic has not changed the decision of most UK trainees to work temporarily outside the training pathway after F2. Workforce planners also need to consider the impact of doctors delaying choosing specialty training after F2 on the supply pipeline, as well as the opportunities and challenges presented by more trainees working as locally employed doctors.

- There has been an unprecedented increase in the number of students accepted into UK medical schools due to government policy changes to fund additional places with an increase of 21% of students commencing in 2021/22 from 2020/21’s starts.

- Doctors’ future career intentions are changing with the proportion of doctors taking hard steps towards leaving UK practice increasing from 4% in 2020, to 7% in 2021. This is highly concerning given the vital importance of retaining doctors for building a sustainable medical workforce.
Introduction

In the UK, safe and effective patient care depends on the recruitment, retention and ongoing development of a very large number of doctors. The challenge is to ensure that the healthcare system is equipped with doctors holding a wide variety of skills and expertise. This task has been especially demanding during the coronavirus (COVID-19) pandemic, when both the pressure and workload faced by many in the UK’s healthcare systems have been extreme.

This chapter focuses on the number of licensed doctors the UK has, the patterns of those joining and leaving the profession, and how these have been affected by the pandemic. We also provide analysis of how the coronavirus pandemic has affected trainees and medical students, and what this all means for the future capacity of the workforce.
The number of doctors with a licence to practise

**Steady increase in licensed doctors, with a time-limited pandemic effect**

From 2012 to 2021, the number of licensed doctors grew by more than 42,000 people (Figure 33) to 274,891. The largest year-on-year increase was from 2019 to 2020 (8%) but this is largely explained by emergency measures we took in the early stages of the pandemic. Figure 33 includes a group called temporary emergency register (TER) doctors for 2020 and 2021 that are described in Box 4. There was also a large group of UK graduates that were registered earlier (in April 2020) than the usual month of August, so are a part of the 2020 total and not 2021, which is described further in Box 5.

While the number of licensed doctors is not the same as the number of doctors working in the UK in Whole Time Equivalent (WTE) terms, 2012 to 2021 data from the four UK healthcare systems\(^8, \, 9, \, 10, \, 11\) show that it is a good proxy as the ratio of WTE to total headcount of doctors was at least 0.9.

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**Figure 33: Registered doctors in the UK, by licence status and including temporary emergency register (TER) doctors**

<table>
<thead>
<tr>
<th>Year</th>
<th>Licensed doctors</th>
<th>Non-licensed doctors</th>
<th>TER</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>220,000</td>
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<tr>
<td>2015</td>
<td>240,000</td>
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<tr>
<td>2017</td>
<td>260,000</td>
<td>0</td>
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</tr>
<tr>
<td>2019</td>
<td>280,000</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>2021</td>
<td>300,000</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>
Box 4: Temporary emergency registration (TER)

We offered TER to over 30,000 doctors, and between 26 March 2020 and 24 June 2020 we gave 28,076 doctors TER or restored their licences, under our emergency powers. These doctors included:

- 12,076 doctors with a UK address, who were GMC-registered, but did not currently hold a licence to practise
- 16,000 doctors with a UK address, who had given up their registration between three and six years ago (2014–17).

Only doctors with no outstanding fitness to practise investigations or sanctions were granted temporary registration. Doctors were able to opt out of temporary registration at any point and for any reason. The numbers shown in Figure 1 include TER doctors who did not opt out before 30 June 2020 and were still licensed as of 30 June 2021.

Once the Secretary of State advises that there is no longer a national state of emergency, we will revoke all temporary registrations and TER doctors will no longer be entitled to practise as a doctor. They can maintain their right to practise if they apply through the normal registration application process.

Box 5: Foundation interim year 1 (FiY1)

To reduce the effect of an anticipated sudden increase in workforce pressures caused by the coronavirus pandemic, we emailed all final-year UK medical students in April 2020 inviting them to apply for provisional registration in newly created Foundation interim year 1 (FiY1) posts. Those who had met the requirements of their degree, and had been graduated by their medical school, were given a provisional licence to practise as doctors from 27 April 2020 – several months ahead of August when they would normally have joined the workforce. By 30 June 2020, we had granted 6,868 UK graduates provisional registration.
Fewer doctors are planning to reduce their contracted hours than before the pandemic, although there has been a slight increase in 2021

Across all the doctors surveyed in the 2021 Barometer survey, reducing contracted hours was a common intention they were considering for the year ahead. Although the proportion of doctors planning in this way reduced sharply between 2019 and 2020 (Figure 34) from 41% to 31%, there was a small increase from 2020 to 2021 of four percentage points. This still represents a large fall from pre-pandemic levels in 2019.

It is not possible to say whether this reduction is driven by doctors’ wishes, or whether they do not feel that reducing their hours is a realistic option at this stage of the pandemic. An increasing opposing trend – doctors wishing to work more hours – is not evident, which could be consistent with a lack of real opportunity to reduce hours.

Figure 34: Proportion of doctors likely to reduce contracted hours in the next year

<table>
<thead>
<tr>
<th></th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>GPs</td>
<td>52%</td>
<td>35%</td>
<td>47%</td>
</tr>
<tr>
<td>Specialists</td>
<td>51%</td>
<td>37%</td>
<td>42%</td>
</tr>
<tr>
<td>Doctors in training</td>
<td>26%</td>
<td>26%</td>
<td>28%</td>
</tr>
<tr>
<td>SAS and LE</td>
<td>28%</td>
<td>25%</td>
<td>21%</td>
</tr>
<tr>
<td>All doctors</td>
<td>41%</td>
<td>31%</td>
<td>35%</td>
</tr>
</tbody>
</table>

*NET likely = ‘fairly likely’ or ‘very likely’*

\[ n = 3,876 \text{ (all doctors) the Barometer survey 2019, QB1_1} \quad n = 3,693 \text{ (all doctors) the Barometer survey 2020, QB1_1} \quad n = 3,386 \text{ (all doctors) the Barometer survey 2021, QB1_1} \]

Values do not add up to 100% as not all response options are included.
Doctors joining the UK workforce

The overall number of doctors with a licence to practise is the net effect of doctors joining and leaving the UK workforce. We now look at each in turn. Our data show information that is important for interpreting the impact of the pandemic on workforce numbers. We share conclusions and highlight where we feel caution is needed when interpreting changes in both international and UK doctors joining the workforce.

The number of IMGs joining the UK workforce has fallen by a third in the last year but there were also fewer IMG leavers and the total number of IMGs actually grew

2021 data revealed a sharp reduction in international medical graduates from outside the EEA (IMGs) joining the UK workforce (Figure 35), which is unsurprising given the issues created by the pandemic. In fact, the number joining in 2021 was roughly the same as in 2019, which was the second-largest year covered by the data we hold.

Countries which previously provided large numbers of doctors for the UK workforce had substantive restrictions in 2021. A good example is India, from which we have seen the number of doctors joining the register fall by almost a third (31%), from 2020 to 2021 (1,830 and 1,261, respectively). India was on the Government’s ‘red list’ from 23 April to 8 August 2021, making travel more challenging, and increasing uncertainty for those considering a life-changing decision to work in another country.

There was a 6% growth in the overall number of licensed IMGs between 2020 and 2021 (from 72,972 to 77,499). We cannot quantify the number of IMG leavers between 1 July 2020 and 30 June 2021 with confidence at this point in time. However, the overall growth shows that although fewer IMGs joined, there must also have been considerably fewer leaving.

While the overall number has not reduced, there could be impacts from the short-term disruption to inflows and outflows caused by the pandemic that are not yet clear. Clearly, the UK has remained an attractive destination for IMGs despite the pandemic – not only are IMG joiners similar to the second-highest year ever, but we have also seen all places filled at our recently expanded PLAB centres.
Figure 35: Doctors taking up (or returning to) a licence to practise, by primary medical qualification (PMQ) (excluding temporary emergency registered doctors), from 2012–21

UK

EEA

IMG

Year

Denotes FiY1 doctors (see Box 5)
Box 6: Professional and Linguistics Assessment Board (PLAB) changes during the pandemic

The PLAB test helps us to make sure doctors who qualified abroad have the right knowledge and skills to practise medicine in the UK.

The test is in two parts. PLAB 1 is a written multiple-choice exam taken in test centres around the world. PLAB 2 is taken after the first test has been passed and is a practical objective structured clinical exam (OSCE). It is held at the GMC clinical assessment centre in the UK.

The number of doctors progressing through PLAB tests has been compromised by the UK COVID-19 regulations preventing face-to-face activities, and the subsequent social distancing guidelines and travel restrictions.

Although the PLAB 1 tests were affected differently, according to the circumstances in specific countries, many ended up being cancelled. The GMC ran additional sessions in October 2020 and doubled the capacity of some testing venues where previous exams had been cancelled, to minimise delays. PLAB 2 tests were suspended by the GMC in March 2020 because of lockdown and social distancing requirements, and when the assessment centre re-opened in August, it was with a reduced capacity, due to temporary social distancing restrictions.

The impact of this on doctors’ overall decisions to move to the UK and practise cannot currently be quantified. Many doctors will rebook a later slot, so the length of any delay to the start of their UK practice may not become apparent for some time. We know that in 2019, 8,709 candidates sat the PLAB 2 exam, while in 2020 the number was 3,654.

To respond to this, we have built a second PLAB 2 assessment centre – doubling the capacity – which opened in June 2021, despite the fact that numerous travelling restrictions were still in place, affecting doctors travelling to the UK. The original GMC assessment centre’s annual capacity for exams has been reduced from 11,000 per year to 7,000 per year by social distancing considerations. But the new testing centre has expanded the capacity beyond the pre-pandemic limit.
The Middle East is now the second-highest source of new IMG doctors after South Asia

Graduates taking up a licence with a primary medical qualification (PMQ) from Middle Eastern countries increased from 303 in 2012 to 2,463 in 2020. At that point the region had overtaken Africa as the second-highest contributor of doctors joining the UK workforce. As was the case for almost all regions, there was a decrease in joiners in 2021 but the Middle East remained the second-largest annual contributor of non-UK graduates to the UK medical workforce, after South Asia (Figure 36).

Figure 36: Doctors taking up (or returning to) a licence to practise, by world region (excluding TER doctors), from 2018–21

<table>
<thead>
<tr>
<th>Region</th>
<th>2018 Number of doctors</th>
<th>% change</th>
<th>2019 Number of doctors</th>
<th>% change</th>
<th>2020 Number of doctors</th>
<th>% change</th>
<th>2021 Number of doctors</th>
</tr>
</thead>
<tbody>
<tr>
<td>United Kingdom (UK)</td>
<td>7,337</td>
<td>+2%</td>
<td>7,511</td>
<td>+93%</td>
<td>14,459</td>
<td>-94%</td>
<td>911</td>
</tr>
<tr>
<td>EEA - Northwestern Europe</td>
<td>601</td>
<td>+3%</td>
<td>622</td>
<td>+10%</td>
<td>687</td>
<td>-32%</td>
<td>467</td>
</tr>
<tr>
<td>EEA - Central Europe, Eastern Europe, Baltic countries</td>
<td>640</td>
<td>+13%</td>
<td>722</td>
<td>-1%</td>
<td>714</td>
<td>+3%</td>
<td>732</td>
</tr>
<tr>
<td>EEA - Southern Europe</td>
<td>722</td>
<td>+6%</td>
<td>764</td>
<td>+13%</td>
<td>867</td>
<td>-3%</td>
<td>845</td>
</tr>
<tr>
<td>Non-EEA Europe</td>
<td>138</td>
<td>+20%</td>
<td>165</td>
<td>+29%</td>
<td>213</td>
<td>-8%</td>
<td>195</td>
</tr>
<tr>
<td>USA and Canada</td>
<td>63</td>
<td>-10%</td>
<td>57</td>
<td>0%</td>
<td>57</td>
<td>-21%</td>
<td>45</td>
</tr>
<tr>
<td>Africa</td>
<td>1,122</td>
<td>+63%</td>
<td>1,832</td>
<td>+27%</td>
<td>2,333</td>
<td>-44%</td>
<td>1,303</td>
</tr>
<tr>
<td>Middle East</td>
<td>770</td>
<td>+75%</td>
<td>1,344</td>
<td>+83%</td>
<td>2,463</td>
<td>-39%</td>
<td>1,510</td>
</tr>
<tr>
<td>South Asia</td>
<td>2,287</td>
<td>+24%</td>
<td>2,832</td>
<td>+47%</td>
<td>4,155</td>
<td>-27%</td>
<td>3,021</td>
</tr>
<tr>
<td>Rest of Asia</td>
<td>276</td>
<td>+55%</td>
<td>429</td>
<td>+44%</td>
<td>618</td>
<td>-7%</td>
<td>577</td>
</tr>
<tr>
<td>Oceania</td>
<td>250</td>
<td>-11%</td>
<td>222</td>
<td>+29%</td>
<td>287</td>
<td>-52%</td>
<td>137</td>
</tr>
<tr>
<td>South, Central and Latin America, and the Caribbean</td>
<td>196</td>
<td>+27%</td>
<td>249</td>
<td>+28%</td>
<td>319</td>
<td>-34%</td>
<td>210</td>
</tr>
<tr>
<td>Total</td>
<td>14,402</td>
<td>+16%</td>
<td>16,749</td>
<td>+62%</td>
<td>27,172</td>
<td>-63%</td>
<td>9,953</td>
</tr>
</tbody>
</table>
The number of doctors joining via the IMG PLAB route has been particularly affected by the pandemic

Most doctors (92%) from Nigeria joined the register via the IMG PLAB route in 2019, which has been affected by the pandemic (see Box 3). The number of doctors joining the register with a Nigerian PMQ decreased by more than a third (38%) in 2020 to 825 (from 1,335 in 2019). Other routes to joining the UK register, such as IMG PGQ† and IMG Sponsorship‡ were not as strongly affected, and the same dramatic decreases in doctors joining were not seen among doctors from countries which primarily use those routes.

EEA graduates are increasingly joining as SAS and LE doctors rather than specialists

Since the introduction of English language testing for EEA doctors in June 2014, the number of graduates joining from EEA countries has reduced, to stabilise at around 2,000. Of these, the proportion who joined the specialist register has also decreased from 33% (2012) to 20% in 2021, with much of this change occurring since 2014.

Over the same period, the proportion of EEA graduates joining as SAS or LE doctors increased from 57% to 76%. Only about 3% to 6% of those who initially joined as SAS or LE went on to join either the GP or specialist registers within two years of joining.

There is evidence that the region of the EEA from which a doctor joins also has an impact on the type of role they will go into. There are almost 6,827 EEA graduates working as SAS and LE doctors in the UK. Of these, 51% (3,504) graduated from six Eastern European countries,† with Romanian graduates being the largest group. All of these countries have more SAS and LE registered doctors than specialists working in the UK, except for Hungary.

By contrast there are 11,006 EEA graduates on the specialist register with 51% (5,563) coming from Southern or Northwestern European countries. This suggests that doctors coming from Eastern Europe are more likely to join the SAS and LE register than the specialist register.

Gradual increase in UK graduates joining the workforce is masked by 2020 action to expedite their registration

A dramatic increase in the number of UK graduates gaining a licence to practise (Figure 36) was the result of our action to accelerate the registration of UK graduate doctors earlier in 2020 than normal, in response to the demands of the pandemic. The net effect of this is neutral, with the average of the 2020 and 2021 numbers totalling 7,685 – which continues the trend increase of UK graduate joiners since 2017.

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* Route where the applicant successfully completed one of GMC-approved postgraduate qualifications (PGQ)
† This route applies to applicants who have been selected for sponsorship under an arrangement approved by the GMC
‡ Romania, Poland, Czech Republic, Bulgaria, Hungary and Slovakia.
Chapter 3: Workforce

Doctors in the UK training pipeline

As reported in chapter 2, trainees’ and medical students’ experiences have been greatly affected by lockdown restrictions. At the same time, there have been calls\(^{13}\) for the number of doctors to be increased, so it is important we share our data on the overall pipeline of UK graduates who are critical to our future workforce.

Medical students intake rises again

From the 2011/12 academic year until 2018/19, the number of medical students in the UK stayed close to 8,000 but there has been growth since then with 9,450 in the 2019/20 cohort and 10,403 in the 2020/21 cohort.\(^{14}\) The most recent cohort has been influenced by the pandemic, which is described in Box 7, and created a very large cohort.

Box 7: The impact of the pandemic on UK medical school places and the future postgraduate pipeline

Applications to UK medical schools have increased significantly during the pandemic.

In the UK, the number of medicine places is regulated by the UK governments. There is a limit on how many students an institution can recruit each year. This cap is set in recognition of the high cost of a medicine degree (which is subsidised by the Government) and to ensure that every medical student has access to safe and appropriate placements and training throughout their studies.

Since 2017, the number of applicants for UK medicine courses has risen each year by around 1,500. However, in 2020, applicants for UK medicine courses for the 2021/22 academic year increased by 21% (4,980) to 28,690.\(^{15}\)

Applications to medical school exceed the availability of places. Because not every student attains the required entry grades for a specific course, universities accept more applications than they have spaces, to make sure their allocation is filled.

Historically, high grades and deferrals have led to an increase in the provision of medical school places.

In 2020, A level exams in England, Northern Ireland and Wales were cancelled because of the pandemic, as were Highers and Advanced Highers in Scotland. Results for that year were based on teacher assessment and, ultimately, many more students achieved higher grades than might have been expected in a normal year. This meant many university courses – including medicine – were oversubscribed.

In response, the UK Government increased the provision of medical school places. The confirmed intake of medical students rose from 9,450 for the 2019/20 cohort to 10,403 for the 2020/21 cohort. Furthermore, 450 potential medical students were told they would be guaranteed a place in the following year’s cohort (2021/22) if they deferred their start date. Clearly, increasing the medical school intake must not be allowed to compromise quality of training, patient safety, or the training pathway.
However, in 2021, A level, Higher and Advanced Higher exams were once again cancelled, with teachers asked to assess individual marks. In response to both the significant increase in applications and historically high grades, the Department for Education announced that extra places at medical schools would again be added, as well as additional funding for higher education institutions across England to fulfil these offers.

Despite this, many medical schools were again oversubscribed. Some offered deferrals, and the Medical Schools Council announced a scheme in which students who held an offer for an oversubscribed medical school, would be offered £10,000 to change their destination university. 16

The UK relies heavily on EEA and IMG graduates to fill vacancies. Given the already-reported disruptions to the non-UK pipelines of doctors joining the profession, the case for relaxing limits on the number of medical students and subsequent foundation placements in the UK, has been strengthened.

Any future increases in medical school places must be appropriately managed to ensure that the quality of undergraduate education remains high. The introduction of larger cohorts will require strategic planning and funding to minimise bottlenecking issues within the postgraduate training pathway.

The larger student cohorts of 2020/21 and 2021/22 will need to be safely accommodated within the Foundation Programme in four to five years’ time and be provided with the right opportunities and experiences.

Larger cohorts must not lead to a reduction in the number of opportunities for trainees to gain practical and clinical experience. They must also not put unsustainable demands on trainers, or lead to any compromise to patient safety.

Another possible effect of larger cohorts may be to increase the competitiveness of the application process for specialty training programmes, which might prompt more trainees to work outside the training pathway for longer, or to step off the pathway altogether.

We will work with partners across undergraduate and postgraduate medical education, and employers, to track the experiences of trainees and consequences of the increased intakes on them.
GP training programmes are especially reliant on IMG doctors

IMGs made up 17% of all trainees in 2021. So, issues affecting the supply of new IMGs into training may lead to a shortfall in specialists in a few years’ time, when training programmes starting in 2020 or 2021 have ended.

This issue is likely to be felt more acutely in certain roles than in others. The proportion of GP trainees who are IMGs is 34% – about double the proportion of all trainees. GP training, and therefore the future capacity of the GP workforce, will be particularly affected by any decrease in IMG doctors joining the register. The specialty programmes with the next-highest proportions of IMGs that could be at risk of a constricted pipeline are medicine (22%) and psychiatry (23%).

The pandemic has not changed the decision of most UK trainees to work temporarily outside the training pathway after F2

Over the last decade, more trainees have chosen to delay choosing specialty training – typically after the completion of F2. Most doctors use this time to gain additional experience, often working in different roles within the UK healthcare systems, rather than taking a break from working in medicine altogether. This trend has continued, increasing by around three percentage points a year, despite the pandemic (Figure 5). Seven out of ten (69%) of 2019/20’s F2s chose to delay their choice of further postgraduate training in 2020/21.

Most trainees who delay choosing specialty training return to the pathway within three years – 89% of the 2016/17 F2 cohort were in core or specialty training by 2020/21 (Figure 37).

Historically, many doctors have also temporarily worked overseas at this point in their careers, although there have understandably been limited opportunities to do so in the last two years because of coronavirus.

More than 1,000 doctors gave us qualitative feedback about what they did during their time away from the training pathway as a part of our 2018 research – ‘Training pathways 2: why do doctors take breaks from their training?’ Of this group of doctors, many gave multiple answers, including:

- around three out of five continued to work in the NHS
- a third worked or volunteered abroad
- a fifth had carried out further study or research.

In the 2021 national training survey (NTS), 62% of F2s said they felt prepared to take on the role of a CT1/ST1, whereas 14% did not. We know that the decision to delay choosing specialty training after F2 is driven by a wide range of ‘push’ and ‘pull’ factors. These include:

- feelings of preparedness
- wellbeing
- uncertainty about specialty choice or career direction
- a desire to develop broader professional, clinical, and soft skills to support a long-term career in medicine.

Although delaying entry into a further training post after F2 is not a new trend, it is important to reiterate that it is now an established feature of the pathway. As such, employers and medical education providers need to recognise the value of temporarily working outside the pathway, both for trainees’ professional and personal development, and to support the wider system.
Workforce planners also need to consider the impact of doctors delaying choosing specialty training after F2 on the supply pipeline, as well as the opportunities and challenges presented by more trainees working as locally employed doctors.

One factor driving this trend to delay choosing specialty training after F2 is the increased competition for certain specialty programmes or locations, so the 2020 and 2021 increases in medical school places (described in Box 4) may further accelerate this trend.
Doctors leaving the UK workforce

**Sharp decrease in doctors leaving during the pandemic**

The proportion of doctors leaving the profession has been on a downward trajectory since 2016 and this proportion dropped further in 2020 with a particularly large drop during the first UK lockdown (Figure 38). The data in Figure 38 illustrate the number of doctors who voluntarily erase from the register (VE) or relinquish their licence (RL). Some of these doctors may only be taking short breaks from clinical practice and may return – however when that is accounted for, the trend is broadly the same.

While it is too early to know whether there will be a return to the longer-term downward trend, the number of doctors leaving in the first six months of 2021 has been returning to 2019 levels.

**Figure 38: Number of doctors leaving, measured via VE/RL, by month from 2018–21**

No. of doctors

![Graph showing numbers of doctors leaving by month from 2018 to 2021.](image-url)
The Barometer survey shows that there has been an increase in the proportion of doctors considering retirement since 2020 (from 7% to 10%), which indicates that some may have been postponing this decision at different stages of the pandemic.

The drop in the number of leavers from 2019 to 2020 was consistent across all age groups, but in 2021 (while the pandemic continued) doctors in each age group resumed a similar pattern of leaving to the one established before the pandemic. Our analysis shows that at this time there remains a group of older doctors who are continuing to delay their retirement. Although this is beneficial to the workforce for now, it presents a risk for the future as we are uncertain as to when these doctors will decide to leave.

**Figure 39: Doctors successfully applying to join the register, by route to registration (excluding TER doctors), from 2013 to 2021 using mid-year snapshots of preceding 12 months**

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>UK</td>
<td>6,788</td>
<td>8,416</td>
<td>7,617</td>
<td>8,452</td>
<td>6,728</td>
<td>8,245</td>
<td>7,535</td>
<td>10,887</td>
<td>2,819</td>
</tr>
<tr>
<td>EEA</td>
<td>3,428</td>
<td>3,748</td>
<td>3,231</td>
<td>2,488</td>
<td>2,433</td>
<td>2,266</td>
<td>2,634</td>
<td>2,950</td>
<td>2,305</td>
</tr>
<tr>
<td>IMG PGQ</td>
<td>425</td>
<td>473</td>
<td>555</td>
<td>698</td>
<td>912</td>
<td>1,313</td>
<td>2,174</td>
<td>3,251</td>
<td>2,212</td>
</tr>
<tr>
<td>IMG PLAB</td>
<td>1,293</td>
<td>1,230</td>
<td>1,209</td>
<td>1,578</td>
<td>1,738</td>
<td>2,676</td>
<td>3,680</td>
<td>5,574</td>
<td>3,154</td>
</tr>
<tr>
<td>IMG Sponsorship</td>
<td>287</td>
<td>403</td>
<td>503</td>
<td>604</td>
<td>757</td>
<td>941</td>
<td>1,046</td>
<td>1,363</td>
<td>1,034</td>
</tr>
</tbody>
</table>

* Please note that this is a measure of the number of doctors applying through each route from June to June each year and so will not match to the numbers of licensed doctors on each 30 June shown earlier in this chapter.
Doctors joining by UK or IMG PLAB routes tend to stay in UK practice longer

Figure 40 shows the proportion of doctors from the five main routes described in Figure 40 who stayed for at least six years after joining. The IMG sponsorship route is associated with doctors on fixed, short-term contracts, so it is unsurprising that this group had the smallest proportion still licensed, six years after joining. Doctors joining through IMG PGQ and EEA routes also tended to stay for a shorter period than UK and IMG PLAB doctors – most for between one and three years.

It is important to recognise the vital importance that these doctors might have for the UK healthcare system in filling gaps swiftly in response to shifts in demand. These numbers help everyone in the system to understand better how long we might expect a doctor to stay given their route, and to factor that into workforce planning projections. It may also help identify groups of doctors not staying as long as we would hope, helping to shape initiatives for improving retention.

<table>
<thead>
<tr>
<th>Route to registration</th>
<th>Year joining the register and staying for 6 or more years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2012</td>
</tr>
<tr>
<td>UK</td>
<td>90%</td>
</tr>
<tr>
<td>EEA</td>
<td>44%</td>
</tr>
<tr>
<td>IMG PGQ</td>
<td>44%</td>
</tr>
<tr>
<td>IMG PLAB</td>
<td>81%</td>
</tr>
<tr>
<td>IMG sponsorship</td>
<td>28%</td>
</tr>
</tbody>
</table>
**Doctors' future career intentions**

In 2021 the proportion of doctors intending to make any career change remained almost unchanged (58% compared with 57% in 2020). The contrast with the 71% recorded in 2019 suggests that a significant number of doctors have put plans to change on hold or have so far postponed instigating such changes during the pandemic. Figure 41 describes the range of career changes doctors had said they were planning to make.

Doctors were still being less likely than in 2019 to make career choices that reduced their time spent on clinical activities (such as leaving the profession, taking a career break, or reducing their contracted hours), and fewer were planning to leave the profession completely. However, doctors were also less likely to plan to increase their hours.

---

**Figure 41: Doctor's future intentions, from 2019 to 2021**

<table>
<thead>
<tr>
<th>Planned parental or caring leave</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>10%</td>
<td>8%</td>
<td>8%</td>
</tr>
</tbody>
</table>

**Move to private practice or increase proportion of time spent working privately**

<table>
<thead>
<tr>
<th></th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>19%</td>
<td>13%</td>
<td>13%</td>
</tr>
</tbody>
</table>

**Move to a role with less clinical workload**

<table>
<thead>
<tr>
<th></th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>19%</td>
<td>29%</td>
<td>24%</td>
</tr>
</tbody>
</table>

**Move to practising abroad**

<table>
<thead>
<tr>
<th></th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>12%</td>
<td>13%</td>
<td>13%</td>
</tr>
</tbody>
</table>

**Switch to locum work**

<table>
<thead>
<tr>
<th></th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>11%</td>
<td>13%</td>
<td>13%</td>
</tr>
</tbody>
</table>

**Reduce contract hours**

<table>
<thead>
<tr>
<th></th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>31%</td>
<td>35%</td>
<td>41%</td>
</tr>
</tbody>
</table>

---

*Doctors could provide multiple answers, and so can be counted in more than one row, totals do not add up to 100% therefore.

\[\text{NET likely = 'fairly likely' or 'very likely'}\]

n = 3,876 (all doctors), the Barometer survey 2019, Q81. n = 3,693 (all doctors), the Barometer survey 2020, Q81. n = 3,386 (all doctors), the Barometer survey 2021, Q81. Values do not add up to 100% as doctors could choose multiple options
The complex circumstances of the pandemic are certainly affecting doctors’ decisions and plans, but we do not know the extent to which doctors’ stated intentions will translate into action. As part of the 2021 Barometer survey, we asked doctors what steps they had taken towards leaving the profession, in cases where they were planning to leave for reasons other than retirement. This showed an increase in the proportion of doctors that have taken hard steps towards leaving.

Figure 42: Steps taken by doctors who reported they were likely to leave the profession (excluding retiring), 2021

For doctors who said they were likely to leave the UK medical profession in the next year. What steps, if any, have you taken towards leaving the UK medical profession?

<table>
<thead>
<tr>
<th>Step</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discussed it with others</td>
<td>55%</td>
</tr>
<tr>
<td>Researched alternative career paths</td>
<td>46%</td>
</tr>
<tr>
<td>Contacted a recruiter</td>
<td>22%</td>
</tr>
<tr>
<td>Applied for, or attended training to prepare for, a new role</td>
<td>16%</td>
</tr>
<tr>
<td>Applied for other role(s) outside of medicine</td>
<td>8%</td>
</tr>
<tr>
<td>I have not taken any steps so far</td>
<td>21%</td>
</tr>
</tbody>
</table>

36% any ‘hard’ steps taken to leave the profession = 7% of all doctors

n = 690 (doctors likely to leave UK medical profession, excluding retirement), the Barometer survey 2021, QB3
Values do not add up to 100% as doctors could choose multiple options

More doctors taking hard steps to leave since 2020 across all register types

Overall, the proportion of doctors taking hard steps to leave the profession has increased from 4% in 2020 to 7% in 2021. Hard steps include contacting a recruiter, applying for (or attending training to prepare for) a new role, or applying for another role outside medicine.

These steps, where taken, did not significantly vary by register type, except that specialists were more likely to have contacted a recruiter (28%). GPs, SAS and LE doctors, specialists and doctors in training gave broadly similar answers.
Wellbeing concerns and a wish to have more non-working time is behind many intended career changes to leave the profession, permanently or temporarily.

In order to improve retention it is important to understand the reasons why doctors decide to leave the UK profession. Figure 43 shows the top two reasons identified by doctors behind their most likely career change in the coming year. Each marks a move away from clinical practice in the UK and it is concerning that the adverse impacts of doctors’ roles on their wellbeing features so prominently, as does the potential for better treatment in future for those looking to move abroad.

**Figure 43: The top two reasons for doctors’ most likely career change in the coming year**

<table>
<thead>
<tr>
<th>Reasons why making career change</th>
<th>Retire and leave the medical profession</th>
<th>Reduce contracted hours</th>
<th>Leave the medical profession*</th>
<th>Take a career break</th>
<th>Move to practise abroad</th>
</tr>
</thead>
<tbody>
<tr>
<td>The demands of my current role(s) are adversely impacting my wellbeing</td>
<td>65% [n = 117]</td>
<td>68% [n = 552]</td>
<td>79% [n = 60]</td>
<td>75% [n = 67]</td>
<td>71% [n = 179]</td>
</tr>
<tr>
<td>I want to have more non-working time (e.g. with my family, leisure time)</td>
<td>50% [n = 117]</td>
<td>70% [n = 552]</td>
<td>73% [n = 67]</td>
<td></td>
<td>53% [n = 179]</td>
</tr>
</tbody>
</table>

* for a reason other than retirement

n provided in table for each career change doctors selected as their most likely in the year ahead, the Barometer survey 2021, QB2. Values do not add up to 100% as doctors could choose multiple options.
Conclusion

The coronavirus pandemic has affected the number of doctors joining the UK medical workforce from abroad, with a sharp reduction in IMG joiners being seen over the last year and certain countries affected more than others. However, the total number of IMGs grew by 6%, suggesting that there was a more sizable reduction in the numbers of IMGs leaving. This appears to show that although there have not been workforce shortages during the pandemic, our workforce has been reliant in recent years on a sizeable influx of overseas doctors. So we will continue to monitor closely the situation as the pandemic evolves.

It is still too early to tell what the medium- and long-term effects of the coronavirus pandemic and Brexit will be. It is reasonable to speculate that the number of doctors joining from non-EEA countries may begin to return to previous levels where travel restrictions were a major factor influencing their joining. However, we know that decisions to move countries are driven by complex factors. We have recently published an initial report on the factors influencing migration and are embarking on a programme of research to examine this in more detail.

The overall rate of leaving did decrease during lockdown, but may now be increasing again. Based on doctors’ career intentions and the proportion taking hard steps towards leaving, this may lead to an increase to past rates, or even to higher ones, in the near future. Retaining doctors will continue to be a critical part of sustaining the workforce needed to deliver safe and effective care, and the findings presented in this chapter should highlight this issue. Specifically, we found that certain workplace pressures from previous years are returning and that some of the short-lived effects of the pandemic that improved retention are now subsiding. This is concerning as it is clear that the adverse effects of doctors’ roles on their wellbeing is by far the most common reason behind decisions to leave the UK profession before retirement.

* We explored this further through the lens of doctors’ workplace experiences, wellbeing, and role satisfaction in chapter 1.
Building towards a positive future
Summary

- Throughout the pandemic a range of innovative new approaches and adaptations has been implemented. Evaluating and learning from these will be vital in ensuring that best practice approaches are identified and retained.

- Ensuring that all healthcare settings are compassionate, inclusive, and focused on supporting workforce wellbeing will continue to play a vital role in ensuring patient safety.

- Multidisciplinary team working has been a vital element of effective working practices during the pandemic and needs to be retained as the healthcare system resets.

- We need to learn from the flexible and adaptable approaches to delivering patient care that have been accelerated during the pandemic, such as using remote consultations, triaging cases to the most appropriate healthcare professional, and sharing knowledge between professionals.

- Visible and accessible leadership will help to underline the lessons of effective multidisciplinary team working and visible leadership learned during the pandemic, and to integrate and make best use of other healthcare professionals in delivering care.
The opportunity to retain positive changes is now

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

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

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

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

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

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

See Box 8 for our evidence about these interrelationships.

* See chapter 1 for more detail.
Box 8: Our data on the relationships between risk of burnout, patient safety and working environments

Doctor satisfaction:

- High workloads/long hours were the most frequent reason given for feeling dissatisfied (33%).
- Doctors at a high risk of burnout were most likely to report being dissatisfied (68%) compared with those with a very low risk of burnout (4%), and more likely to feel unable to cope with their workload at least weekly (44% vs 12%).

Patient care and patient safety:

- 29% of doctors reported seeing patient safety or care compromised while being treated by a doctor over the past year. This was higher for doctors with a high risk of burnout (49%), those who felt unable to cope at least weekly (45%), and for those who were dissatisfied (48%).
- Pressure on workloads and delays to patient care were cited by doctors as barriers to good safe patient care (by 69% and 54% of doctors respectively), and as contributing factors to patient care/safety compromises (by 65% and 54% of doctors respectively).
- Doctors who said that the pandemic had a negative impact on patient care were more likely to report being dissatisfied (45%) than those who said the pandemic had a positive effect on patient care (8%).
Intention to leave the profession, and taking hard steps towards leaving:

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

7% of doctors have taken hard steps towards leaving.

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

Working environments, leadership, and management:

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

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

40% of doctors with a high risk of burnout were more likely to disagree that clinical leaders were readily available (40%) and that their organisation encourages a culture of teamwork (32%) compared to doctors with a very low risk of burnout (9% and 6% respectively).
Many of the positives achieved during the first year of the pandemic have been retained and even improved upon, such as the sharing of knowledge and experiences across the medical profession – 60% of doctors in 2021 saw an improvement in knowledge sharing, compared with 54% in 2020. Doctors also feel access to developmental or learning opportunities have improved (30% in 2021 compared with 25% in 2020).6

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

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

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

**Figure 44: Changes to doctors’ experiences between 2019 and 2021**

<table>
<thead>
<tr>
<th></th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of doctors who took time off work due to stress</td>
<td>12%</td>
<td>14%</td>
<td>17%</td>
</tr>
<tr>
<td>Proportion of doctors struggling to provide a sufficient level of patient care weekly</td>
<td>34%</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Proportion of doctors who were satisfied or very satisfied in their day to day work</td>
<td>32%</td>
<td>42%</td>
<td>43%</td>
</tr>
<tr>
<td>Proportion of doctors at high risk of burnout</td>
<td>10%</td>
<td>16%</td>
<td>17%</td>
</tr>
<tr>
<td>Proportion of doctors who found their work frustrating</td>
<td>34%</td>
<td>22%</td>
<td>32%</td>
</tr>
</tbody>
</table>

Values do not add up to 100% as not all response options are included.
Compassionate cultures help retain the positive changes made during the pandemic

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

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

Compassionate and visible support from leadership has strengthened supportive workplace cultures

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

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

The pandemic has taught me that visible leadership is so important. Wellbeing posters and screen savers aren’t the same as putting your hand on someone’s shoulder and asking if they’re alright. It’s as important as having counselling facilities.”

Changes to Working Practices, NHS Hospital Manager

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

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

Our research published in 2019 found patterns of ‘insider’ and ‘outsider’ groups of doctors within the UK workforce. Being in an outsider group has negative consequences for doctors, including a lack of supportive induction into new workplaces, not receiving timely feedback on performance, and exclusion from informal social support networks. However, the early stages of the coronavirus pandemic created a sense that ‘we’re all in this together’ which could be consistent with a reduction in the outsider status of some doctors. Many doctors reported positive changes in team working during the pandemic, and feeling supported by immediate colleagues and senior medical staff. This was broadly consistent with data from 2020 and 2021.
We have been repeatedly clear\(^6,\,23,\,24\) that inclusive workplaces can help reduce patient harm by ensuring doctors receive the support and constructive feedback they need to do their job effectively. When this is lacking, it can lead to a gradual decrease in performance and eventually to breaches of professional standards that require us (the GMC) to take action.\(^1\)

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

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

Supporting workloads and efficient ways of working

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

Helping medical practice become more efficient using interdisciplinary team working

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

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

Newer types of team members in primary care are likely to grow in number in the future. These include care coordinators, who ensure patients gain access to the support they need and who sort out missing referrals. There are also social prescribers, who look at the social determinants of health (such as housing, finances and food poverty) and provide a patient with clear, tangible plans to address their problems. Indirect patient care and administration account for more than a quarter of the GP workload.\(^25\)
To enhance understanding among doctors about the MAP roles, the Care Quality Commission (CQC) has issued a ‘myth buster’ about the responsibilities of physician associates in primary care, to clear up common misconceptions about the responsibilities and accountabilities of those who employ these professionals. As this professional group of MAPs grows, national bodies and workforce planners need to consider how best to deploy MAPs if we are going to make the most of this role being brought into regulation and expanded. Additionally, employers will need to be clear about the responsibilities of MAPs and what is expected of them.

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

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

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

“I have a work laptop connected to VPN, I have got so much done.”

Case Study, specialist doctor

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

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

* See chapter 1 for more detail.
and management. It will be important to evaluate what mix of home-based and on-site working offers the best outcomes. For example, it may be sensible to allow some administrative work to be done from home, while physical examinations may be better done face to face.

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

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

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

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

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

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

**Innovative programmes require clear support and guidance**

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

However, some aspects of these innovative systems can be demanding, such as the requirement to respond within 48 hours to eConsult requests. Providing such easy access, relative to other routes, may prevent GPs from organising their time as effectively, and may dissuade patients from appropriate self-management of minor ailments. There is also a risk that marginalised groups – particularly some elderly, people with learning difficulties,
non-English speakers, and those without Wi-Fi or smartphones – may be excluded from this type of service.

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

“I love the job of being a GP but am frustrated and tired due to the ‘never full’ aspect of primary care. We simply cannot meet patient expectations or demand any more. We have been deluged with eConsults as an additional lane of work entering the practice.”

*2001 Barometer survey, open text response, GP*

**Innovative approaches to service delivery are improving patient care**

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

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

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

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

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

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

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

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

We can do this by:

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

The coronavirus pandemic has presented significant challenges to workloads, with the risk of burnout growing alongside treatment backlogs. However, improvements to interdisciplinary and multidisciplinary teamwork have helped mitigate some of these difficult circumstances. Inclusive workplaces are part of the solution and can help break down the insider/outsider dynamics in the workforce that cause disparities in support for some doctors. The ultimate aim is for doctors to receive the workplace support they need to achieve high professional standards and deliver good patient care. This is further addressed by our ‘Fair to refer?’ research which made a clear recommendation that senior leaders engage more regularly with staff to listen and take action, in particular to better support some ‘out groups’ of doctors such as those in ethnic minority groups.
Doctors’ satisfaction and ensuring a sustainable workforce are linked with positive working environments that foster a compassionate and constructive working culture. These goals are best managed through visible and compassionate leadership which works to ensure that all positive culture changes observed are permanently incorporated into the working environment.

Lessons can be learned from the rapid evolutions and adaptations of doctors’ working practices over the course of the coronavirus pandemic, but manageable workloads remain a key factor in providing good and safe patient care. New ways of working – such as delivering remote care, working from home, and virtual training and meetings – have acted as catalysts for welcome improvements in doctor wellbeing and efficiency. Clear support and guidance from the health system is needed to ensure that these positive aspects become permanent features.
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AoMRC</td>
<td>Academy of Medical Royal Colleges</td>
</tr>
<tr>
<td>ARCP</td>
<td>Annual review of competency progression</td>
</tr>
<tr>
<td>BMA</td>
<td>British Medical Association</td>
</tr>
<tr>
<td>BME</td>
<td>Black and minority ethnic</td>
</tr>
<tr>
<td>CCG</td>
<td>Clinical commissioning group</td>
</tr>
<tr>
<td>CT (1-3)</td>
<td>Core training (years one to three)</td>
</tr>
<tr>
<td>CCT</td>
<td>Certificate of completion of training</td>
</tr>
<tr>
<td>CPD</td>
<td>Continuing professional development</td>
</tr>
<tr>
<td>CQC</td>
<td>Care Quality Commission</td>
</tr>
<tr>
<td>CSA</td>
<td>Clinical Skills Assessment</td>
</tr>
<tr>
<td>DHSC</td>
<td>Department of Health and Social Care</td>
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<td>European Economic Area</td>
</tr>
<tr>
<td>FiY1</td>
<td>Foundation interim Year 1</td>
</tr>
<tr>
<td>F1</td>
<td>Foundation year 1</td>
</tr>
<tr>
<td>F2</td>
<td>Foundation year 2</td>
</tr>
<tr>
<td>GMC</td>
<td>General Medical Council</td>
</tr>
<tr>
<td>HEE</td>
<td>Health Education England</td>
</tr>
<tr>
<td>HEIW</td>
<td>Health Education and Improvement Wales</td>
</tr>
<tr>
<td>IA</td>
<td>Integration Authority</td>
</tr>
<tr>
<td>IMG</td>
<td>International medical graduate</td>
</tr>
<tr>
<td>LE</td>
<td>Locally employed doctors</td>
</tr>
<tr>
<td>LTP</td>
<td>Long Term Plan (NHS England)</td>
</tr>
<tr>
<td>LTFT</td>
<td>Less than full time</td>
</tr>
<tr>
<td>MSC</td>
<td>Medical Schools Council</td>
</tr>
<tr>
<td>NES</td>
<td>NHS Education for Scotland</td>
</tr>
<tr>
<td>NTS</td>
<td>National training survey</td>
</tr>
<tr>
<td>PLAB</td>
<td>Professional and Linguistic Assessments Board</td>
</tr>
<tr>
<td>PMQ</td>
<td>Primary medical qualification</td>
</tr>
<tr>
<td>PPE</td>
<td>Personal protective equipment</td>
</tr>
<tr>
<td>RCGP</td>
<td>Royal College of General Practitioners</td>
</tr>
<tr>
<td>SAS</td>
<td>Staff grade, specialty and associate specialist doctors</td>
</tr>
<tr>
<td>ScotGEM</td>
<td>Scottish Graduate Entry to Medicine</td>
</tr>
<tr>
<td>ST (1-8)</td>
<td>Specialty training (years one to eight)</td>
</tr>
<tr>
<td>TER</td>
<td>Temporary emergency register</td>
</tr>
<tr>
<td>UKMED</td>
<td>UK medical education database</td>
</tr>
<tr>
<td>VLE</td>
<td>Virtual learning environment</td>
</tr>
</tbody>
</table>
A note on research and data

Much of the analyses 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

In 2021 we commissioned ‘the Barometer survey 2021’, an independently delivered research project exploring the experiences of doctors in the UK, and research on changes to doctors’ working practices. The research methods of these projects are outlined below.

The state of medical education and practice barometer survey 2020

This research was carried out by IFF Research. The Barometer survey was first conducted in 2019 and was designed to both build on previous work and provide a baseline for annual tracking of doctors’ experiences in the workplace, adaptations they are making to cope with pressure, and their career intentions. Some changes were made last year, in the Barometer 2020, to refine some questions and to ask doctors about their experiences in relation to the coronavirus (COVID-19) pandemic.

The Barometer 2021 survey built on some of the changes made in 2020, but while the Barometer 2020 asked some key indicator questions concerning the period from the start of 2020, the Barometer 2021 reverted to asking doctors about the past year. Comparisons between results from different years have the caveat that the periods of time to which they relate may differ for 2020.

The Barometer 2021 retained some questions about doctors’ experiences during the COVID-19 pandemic, with the added inclusion of patient care, doctor-patient relationship, and cooperation between different parts of the healthcare system. Remote care was broken out into separate questions to facilitate more detailed understanding of how much care doctors provided remotely, how this compares with before the pandemic, and how often doctors had to provide remote care when they felt face to face care would have been more suitable.

In addition, a question was added to the Barometer 2021 asking doctors what they consider to be the main barriers to providing patient care over the last year. This more general question was additional to questions on whether doctors experienced a situation in which patient safety or care was compromised, and contributing factors in the last such specific case, which were also asked.

Barometer sample and respondents

The sample of doctors questioned in the Barometer 2021 survey was selected to reflect, as far as possible, the characteristics of the UK’s overall population of doctors. The research includes representative coverage of the four nations of the UK.
Over June and July 2021, a total of 3,386 doctors currently working in the UK were surveyed via an online survey. The results were weighted against GMC population data on the basis of age, registration status, ethnicity and place in which primary medical qualification was gained. Engaging doctors was challenging, and measures were taken to increase responses from doctors in training and SAS/LE doctors.

The tables below give a breakdown of the 3,386 respondents (i.e. actual unweighted numbers) by various characteristics. The totals for most tables are less than the overall number of respondents (3,386) because not all respondents provided information for the relevant question (including answering ‘don’t know’ or ‘prefer not to say’). The total for registration type is greater than the overall number of respondents (3,403 compared with 3,386) because some doctors are on more than one register.

### Registration type

<table>
<thead>
<tr>
<th></th>
<th>GP</th>
<th>Specialist</th>
<th>Training</th>
<th>SAS/Non-training</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>895</td>
<td>1,759</td>
<td>337</td>
<td>366</td>
<td>46</td>
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</tbody>
</table>

### Primary medical qualification

<table>
<thead>
<tr>
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<th>UK</th>
<th>EEA</th>
<th>Outside UK/EEA</th>
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<tbody>
<tr>
<td></td>
<td>2,426</td>
<td>257</td>
<td>650</td>
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### Nation

<table>
<thead>
<tr>
<th></th>
<th>England</th>
<th>Northern Ireland</th>
<th>Scotland</th>
<th>Wales</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2,759</td>
<td>60</td>
<td>330</td>
<td>143</td>
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</table>

### Ethnicity

<table>
<thead>
<tr>
<th></th>
<th>White</th>
<th>BME (all)</th>
<th>Asian/Asian British</th>
<th>Black/Black British</th>
<th>Mixed or multiple ethnic groups</th>
<th>Other ethnic group</th>
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<tbody>
<tr>
<td></td>
<td>2,292</td>
<td>887</td>
<td>613</td>
<td>97</td>
<td>91</td>
<td>86</td>
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</table>

### Gender

<table>
<thead>
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<th></th>
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<th>Female</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>1,716</td>
<td>1,535</td>
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### Disability

<table>
<thead>
<tr>
<th></th>
<th>Disabled</th>
<th>Non-disabled</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>280</td>
<td>2,990</td>
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</table>

### Age

<table>
<thead>
<tr>
<th></th>
<th>Under 30 years old</th>
<th>30–34</th>
<th>35–39</th>
<th>40–44</th>
<th>45–49</th>
<th>50–59</th>
<th>60 years and over</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>209</td>
<td>209</td>
<td>226</td>
<td>341</td>
<td>487</td>
<td>1,214</td>
<td>438</td>
</tr>
</tbody>
</table>
Indicators of burnout in the Barometer survey 2021

Burnout is a state of emotional, mental and often physical exhaustion caused by prolonged or repeated work-related stress. Feeling depressed and lacking motivation are characteristics of burnout. The Barometer survey 2021 included seven questions from the Copenhagen Burnout Inventory,¹ an internationally recognised and validated tool for assessing the physical and psychological fatigue associated with burnout.

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

1. Is your work emotionally exhausting?
2. Do you feel burnt out because of your work?
3. Does your work frustrate you?

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

4. Do you feel worn out at the end of the day?
5. Are you exhausted in the morning at the thought of another day at work?
6. Do you feel that every working hour is tiring for you?
7. Do you have enough energy for family and friends during leisure time?

Differing risk levels for burnout were suggested by the number of indicators to which participants gave a ‘negative’ score, where a negative score was:

- for questions one to six, answering a question with experienced to a ‘high’ or ‘very high’ degree, or experienced ‘often’ or ‘always’
- for question seven (energy for family and friends), answering experienced ‘seldom’ or ‘never’.

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

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

Workload intensity

The Barometer 2021 included new questions about the intensity of the workload of doctors. Doctors were asked to estimate the percentage of working days, over the last year, on which the intensity of their workload was high, moderate, and low. In addition, as part of asking about their experiences, doctors were asked how often they found it difficult to take breaks due to workload intensity.

Working arrangements

Prior to 2020, participants were asked how many hours they were contracted to work each week, and this was used to estimate the proportions working full time and less than full time, based on assumptions about their full-time hours.

However, the complexity of doctors’ contracts and working hours means it is difficult to define how many doctors are working less than full time. The assumed full-time hours were approximate and not reflective of the contracts of all doctors.

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In line with the Barometer 2020, the Barometer 2021 asked doctors to select the best description of their current working arrangement from a list that included the following options:

- permanent – full-time
- permanent – part-time
- fixed or temporary – full-time
- fixed or temporary – part-time
- some other working arrangement.

Open responses

The Barometer included questions which offered participants the opportunity to make an unprompted, free text response.

For example:

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

The free text responses by all participants have been analysed and coded for key themes. Counting the occurrence of these themes forms the basis for the quantification presented in this report. The number of subjects covered in participants’ free text responses may be fewer than would result from a similar question giving a selection of subjects to choose from, but overall a wide range of subjects is gathered, which may include themes that would not have been included in a closed selection of responses.

NET values

‘NET’ values are used when responses have been grouped to give an overall figure. For example, the values of responses ‘somewhat satisfied’ (27%), ‘satisfied’ (35%), and ‘very satisfied’ (8%) together produce ‘NET satisfied’ (70%) while ‘satisfied’ and ‘very satisfied’ are combined to produce ‘NET most satisfied’ (43%).

Asking about support

Support has emerged as a key theme in recent years, and accordingly the Barometer survey includes questions to enable exploration of the relationships between support from different colleagues and other workplace experiences.

Based on doctors’ discussions of feeling unsupported in previous research, the Barometer 2019 asked about support using the following phrasing:

*How frequently, if at all, over the last year have you experienced the following? Felt unsupported by my immediate colleagues/senior medical staff/non-clinical management*

However, responses to questions using this phrasing did not enable determination of doctors feeling supported. This made discussion of the results difficult, with use of double negatives such as ‘never feeling unsupported’ being necessary.

To address this, the Barometer 2020 and the Barometer 2021 asked about support using the following phrasing:

*To what extent do you agree with the following statements? I am supported by my immediate colleagues/senior medical staff/non-clinical management*

This means that direct comparison with responses to the support questions prior to 2020 is not possible.
Changes to doctors' working practices research

This GMC commissioned Trajectory Partnership to undertake qualitative research exploring the implications of changes to doctors' working practices that are emerging following the COVID-19 pandemic. Acumen Fieldwork supported recruitment of participants.

The first stage of the research was a rapid review of external and internal materials exploring changes to doctors' practices over the pandemic. The primary research involved eight focus groups with frontline doctors followed by a further 19 depth interviews with clinical and non-clinical managers.

The eight focus groups comprised two with GPs, two with secondary care specialists, two with doctors in training, and two with SAS/LE doctors. Each group contained four to six doctors. The 19 depth interviews included six primary care clinical leads, five secondary care clinical leads, two GP practice managers, four NHS hospital managers, and two private services managers. The focus groups and interviews were carried out in August and September 2021.

The 'state of medical education and practice in the UK' case studies

One-on-one interviews were conducted by an independent author with seven doctors to learn about their experiences of practising over the past year and their thoughts on what medicine and healthcare is emerging into. The case studies based on these interviews reflected the diversity of experiences among the medical workforce in 2021. However, as the number of doctors interviewed was small the case studies have not been given undue weight and have not been used to make inferences about the overall UK doctor population. Rather, the Barometer 2021 survey enabled analysis of the overall workforce, and the case studies were used to illustrate and add insight to the Barometer findings.

The seven doctors were interviewed in July and August 2021. These doctors were found using GMC network contacts with participants opting in to participate in the case studies. It is acknowledged that this process did not have the rigour of a research project, such as the Barometer survey, but an effort was made to find doctors that represented variety across a range of different factors, such as register type, specialty, the nation of the UK in which they practice, and personal attributes such as age and ethnicity.

* 24 participants had not yet graduated when they signed up; they probably did not do an FiY1 post, but this cannot necessarily be assumed. Two respondents to the August 2020 questionnaire did not respond to this question.
GMC surveys

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

The national training surveys

Every year, the GMC surveys doctors in training to get their views on their training and the environments where they work. The survey also asks trainers to report their experience from their perspective as a clinical and/or educational supervisor. These findings have been included in previous editions of ‘The state of medical education and practice in the UK’.

The national training survey ran from 20 April to 25 May 2021 after an extension from the original 18 May end date. This was slightly later and shorter than the usual March to April survey window of previous years. After running a bespoke national training survey in 2020 looking at how doctors were initially affected by the pandemic, this year it returned to its full length and standard question set.

However, having identified several challenges in the 2020 survey – such as reduced opportunities for trainees to gain necessary skills and experiences – we also introduced a series of specific questions for trainees this year which focus on training recovery. These covered:

- meeting curriculum outcomes
- decisions about the Annual Review of Competence Progression (ARCP) outcome
- training catch-up
- alternative opportunities to learn/train eg simulation activities
- workplace-based assessments
- access to and preparedness to sit exams.

Over 63,000 doctors in training and trainers completed this year’s survey. 76% of all trainees in the UK responded (over 46,000), and 32% of all trainers (over 16,000). These response rates are much higher than in 2020 (47% and 22%), but lower than the usual response rates, e.g. 95% and 45% in 2019. Despite this, we are confident that the number of responses gives us a representative sample of the trainee and trainer population. And, unlike 2020, we can provide detailed information about individual sites via our reporting tool, where at least three doctors have responded, to protect anonymity.

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

Our data

Every year, the GMC surveys doctors in training

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. Percentages in all tables are rounded and may not add up to 100%.

Data for the analysis of the profession in 2021 refer to the medical register (known as the List of Registered Medical Practitioners), the GP Register
A note on research and data

and the Specialist Register on 30 June 2021. Data for the analysis of the change between 2012 and 2021 refer to the state of the registers on 30 June of each year between 2012 and 2021. Where data for fitness to practise activity are aggregated over 2012–20, the number of doctors is 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 and the Specialist Register are excluded unless stated otherwise.

FiY1 doctors

In 2020, 6,868 UK graduates were awarded provisional registration, and 4,662 FiY1 posts were filled between April and July 2020. Although in 2020 those doctors were excluded from tables of all registered doctors and reported separately, this year their counts were added to 2020 counts.

Temporary registration

Data for doctors on the temporary register (doctors re-registered to help with the coronavirus pandemic) refer to the medical register on 30 June 2020 and 30 June 2021 and therefore don’t include any doctors who decided to opt out before 30 June 2020, and do include any doctors who subsequently opted out after 30 June 2021. Numbers of TER are reported in separate tables added to the national and regional tables reporting on number of doctors on the medical register.

Fitness to practise data

Fitness to practise data for 2012–20 was for enquiries either received or closed between 1 January 2012 and 31 December 2020. The data were drawn from the GMC’s database on 27 May 2021. 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. 69% of complaints that originated in 2020 and were investigated did not yet have an outcome (714 complaints) when the data were drawn from the GMC database.

Data on doctors in training

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 ahead of the 2021 national training surveys – it was accurate on 20 April 2021.

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 – 162 doctors were in this group in 2021.
A note on research and data

Data relating to the age of a doctor

A small group of doctors on the register have no date of birth recorded (1.6% in 2012 and 0.7% in 2021). In these cases, we subtract 24 years from the full date that they passed their primary medical qualification (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 8.8% of licensed doctors on the register in 2021.

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, doctors are considered:

- **British nationality** if at least one of their nationalities is British, or derives from a country that qualifies them for British citizenship.

- **EEA nationality** if they are not British and 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.

- **Non-EEA nationality** if all their nationalities are from countries outside the EEA.

In 2021 we had no nationality information for about 51,481 doctors (18.7% of all licensed doctors).

Regional and country data

Doctors were located using the Agora location algorithm. We first look into NHS contracts data (Electronic Staff Record (ESR), Primary Care Information Service (PCIS), Scottish Workforce Information Standard System (SWISS) and GPREF databases) and first prioritise full-time contracts, followed by permanent part-time contracts, and then other part-time contracts.

If a doctor doesn’t appear in any of the sources above but is in training, we use the location of their training as defined in the NTS for that year.

For those without an NHS contract record who are not in training, we then use the location of their designated body. However, certain types of designated body are not reliable for determining location (such as a locum agency) and so some doctors can only be located by the address a doctor has provided us for registration.

It is important to note that all doctors in Northern Ireland are located using only training data and registered address. Also, there are no NHS contracts data available for GPs in Wales.

The regions of England are grouped according to regions defined by the Office for National Statistics.

Sustainability and transformation partnerships in England are grouped according to NHS England structure, regional Healthcare Boards in Scotland follow the structure of NHS Scotland, Local Health Boards in Wales follow the structure of NHS Wales, and Health and Social Care Boards in
Northern Ireland are grouped according to HSC Northern Ireland structure.

Countries are grouped into regions on the following basis:


**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, Cyprus, Greece, Italy, Malta, Portugal, Slovenia and Spain.

**Non-EEA Europe**: Albania, Belarus, Bosnia and Herzegovina, Kosovo, Moldova, Montenegro, North Macedonia, 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, Aruba, 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, St. Vincent and The Grenadines, Suriname, Trinidad and Tobago, Uruguay and Venezuela.

**Oceania**: Australia, Cook Islands, Fiji, New Zealand and Papua New Guinea.
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