Caring for doctors Caring for patients

How to transform UK healthcare environments to support doctors and medical students to care for patients

Professor Michael West and Dame Denise Coia

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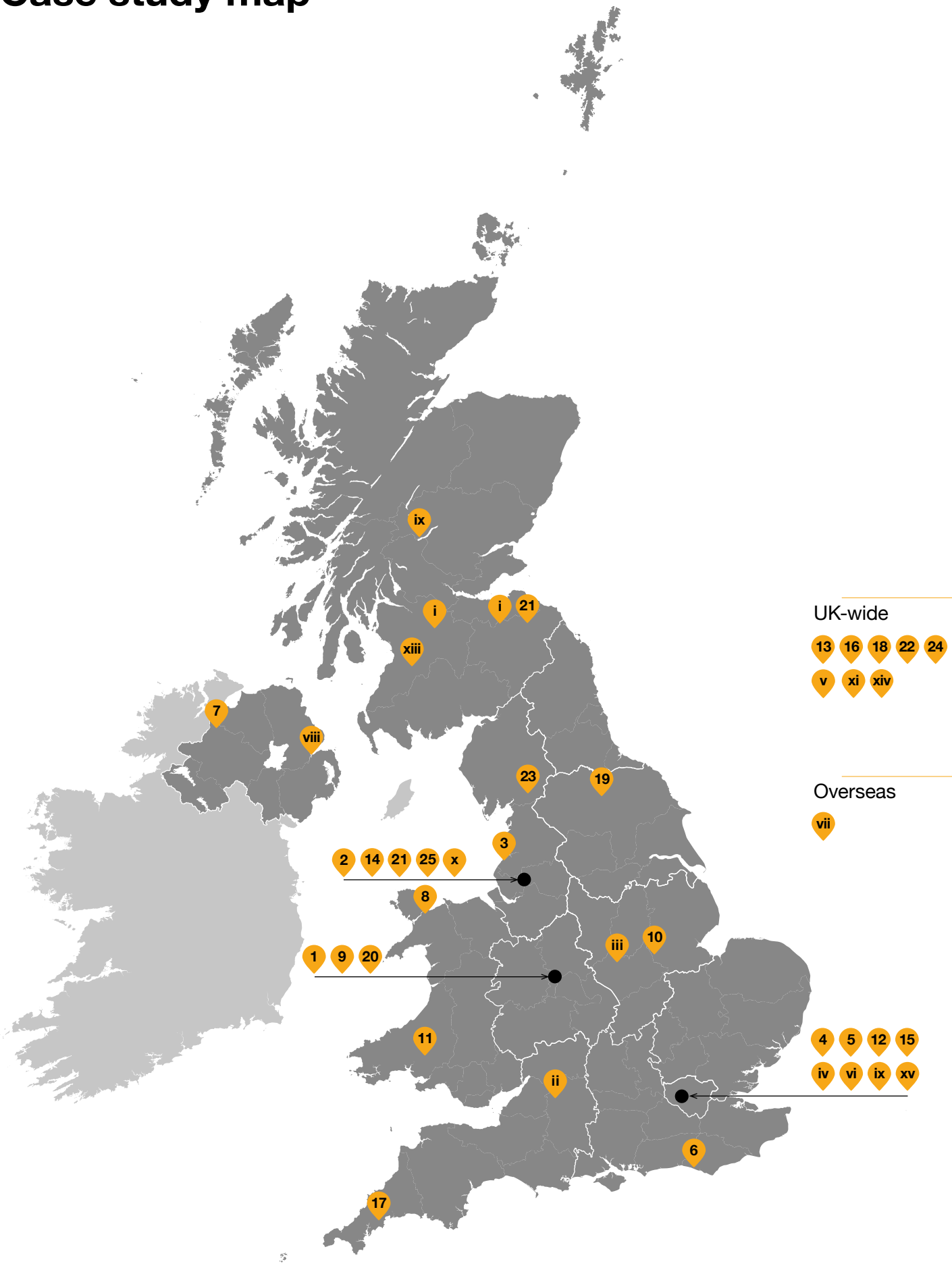
Case study map



Key

A – Autonomy/control

B – Belonging

C – Competence

Annex 3 – Additional case studies

Glossary

AHP	Allied Health Professions
ARCP	Annual Review of Competency Progression
BME	Black and Minority Ethnic
BMJ	British Medical Journal
CCG	Clinical Commissioning Group
CLP	Clinical Leadership Programme
CPF	Clinical Placement Facilitator
CPS	Clinical Placement Supervisor
EPR	Electronic Patient Record
F1	Foundation Year 1
FOI	Freedom of Information
FT	Foundation Trust
GCM	General Clinical Mentor
GP	General Practitioner
HSC	Heath and Social Care
IMG	International Medical Graduate
ISG	Improving Surgical Training
IT	Information Technology
LGBT	Lesbian, Gay, Bisexual and Transgender
NAC	Newly Appointed Consultant
NTS	National Training Survey
SAS	Staff grade, associate specialist and/or specialty doctor
ScotGEM	Scottish Graduate Entry Medicine programme
WRES	Workforce Race Equality Standard

Abbreviations for organisations

AAGBI	Association of Anaesthetists of Great Britain and Ireland
BMA	British Medical Association
CQC	Care Quality Commission
DOH	Department of Health
FMLM	Faculty of Medical Leadership and Management
GCC	General Chiropractic Council
GDC	General Dental Council
GMC	General Medical Council
GOC	General Optical Council
GOsC	General Osteopathic Council
GPhC	General Pharmaceutical Council
HCPC	Health and Care Professions Council
HEE	Health Education England
HEIW	Health Education and Improvement Wales
HIS	Healthcare Improvement Scotland
HIW	Healthcare Inspectorate Wales
HSCNI	Health and Social Care Trusts in Northern Ireland
HSE	Health and Safety Executive
ISD	Information Services Division
MSC	Medical Schools Council
NES	NHS Education for Scotland
NHS	National Health Service
NIMDTA	Northern Ireland Medical and Dental Training Agency
NISCC	Northern Ireland Social Care Council
NMC	Nursing and Midwifery Council
PMCAT	Primary Medical Care Advisory Team
PSNI	Pharmaceutical Society of Northern Ireland
QUB	Queens University Belfast
RCGP	Royal College of General Practitioners
RCoA	Royal College of Anaesthetists
RCP	Royal College of Physicians
RCS	Royal College of Surgeons of England
RQIA	Regulation and Quality Improvement Authority
SAMD	Scottish Association of Medical Directors
SCW	Social Care Wales
SSSC	Scottish Social Services Council

Foreword

Foreword

In 2018 the General Medical Council asked Professor Michael West and Dame Denise Coia to carry out a UK-wide review into the factors which impact on the mental health and wellbeing of medical students and doctors.

The detailed practical proposals in this report provide a road map to health service leaders faced with the challenge of developing healthy and sustainable workforces.

It may not yet feel like it for those on the frontline, but we are seeing positive change. Intentions are becoming actions. There is now clear consensus across the health service on a range of issues that affect patient welfare and doctors' wellbeing. All the evidence indicates that organisations who prioritise staff wellbeing and leadership provide higher quality patient care, see higher levels of patient satisfaction, and are better able to retain the workforce they need.

Whilst the report emphasises the need for organisations to have leaders that act compassionately and promote wellbeing, it also makes clear that all doctors have an important leadership contribution to make.

The time is now. The development of people strategies across all four countries of the UK provides an opportunity to drive real and lasting change, to deal with the problem rather than the symptoms.

This is not just about money; it is about behaviour and actions. If we act together we will avoid losing good doctors and seize a golden opportunity to tackle the challenges the health service must meet now and in the future. But there must be greater consistency across the UK. The findings and recommendations from this review aim to achieve that, so that together we can deliver the cultures and working environments that doctors and patients deserve.

We accept all the recommendations for us, and we encourage all organisations referenced in this report to do the same. Promoting and supporting the work identified in this report will be a priority for the GMC in the years ahead.

Making the NHS a better place to work and able to meet the needs of our patients must be a shared endeavour – none of us can assume that it is someone else's job.

Dame Clare Marx DBE DL FRCS
Chair, General Medical Council

Co-chairs of the review

Co-chairs of the review

Professor Michael West

Professor Michael West is a Senior Visiting Fellow at The King's Fund, London and Professor of Organisational Psychology at Lancaster University Management School. He is a fellow of a number of societies, associations and academies.

For over 30 years, the focus of his research has been culture and leadership in organisations, and team and organisational innovation and effectiveness, particularly in relation to the organisation of health services.

Michael has provided policy advice to many UK and international health service organisations, including the Department of Health and Social Care in England, Health Education England, NHS Improvement, the Department of Health in Northern Ireland and Health Education and Improvement Wales.

He has also worked directly with a number of NHS trusts and health boards across the UK to develop compassionate leadership and cultures of high quality care for patients.

Dame Denise Coia

Dame Denise Coia is a clinical psychiatrist and leader in the field of mental health. She was a medical advisor to the Scottish government on mental health issues from 2006, and she conducted the review on Child and adolescent mental health services in Scotland. She previously held the position of Chair of Healthcare Improvement Scotland and was Vice President of the Royal College of Psychiatrists.

Executive summary

Executive summary

Patient safety depends on doctors' wellbeing

Medicine is a tough job, but we make it far harder than it should be by neglecting the simple basics in caring for doctors' wellbeing.

The wellbeing of doctors is vital because there is abundant evidence that workplace stress in healthcare organisations affects quality of care for patients as well as doctors' own health[1-5]. In two studies, researchers found that doctors with high levels of burnout had between 45% and 63% higher odds of making a major medical error in the following three months, compared with those who had low levels[6].

> There is abundant evidence that workplace stress in healthcare organisations affects quality of care for patients as well as doctors' own health.

Patient satisfaction is also markedly higher in healthcare organisations and teams where staff health and wellbeing are better[1-5]. And there are many good examples of such teams and organisations across the UK.

The wellbeing of doctors is also vital because it is linked to a significant problem with retaining doctors, which is exacerbating existing difficulties with providing the numbers of doctors needed to support our health services[7]. Just under half of doctors working in hospitals and other secondary care organisations in England are considering leaving the organisations in which they work (47%, 2018 NHS Staff Survey in England[8]). Nearly one in five (17%) are considering leaving the National Health Service (NHS) altogether[8], and the same patterns are seen across the UK (Health and Social Care Northern Ireland 2015 Staff Survey and NHS Wales Staff Survey 2018)[9-10].

> The wellbeing of doctors is vital because it is linked to a significant problem with retaining doctors.

The eighth National GP Worklife Survey in England, published in 2017, reported the lowest levels of job satisfaction among GPs and revealed the highest levels of stress since the survey began in 1998; it also showed that 35% of GPs were intending to quit direct patient care within the next five years[11]. In Scotland 26% of GPs said they are unlikely to be working in general practice in five years' time, citing unsustainable workloads and unmanageable stress levels as the main reasons[12].

Over a third of doctors working in secondary care also indicated that they'd been unwell as a result of work-related stress in the previous year, 37% of doctors in the 2018 NHS Staff Survey in England[8]; 36% of doctors in the 2015 Health and Social Care Northern Ireland (HSCNI) Staff Survey[9]; and 34% of doctors in the NHS Wales Staff Survey 2018[10].

> Our aim should be to ensure that the NHS is a model for the world, in creating workplaces that support doctors and other healthcare staff by promoting their mental health and wellbeing.

Nearly one in four doctors in training in the UK, and one in five trainers said they felt burnt out to a high or very high degree because of their work (2018, General Medical Council (GMC) national training surveys (NTS))[13]. And nearly half of doctors in training reported working beyond their rostered hours, while one in five said that their working pattern had left them short of sleep.

Our aim should be to ensure that the NHS is a model for the world, in creating workplaces that support doctors and other healthcare staff by promoting their mental health and wellbeing. This is consistent with the service's core purpose, to develop the health of our population – of which doctors, numbering more than 300,000, constitute a sizeable group[14]. Doctors' health and wellbeing are critical to the quality of care they're able to provide for patients and communities; affecting their compassion, professionalism and effectiveness[1-5]. While this review has covered the wellbeing of the medical profession, it is important to note the issues apply to other staff working alongside doctors in healthcare, as highlighted by Health Education England's (HEE) NHS Staff and Learners' Mental Wellbeing Commission.

Ensuring that working conditions, in both primary and secondary care, are supporting doctors in their work is fundamental to the success of our health services. Including private funding, the total cost of training a doctor is over half a million pounds[15]; yet many workplace environments are not designed to ensure best use of their skills. Instead, workplace factors are often reducing productivity and undermining good patient care, by damaging the health and wellbeing of doctors[1-5].

We face a situation that demands integrated and targeted action to address the underlying factors that affect doctors' wellbeing. There are some primary and secondary care organisations that are effectively supporting doctors to do their vital work and we have included case studies in this report to show how they are doing this. This should be achievable in all healthcare settings.

System partners, including regulators and improvement bodies, have a role in working with the profession, employers of doctors, and each other to improve doctors' working lives. Existing initiatives include:

- The People Plan by NHS England
- The Health and Social Care Workforce Strategy 2026: Delivering for Our People, in Northern Ireland
- The Ministerial Short Life Working Group on Culture, and Project Lift, in Scotland
- The Health and Social Care Workforce Strategy and the Health and Social Care Leadership Framework, in Wales

> We must build on good practice and these initiatives to create the conditions to ensure the NHS attracts, supports and retains its doctors.

The GMC has said it is keen to cooperate with those coordinating these programmes to ensure the wellbeing of doctors.

We must build on good practice and these initiatives to create the conditions to ensure the NHS attracts, supports and retains its doctors. That is the aim of this review.

Review approach

The focus of this report is on identifying causes, consequences and solutions. The review aimed to take account of the experience of all doctors and medical students working and learning within the UK's healthcare systems, in both primary and secondary care. The starting point is understanding the needs of doctors in the workplace.

ABC of doctors' core needs

To ensure wellbeing and motivation at work, and to minimise workplace stress, people have three core needs, and all three must be met.

A **Autonomy/control** – the need to have control over our work lives, and to act consistently with our work and life values.

B **Belonging** – the need to be connected to, cared for, and caring of others around us in the workplace and to feel valued, respected and supported.

C **Competence** – the need to experience effectiveness and deliver valued outcomes, such as high-quality care.

The review identified inspiring examples of organisations that meet these three core needs for doctors. An integrated, coherent intervention strategy will transform the work lives of doctors, their productivity and effectiveness, and thereby patient care and patient safety.

We've focussed on developing greater consistency of good work environments across the four UK countries by changing the workplace factors that affect the wellbeing of doctors at work; rather than on initiatives to improve their ability to cope with stress or provide treatment when they become unwell.

Set out in the report are eight vital recommendations, each with several key elements, to address the pressing issues that impact on doctor wellbeing.

This requires that institutions and organisations implement all of the eight recommendations and constituent elements, rather than adopting those that seem the easiest or most attractive. In this summary, we describe the most immediate steps needed under the three headings of autonomy/control, belonging and competence.

Six urgent steps needed

A: Autonomy and control

Voice, influence and fairness

To introduce mechanisms for doctors in primary and secondary care to influence the culture of their healthcare organisations, and decisions about how medicine is delivered.

How: Clinical leaders and managers should consult doctors (and other healthcare staff) and gather feedback about how healthcare teams are established and maintained, how their work is organised and delivered and the response to concerns to ensure a focus on learning not blame.

Work conditions

To introduce UK-wide minimum standards for basic facilities in healthcare organisations.

How: All healthcare employers should provide all doctors with places and time to rest and sleep, access to nutritious food and drink, the tools needed to do their job and should implement the BMA's Fatigue and Facilities charter.

Work schedule and rotas

To introduce UK-wide standards for the development and maintenance of work schedules and rotas based on realistic forecasting that supports safe shift swapping, enables breaks, takes account of fatigue and involves doctors with knowledge of the specialty to consider the demands that will be placed on them.

How: NHS England, NHS Wales, NHS Boards in Scotland and the Department of Health (Northern Ireland) should fully implement the BMA's and NHS Employers' Good Rostering Guide (see new deal monitoring guidance in Scotland) in all healthcare environments.

B: Belonging

Team working

To develop and support effective multidisciplinary team working across the healthcare service.

How: All healthcare organisations should review team working and ensure that all doctors are working in effectively functioning and, ideally, multidisciplinary teams. The teams should have a shared purpose and clear objectives (one of which is team member wellbeing). Team members should be clear about their roles and meet regularly to review their performance, including inter-team/cross-boundary working. Quality improvement should be a core function of all teams.

Culture and leadership

To implement a programme to ensure healthcare environments have nurturing cultures enabling high-quality, continually improving and compassionate patient care and staff wellbeing.

How: All UK healthcare organisations that haven't already done so, should start and implement a programme of compassionate leadership across all healthcare sectors; and they should obtain feedback from doctors and healthcare staff to evaluate its effectiveness. It should include mechanisms to ensure clinical leads and other leaders of doctors at all levels in the healthcare system are recruited, selected, developed, assessed and supported to model compassionate and collective leadership.

C: Competence

Workload

To tackle the fundamental problems of excessive work demands in medicine that exceed the capacity of doctors to deliver high-quality safe care.

How: All organisations that oversee the work of doctors should undertake, in collaboration with doctors, a programme to review workload in their organisations. This will help them to use resources in the most efficient way, to ensure workloads do not exceed doctors' ability and capacity to deliver safe, high-quality care. Initiatives are underway across the UK to increase staffing numbers and this should be supported by additional solutions including, but not restricted, to:

- A programme to deploy and develop alternative roles to enable doctors to work at the top of their competence, supported by effective multidisciplinary team working in all areas of healthcare, and to support doctors to return to work after a break in practice.
- A review of new technologies being used in UK healthcare systems to increase efficiency, working with the voluntary sector, and focusing on preventive care.
- A programme of process improvements that increase productivity especially by supporting communication in regular team meetings between healthcare staff.

These urgent steps emphasise the responsibility of organisations that oversee and provide healthcare across the four UK countries. But we also highlight the importance of involving doctors themselves in making these improvements. Their collective voice is a powerful force for change.

All the recommendations in the report are provided in full in the action plan at Annex 1. They include other elements that are necessary to tackle the issues of:

- voice, influence and fairness
- work conditions
- rotas and work schedules
- team working
- culture and leadership
- workload

There are also recommendations relating to training and development, and to management and supervision.

Our call to action

There is now much evidence for the beneficial effects of compassion on patient outcomes and on the wellbeing of those who provide care. Neglect, incivility, blaming and harassment have quite opposite effects. Helping leaders, doctors and others in healthcare to develop compassionate ways of working will equip them, their teams and organisations to deal effectively with the challenges they face.

> Our call to action is for all NHS leaders to lead with compassion by implementing all the recommendations in this report.

Our call to action is for all NHS leaders to lead with compassion by implementing all the recommendations in this report. Those NHS organisations with cultures of compassion promote fairness, and foster individual, team and organisational wellbeing. And they meet doctors' needs for autonomy, belonging and competence at work, which in turn improves productivity and efficiency, and better promotes the wellbeing of the patients and communities they serve.

That is the challenge and the imperative for leaders and doctors in all NHS and primary care organisations across the UK.

Introduction and aims

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Aims

The aims of this report are to:

- Identify the stressors which are negatively impacting on the health and wellbeing of the 304,000 General Medical Council (GMC) registered doctors and 41,000 medical students in the UK[14].
- Show how to transform doctors' workplaces so they thrive and flourish and are better able to provide the compassionate and high-quality care they and their patients wish them to deliver.

The review was co-chaired by Professor Michael West and Dame Denise Coia. It involved extensive analysis of research literature and data; and engagement across all four countries of the UK with individuals and organisations including:

- doctors and their representative bodies
- postgraduate medical education bodies
- medical royal colleges and faculties
- medical schools, students and undergraduate medical education bodies
- government departments in each country of the UK
- national bodies overseeing health services
- systems regulators/ improvement bodies
- local and international provider organisations and employer bodies
- leading researchers nationally and internationally.

The focus of the report is on identifying the causes, consequences and concrete solutions to poor wellbeing amongst the medical profession.

> Research shows that staff wellbeing significantly improves productivity, care quality, patient safety, patient satisfaction, financial performance and the sustainability of our health services.

In identifying solutions, we have focussed on the many encouraging primary interventions that have been shown to work and which address underlying causal workplace factors. Organisations should ensure that they meet the needs of their workforce by providing wellbeing support and ensuring those charged with caring for patients in the UK themselves get treatment for ill health. However, it is critical that they also tackle the underlying causes of stress such as excessive workload, bullying, poor supervision, discrimination and poor team working rather than focusing solely on the consequences. They should not expect doctors to put up with poor workplace environments.

Doctors' work lives should be fulfilling and life enhancing, challenging though the job is. Research has clearly shown that staff wellbeing significantly improves productivity, care quality, patient safety, patient satisfaction, financial performance and the sustainability of our health services[1-5].

We know that there are many bodies who are addressing these issues, and other organisations which are well placed to make these changes happen. The GMC should take a collaborative approach with those organisations. This report must be a springboard for swift, positive, sustained and effective change in the working lives of doctors.

The context

Drawing on the findings from the annual Labour Force Survey, the Health and Safety Executive has reported that people working in health and social care consistently report higher rates of stress, depression and anxiety related to their work than those in most other sectors[16].

We recognise that all NHS staff are under huge pressure, not just doctors. There are over 100,000 staff vacancies in the NHS in England, representing one in 11 of all posts[7]; HSCNI reported approximately 7,500 vacancies in Northern Ireland, representing one in eight posts[17]; and statistics from NHS Scotland showed 7.8% of medical and dental consultant posts were vacant[18]. There is no official national data on vacancy rates in Wales, but responses from health boards and trusts to a BMA Cymru Wales freedom of information request (FOI) showed a 6.8% vacancy rate[19]. There are also very high levels of staff turnover with large numbers of nursing, midwifery, and medical staff leaving[7].

> The workforce shortage in nursing and medicine threatens the ability of the service to deliver safe, high-quality care for patients, and threatens the wellbeing and commitment of NHS staff.

Sickness absence (a key human indicator of organisational performance) in the NHS in England (3.4%) is twice the rate in the private sector (1.7%)[20]. It is higher in Northern Ireland at an estimated 5.3%[21], Scotland at 5.3%[22], and Wales at 5.6%[23]. Moreover, most NHS organisations struggle to recruit and retain staff. The workforce shortage in nursing and medicine threatens the ability of the service to deliver safe, high-quality care for patients, and threatens the wellbeing and commitment of NHS staff.

Numerous doctors we met told us about unacceptable working and training conditions which damaged their wellbeing and effectiveness. We heard consistent stories of doctors feeling undervalued in the workplace; isolated from seniors, teams and colleagues; unsupported in their roles; fearful of making a mistake and being blamed or prosecuted; overwhelmed by their workloads and feeling that they have little control over their work lives.

Analysis of data from the GMC national training surveys (NTS) shows that, where doctors reported heavy workloads and a lack of supportive environment, there was often a negative impact on wellbeing and effectiveness, although the majority of doctors in training are, on the whole, broadly positive about their educational experience.

When doctors cannot meet patients' needs to the appropriate standard, they often feel moral distress.

Our engagement across the healthcare system revealed that doctors feel they are facing a significant increase in the volume of patients and the complexity of their health needs and demands, without a corresponding growth in support. When doctors cannot meet patients' needs to the appropriate standard, they often feel moral distress[24-25].

Some doctors told us about the mechanisms that had supported them in the past, such as some aspects of strong communities for hospital doctors. Collegiate ties have a positive impact on wellbeing but must be inclusive for all diverse groups of doctors and healthcare staff to be beneficial. Some doctors told us changes in many organisations, such as the loss of team structure, have left them feeling exposed, with increases in bullying, blaming and undermining. Yet, we found examples of some organisations in primary, community and secondary care that have achieved exactly the opposite. Nurturing workplace cultures that are positive, supportive and compassionate.

We begin by describing the incidence and prevalence of strain and mental health problems in the UK's medical workforce.

Incidence and prevalence of strain

Previous research has shown that 50% more NHS staff in England report debilitating levels of work stress compared to the general working population[i]. National staff survey findings in England, Northern Ireland and Wales indicate that between 37% and 40% each year report being unwell because of work stress during the previous year (2018 NHS Staff Survey in England, HSCNI 2015 Staff Survey, NHS Wales Staff Survey 2018)[8, 10, 11]. Such stress is likely to be chronic (measures of work stress repeated over time among healthcare professionals are highly consistent). In the BMA's quarterly survey in 2017 (quarter two), 50% of the 422 doctors who responded reported feeling unwell due to work-related stress during the previous year[26].

In describing levels of stress among doctors, we have relied particularly on results from the NTS, and data available from national surveys of health service staff. However, it's important to note that the content of staff surveys is not consistent across the four countries of the UK (for example, there is no measure of stress currently in Scotland), and as such, in places, we are more reliant on data from the English survey.

The NTS is conducted across the UK and provides valuable insights. It is notable that there is little variation in patterns of findings by country, suggesting that the situation faced by doctors is broadly comparable (where there is variation, we report it below). There is also much more evidence available for secondary than primary care, but we have accessed data on GPs and primary care wherever this is available.

There is a clear need to improve the quality of measurement of stress, workplace wellbeing and related issues across all four country surveys, both because of the inadequacy of some measures, and because some important factors are simply not measured. There is also an urgent need to develop and implement a staff survey across primary care in all four countries using robust, validated and peer-reviewed measures of key workplace factors affecting doctors' wellbeing and mental health.

> Nearly one in four UK doctors in training, and one in five trainers were burnt out to a high or very high degree because of their work.

The 2018 NTS employed an internationally used and validated measure of burnout (Copenhagen Burnout Inventory). This showed that nearly one in four UK doctors in training, and one in five trainers were burnt out to a high or very high degree because of their work. Nearly one in five said they don't have energy for family and friends (spending quality time with loved ones is a key determinant of wellbeing)[13].

[i] The latest Labour Force Survey results from 2015/16 show that 11.7 million working days were lost to work-related stress, anxiety and depression in the UK, with the main factors being "workload pressures, including tight deadlines, too much responsibility and a lack of managerial support" (HSE, 2016). Poor workplace mental health costs UK public sector employers between £8 and £10 billion per year.

There is also evidence that while doctors are less likely than other healthcare workers to take time off due to sickness (a rate of 1.3% for hospital doctors compared with 4.2% for all NHS hospital staff[27]), attending work while unwell (presenteeism) may be much more prevalent. The medical and dental staff group also had the lowest rate of sickness absence in Wales, at 1.9% compared with 5.3% across NHS staff[21]. 42% of doctors in England and 47% in Wales report having recently attended work despite not feeling well enough to perform their duties[8, 10].

Doctors report coming to work when unwell because they feel they have a responsibility to their patients or do not wish to burden colleagues who will pick up the work. But previous research has shown that staff attending work while sick are unlikely to be able to perform effectively, while also passing on their illness to colleagues or patients[28-29].

Work periods of over eight hours carry an increased risk of accidents that accumulates, with twice the risk of an accident at around 12 hours compared with eight hours of work.

Excessive workload and the need to work additional hours create work stress[30]. In Northern Ireland, 27% of doctors in the HSCNI 2015 Staff Survey report working additional paid hours and 93% work additional unpaid hours, with 39% of all respondents working more than five additional unpaid hours per week[9]. In England, the figures from the 2018 NHS Staff Survey are 43% working additional paid hours and 81% working additional unpaid hours[8]. These figures are significant in accounting for some of the most serious effects on doctors' mental health.

The latest NTS showed that nearly half of UK doctors in training worked beyond their rostered hours (England 48.5%, Northern Ireland 50.5%, Scotland 46.9%, Wales 51%), while one in five said that their working pattern had left them short of sleep[13]. Long working hours and shift work impact on doctors' personal safety, increasing the likelihood of occupational accidents and needle-stick injuries[31].

Work periods of over eight hours carry an increased risk of accidents that accumulates, with twice the risk of an accident at around 12 hours compared with eight hours of work. This imperils both patients and doctors[32]. Excessive workload affects patient safety, productivity, efficiency and mental health and wellbeing.

Variation between sub-groups

We have focused on the following sub-groups to reflect important variations in the data on mental health and wellbeing. This is not to prioritise action for any group of either students or doctors, but to highlight important trends relevant to their wellbeing.

Medical students

Studying medicine at university is an intense experience and the course is a demanding one. In the UK, mental health issues are still the most common issue declared to the GMC by UK medical graduates in their application for provisional registration[33]. There has been a large rise in percentages reporting depression, anxiety and stress in the last four years and in the numbers declaring a mental health issue (8% of all 2018 applicants)[33].

Consultants

Stress levels among consultants have stayed constantly high over the last five years (with around 36% reporting illness as a result of work-related stress in the past year in the 2018 NHS Staff Survey in England)[8].

Doctors in training

For this group, stress levels (being unwell because of work stress in the previous year) have risen from 31% in 2014 to 39% in 2018[13]. Doctors in training report higher levels of work-related stress and burnout and lower engagement than consultants[13].

General practitioners (GPs)

Working in primary care can expose doctors to stressors that differ from those in secondary care. A number of GPs told us their working environment can be lonely, with long hours spent seeing many patients without the opportunity to talk with colleagues. Trainees can find that support is lacking in practices struggling with staffing levels, which in turn can lead to inappropriate workloads such as unsupervised home visits. We were told that in addition to lone working, further stressors can include unsustainable patient volume, the added demand of scheduling an average of only ten minutes with each patient, and inadequate time to catch up with other tasks. GPs are also among the specialities that experience denigration from other specialties and this can elicit resistance when they refer patients to secondary care.

The findings of research on the retention of GPs are congruent with studies of hospital doctors in the UK. Poor working conditions (high workload, low job autonomy, long hours, low social support, work-life conflict) and poor mental health (high burnout, symptoms of depression and anxiety) are associated with an increased intention to leave medicine[11-12].

A Commonwealth Fund survey of GPs across 11 countries found that GPs in the UK had the highest levels of stress, with 59% reporting that their job was 'extremely stressful' or 'very stressful', compared with 18% in the Netherlands and an average of 35% across all 11 countries[34]. GPs were the second most likely group of respondents in a 2019 BMA survey of 4,300 doctors and medical students to have a 'high' or 'very high' risk of burnout – behind doctors in training. Respondents who worked more than 51 hours in a week were most likely to be at risk of burnout[35]. The BMA followed this survey by commissioning qualitative research with some of the respondents; the findings were published in the report 'Mental health and wellbeing in the medical profession'[35]. GP trainees had even higher levels of burnout than their non-GP trainee counterparts in the 2019 NTS.[36] England's eighth National GP Worklife survey carried out in 2015 reported the lowest levels of job satisfaction among GPs since 2001 and the highest levels of stress since the start of the survey in 1998[11]. The ninth survey (2017) revealed that 39% of the over 2,000 GPs responding intended to quit direct patient care in the next five years[37]. This had increased from 31% in 2012 and was the highest level recorded since the survey began. Some 85% reported having insufficient time to do the job properly and 92% of having increasing workloads.

Physicians

A recent survey by the Royal College of Physicians (RCP) found that four out of five doctors in training reported that their job 'sometimes' or 'often' caused them excessive stress[38]. More than half revealed that their work negatively affected their physical health and a quarter indicated that it had a serious impact on their mental health. Another report from the RCP focusing on Wales showed that two thirds of trainee physicians in Wales reported regular, frequent rota gaps, with 74% of medical registrars in Wales saying work-life balance is the first thing to suffer[39].

Surgeons

Oskrochi et al. found that surgeons had high rates of depression and psychiatric distress[40]. Surveys of surgeons reveal that between 16% and 36% had high levels of traumatic stress symptoms, with 12% indicating possible post-traumatic stress disorder[41].

Emergency medicine

Doctors working in emergency medicine, where crisis management has become the norm, are amongst those experiencing the highest levels of burnout. The 2019 NTS revealed that doctors working in emergency medicine had very high rates of burnout (69.2% of trainees and 63% of trainers reported moderate or high levels of burnout)[13]. This is considerably higher than the average (49.9% of doctors in training overall and 46.8% of trainers).

Demographic variation

Ethnicity

The evidence on the experience of NHS staff from a black and minority ethnic (BME) background in relation to discrimination at work is stark. The 2018 NHS Staff Survey in England showed that, of those experiencing discrimination at work in the previous 12 months (10% from patients/ relatives etc, and 9% from managers/team leaders or colleagues), doctors are the most likely to experience discrimination on the grounds of ethnicity (57.7% compared with 34.9% across all staff groups)[8]. The level of discrimination on grounds of ethnicity has also risen over the last five years from 52% to the current 57.7%.

'Fair to refer?', independent research by Dr Doyin Atewologun and Roger Kline, commissioned by the GMC, highlighted that managers struggle to give feedback to those from a different ethnic group to them[42]. Discrimination has dramatic influences on workplace stress and physical health[43].

Age

There is no clear pattern of age differential susceptibility to stress amongst doctors. While the perceived stigma surrounding mental health prevents many doctors from seeking help, some studies show that it is usually younger doctors who approach support services[ii].

Gender

Findings on gender are mixed and inconclusive. The systematic review conducted by Imo indicated mixed findings about differences between male and female doctors in burnout and psychiatric morbidity[46]. In contrast, more recent research showed that female GPs reported better mental health than their male counterparts. In the NHS Staff Survey in England, female doctors were somewhat more likely to report musculoskeletal disorders, to report having been unwell as a result of stress during the previous year, and to go to work when unwell[8].

Overall, the evidence is clear that doctors are dealing with high levels of stress in their work which is affecting turnover, absenteeism, presenteeism and performance – and of course the quality of patient care.

We now examine these consequences in more detail.

[ii] The average age of doctors accessing the NHS Practitioner Health Programme, a confidential service for doctors that offers support for mental health issues, has dropped from 51.6 to 38.9 in 10 years. During this time more than 5,000 doctors accessed this service, around two-thirds of whom were women[44]. Similarly, a 2007 study found that the largest group attending MedNet, a confidential consultation service for doctors and dentists in London, were aged between 30-39 years old[45].

Consequences

Longitudinal analyses of data from the NHS Staff Survey in England, have consistently shown associations between staff reports of stressful and unsupportive work environments and poorer patient satisfaction, quality of patient care and financial performance[1-5, 47] and (in the acute sector) increased patient mortality[48]. Better staff wellbeing is linked to positive patient outcomes within NHS organisations.

Below we describe behavioural, physiological and psychological consequences of work stress and strain, detailing the impacts in healthcare.

Behavioural

Cognitive and emotional outcomes of work stress include negative effects on concentration, mood disturbance, depression, anxiety, health complaints and work performance. The consequences for work are considerable such as poor performance, sickness absence, intention to quit and early retirement. There are also effects on productivity, role performance, organisational citizenship behaviour, engagement and, inevitably, patient experience and satisfaction with care[49]. Strain leads to more errors on cognitive tasks including deterioration in memory, reaction time, accuracy and task performance. This has implications for doctors' health and patient safety. Strain is associated with more medical errors amongst healthcare workers[50] and there is now considerable evidence that stress and strain impair doctors' decision-making, productivity and patient safety (including medical errors)[51].

In two studies, researchers found that doctors with high levels of burnout had between 45% and 63% higher odds of making a major medical error in the following three months, compared with those who had low levels[6]. Another study from the University of Washington suggested that doctors experiencing high levels of stress were four times more likely to provide substandard patient care[52]. And a study of 7,905 surgeons by the Mayo Clinic found that highly stressed surgeons were three times more likely to make a major surgical error than those with low stress levels[53]. Among nurses in intensive care units, high stress levels were associated with higher patient mortality rates[54]. A UK survey of 681 doctors working in emergency medicine suggested that compassion fatigue (one symptom of burnout or stress) was associated with reducing care quality standards in a way that could harm patients[56].

Psychological

Psychological burnout, first described by Maslach and Leiter (1997)[56], refers to three sub-dimensions of strain – emotional exhaustion, depersonalisation (becoming hardened and treating patients as objects), and a sense of ineffectiveness[57]. Burnout is associated with sleep deprivation[58], medical errors[53, 59], poor quality of care[52, 60], and low patient satisfaction[61].

Physiological

People in sustained stressful situations are at a higher risk of heart attacks[62], gastrointestinal problems[63-64], poorer functioning of the immune system and of coronary heart disease[62, 65]. Chronic stress is also associated with increased risks of cancer, chronic fatigue syndrome, depression, sleep and eating disorders, and musculoskeletal injury[66-67].

A 2015 meta-analysis of 228 studies assessing ten workplace stressors and health outcomes found that high job demands raised the odds of diagnosed illness by 35% and that long work hours increased mortality by almost 20%[68].

Other consequences

Excessive workload and work stress contribute to higher levels of bullying, harassment and discrimination[69].

In national staff surveys (2018 NHS Staff Survey in England, HSCNI 2015 Staff Survey, NHS Wales Staff Survey 2018, 2017 Scotland Dignity at Work Survey)[8-10, 70]:

- 23-36% of doctors reported being bullied, harassed or abused by members of the public, patients or their carers (England, Northern Ireland, Wales). In Scotland, 33% reported emotional verbal abuse from members of the public.
- 9-16% of doctors reported being bullied by managers and 14-22% reported being bullied by other colleagues (England, Northern Ireland and Scotland). In Wales, 19% of doctors reported being bullied by managers and colleagues combined.

For doctors in training, gender discrimination (among those experiencing discrimination at work) has risen from 33.1% to 43.5%[13]. The level of discrimination experienced by doctors on the grounds of ethnicity has risen over the last five years from 52% to the current 57.7%[8].

How then do we change the workplace factors that are affecting doctors' wellbeing?

To answer this question, it is important to begin by clearly defining what are core human needs at work that, when satisfied, are associated with wellbeing and intrinsic motivation.

ABC of doctors' core needs

The core workplace needs to ensure the wellbeing of doctors are; autonomy and control; belonging; and competence (the ABC of needs)[71]. When these needs are met, people are more intrinsically motivated and have better health and wellbeing. If any one of them is not met, then wellbeing and motivation suffer.

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

How do we translate these elements into appropriate interventions in the many different contexts that doctors operate in?

Our review and the research evidence together suggest that of the three needs outlined in this report, the need for **autonomy or control** is the least met by the health services, where the culture is typically controlling. All doctors (and NHS staff) should feel they have voice and influence in the genuine co-design of services and the management of their organisations. This requires inclusive leadership. Doctors will engage when they feel their organisations are just and fair places to work, where procedures are transparent and fair, particularly in relation to recognition, rewards, rotas, bullying, sexual harassment and discrimination. Workplace conditions make a big difference to the experience of control – having somewhere to get a hot drink or some food on a night shift; a locker to put clothes or valuables in; and having rotas well in advance so that other responsibilities can be managed.

Doctors' needs for **belonging** are met when they work within supportive teams and organisations and feel valued, respected and supported. This requires an organisational commitment to the delivery of high quality and compassionate care; leadership and management that ensure trust, motivation and compassion; clear, agreed and manageable work objectives for all; and effective team and inter-team working. This necessitates inclusive and compassionate leadership at every level.

Doctors' need for **competence** is likely to be met first and foremost when their workloads are not chronically excessive. They must also have enabling and supportive clinical leadership and supervisory support, focused on removing obstacles to their work. Directive, controlling leadership that emphasises blame rather than learning and accountability undermines competence. Doctors must be supported to continually grow, develop and learn so that their skills and competence are constantly improving.

The actions that we propose focus on meeting doctors' core needs by not only removing stressors in the work environment but also amplifying factors that promote positive wellbeing. Positive emotions, such as hope, pleasure, compassion, happiness, humour, excitement, joy, love, pride and involvement are important sources of human strength[72-74]. When we feel positive we think in more flexible, open-minded ways and consider a much wider range of possibilities.

This enables doctors to successfully undertake complex tasks such as diagnosis and treatment, and we are more likely to be helpful, altruistic, generous and compassionate. This report therefore addresses both the workplace factors that cause negative emotion and mental ill-health, and those that improve positive emotion and psychological wellbeing.

We offer inspiring examples from across healthcare in the UK of where this has been achieved.

Improving the work environment for doctors

Improving the work environment for doctors

A meta-analysis of 65 international studies[75] examined the effect of protective and detrimental factors on burnout among doctors. Constraining aspects of work such as workload, organisation structure (e.g. inflexible work arrangements), professional values (e.g. compromising standards) and specific demands (working in emergency medicine) were strong predictors of burnout. The findings suggest that multilevel interventions are required to reduce the risk of burnout for doctors – such as changing organisational factors, the functioning of teams and their individual roles.

If we are to transform the work lives of doctors and the quality of patient care, we must implement an integrated intervention strategy.

We have aimed our eight core recommendations at both primary and secondary care. There is an urgent need to develop and implement a staff survey across primary care in all four countries of the UK. This should use robust, validated and published measures of key workplace factors affecting wellbeing and mental health. This will aid further improvements in community care.

If we are to transform the work lives of doctors and the quality of patient care, we must implement an integrated intervention strategy. This requires institutions and organisations to implement all the recommendations below rather than adopting simply those that seem easiest or most attractive. An action plan for the implementation of these recommendations is shown in Annex 1.

In this report, we outline the issues, the evidence, good practice and case studies before making recommendations in relation to each of the core needs for autonomy/control, belonging and competence.

A – Autonomy/ control

A – Autonomy/control

Autonomy/control is probably the most important of the three needs that must be met in the workplace[76].

The key workplace factors identified in this review that impact on autonomy and control are voice and influence in a just workplace; the right work conditions; and manageable and predictable work schedules and rotas.

Voice, influence and fairness

Evidence from the review

Having a voice and influencing decisions within a team or organisation is fundamental to autonomy/control. Equally, we feel more in control when we see our work environments as fair and just. Doctors are among the most skilled and motivated people in any industry, yet they frequently reported not having influence at work and feeling unfairly treated in workplaces that emphasised blame rather than learning.

This reduces the pool of knowledge, creative ideas and experience available to decision makers overseeing our healthcare organisations. It also reduces doctors' engagement, motivation and wellbeing[77]. The challenge for clinical and all other leaders is to empower doctors to influence the direction of their organisations and to implement their ideas for better ways of doing things, in psychologically safe and supportive environments.

The data from the NHS Staff Survey in England revealed that doctors who were able to make suggestions to improve the work of their team/department and had frequent opportunities to show initiative, had higher levels of work engagement, more satisfaction with their organisation, and more satisfaction with their immediate work environment. They were less likely to be intending to leave their organisations and only half as likely to have been unwell in the previous year as a result of work-related stress[8].

Clinical leaders and senior management play an important role in this. In the NHS Staff Survey in England, doctors were asked about the extent to which senior managers try to involve them in important decisions; the extent to which communication between senior managers and staff is effective; whether senior managers act on staff feedback; and even if they knew who the senior managers were in their organisations. The more positively they responded to such questions, the higher were doctors' levels of work engagement, satisfaction with their organisation, and their work environment[8].

Inclusion is fundamental to perceptions of organisational justice. It requires leadership that includes rather than excludes doctors in decisions about key team and organisational processes. This applies both in primary and secondary care[78-79].

Discrimination is a pernicious form of exclusion that is demonstrated in the ways that doctors are recruited, selected, promoted, disciplined and developed. We heard that certain groups may be perceived as 'outsiders' within healthcare environments – for example BME and overseas doctors, female doctors, and doctors who have or who develop a disability, particularly mental ill health. Feelings of disempowerment, which impact on wellbeing, were significantly amplified in these groups. These reports are in line with the findings of the 'Fair to refer?' report commissioned by the GMC into disproportionate referrals by employers[42].

In 2018, 46% of hospital doctors in England were from a BME background, and yet only 16.4% (source: WRES data in England) of medical directors in NHS trusts were of BME origin. In plain numbers, there were only 37 BME medical directors across the 225 NHS trusts in England. In more than three-quarters (77.4%) of all NHS trusts, BME staff reported higher rates of bullying, harassment and abuse from colleagues than white staff[80].

The benefits of diversity include improved performance and innovation. These are realised in cultures or climates of positive inclusion rather than exclusion. Inclusive practices ensure all (including women, BME staff, lesbian, gay, bisexual and transgender (LGBT+) staff, staff with disabilities) influence key decisions and processes within their teams and organisations. This results in a richer information pool, more comprehensive decision making, more positive staff attitudes and higher levels of patient satisfaction[78-79]. Steps should be taken to ensure that the needs of doctors more likely to be perceived as 'outsiders' are considered and are given voice and influence.

Good practice and case examples

We heard of a number of good practice examples to support inclusive and just cultures, including:

- development plans to support teams
- a standardised framework to support learning from incidents
- a guide for creating safe, listening, inclusive and compassionate working environments
- a process for empowering doctors to transform cultures.

Engaging doctors and their teams in designing and driving change by equipping them with data, administrative support, and improvement methodologies is particularly powerful[81].

A substantive piece of collaborative work has been undertaken by a number of organisations in Scotland, forming a Scottish wellbeing advisory group. This group has provided leadership and helped build momentum and negotiating power to make potentially an effective impact on doctors' mental health across NHS Scotland (see more details in Annex 3). In Northern Ireland, the Department of Health has established an Improving Junior Doctors and Dentists Working Lives group. In April 2019, NIMDTA and Queens University Belfast hosted a 'Redefining F1 Summit' to explore the issues impacting Foundation Year 1 doctors in Northern Ireland. This summit addressed several areas, such as the induction and shadowing process and clinical workload and duties.

1 Case study
Voice and influence in practice

In 2013, Birmingham Children's Hospital (BCH) NHS Foundation Trust ran a staff engagement week attended by 1,200 staff. Among other things, workshops asked what would make colleagues feel better at work. Most people highlighted the importance of feeling valued and recognised for what they do, including awareness by the senior leadership team.

The Trust followed this with the development of their own wellbeing programme. This was led by a small team, with support from a committee looking at the staff survey results and with advice from a Consultant in public health.

Anyone who was a manager or team leader of people, e.g. managers, charge nurses, consultants, went on the programme, which was based on the seven steps for a 'team maker' by Professor Michael West. The programme received a lot of positive feedback and highlighted the importance of managers and leaders getting to know the people in their teams, of setting clear objectives and of giving feedback.

In addition, the organisation introduced:

- an employee assistance programme
- free exercise classes
- an annual calendar of wellbeing events, including events promoting health (hydration challenge, blood pressure measurement)
- making use of national campaigns, e.g. mental health awareness week and smoking cessation week, to communicate wellbeing messages
- an annual calendar of events to celebrate diversity and inclusion e.g. Eid celebrations
- listening events using the 'mad, sad and glad' technique, revealing practical things that could be fixed (e.g. lab test requesting system) to support staff wellbeing.

Staff engagement work also led to a better understanding of the experience of doctors in training at the Trust. Doctors in training were encouraged to attend Trust-wide events and leadership meetings and to contribute their ideas, leading to innovation within the organisation. Weekly Thursday morning meetings became the medium for this innovation. Thirty-four rotas were redesigned and new roles were created to support junior doctors' work – advanced clinical practitioners and physician associates. Clinicians led the innovation and developed the new roles. The Trust acknowledged that at points it can be challenging to gain buy-in from all colleagues, but the evidence for this approach is very compelling.

BCH was the first children's hospital to be rated 'outstanding' by the Care Quality Commission (CQC).

The learnings supported the development of approaches after the merger to form Birmingham Women's and Children's NHS Foundation Trust in 2017. Across the organisation, the seven principles of team effectiveness, staff listening sessions and focus on wellbeing were applied in 'hot spot' areas, e.g. neonates and radiology, and this continues to support improvements in staff experience.

2 Case study
Doctors' voice and influence

Engagement of doctors is the cornerstone of Wrightington, Wigan and Leigh NHS Foundation Trust's staff engagement strategy. In 2016, a monthly forum was established, attended by the Chief Executive, Medical Director and Director of Workforce. Doctors in training are encouraged to identify specific topics that they would like the forum to address. This has led to:

- the provision of hot meals for junior doctors working night shifts
- a review of car parking provision for staff working overnight
- improving access to emergency accommodation when staff are too tired at the end of their shift to commute home
- improvements to technology and safe systems of working.

Doctors have also been involved in redesigning rostering and bleep systems.

As part of the Trust's 'Go Engage' programme, there are quarterly Trust-wide and divisional 'Your Voice' surveys that provide granular detail of staff concerns that are then addressed.

3 Case study
Creating just cultures

After developing and piloting its approach in 2016 in collaboration with staff, colleagues and operational managers, Mersey Care NHS Foundation Trust formally introduced its 'Just and Learning Culture' into the organisation in 2017. In doing so, it's aspiring to create an environment where staff feel supported and empowered to learn when things do not go as expected, rather than feeling blamed. The approach (called 'restorative just culture') involves all those who have a stake in a specific adverse event working together to address harms and obligations. In a restorative approach three questions drive the restorative process: who is hurt; what do they need; and whose obligation is it to meet those needs. The Trust has also supported staff psychological safety by developing a 'civility and respect' work stream, to emphasise the role of the bystander, raising awareness of the impact of bullying and encouraging people to speak up. The Trust has developed a standardised framework to support learning from incidents and a guide for colleagues and service users on Just and Learning expectations to describe the shared responsibility to create a safe and compassionate environment. For the first year of the scheme, they set three objectives:

- 72-hour reviews: sharing copy of an incident 72-hour report with all members of the relevant teams within a week of it occurring.
- Share good practice stories: good practice stories published every month for learning from things that went well and from those that did not.
- Improve support for employees: publish quarterly data on the Trust website to transparently demonstrate whether staff felt supported when things had not gone as expected.

The Trust worked to embed the objectives into practice within the year and continues to set annual objectives in partnership with colleagues and ambassadors so as to continuously strive for improvement.

The implementation of restorative practice was followed by a reduction in staff absenteeism, staff turnover, suspensions and disciplinary actions; improved incident reporting and in employees seeking support for workplace issues. There has been a 75% reduction in disciplinary investigations since 2016 and 92% reduction in suspensions. The Trust estimated savings of £2.5 million due to higher productivity, reduced back fill costs due to staff suspensions, reduced time to conduct an investigation and reduced legal and termination costs.

Source: Economic Benefits of Restorative Practice report, prepared by Art of Work for Mersey Care NHS Foundation Trust, 24 September 2018.

Key recommendation one

Voice, influence and justice

To introduce mechanisms for doctors to influence the culture of their healthcare organisations and decisions about how medicine is delivered.

- Clinical leaders and managers should consult doctors (and other healthcare staff) and gather feedback about how healthcare teams are established and maintained, how their work is organised and delivered and the response to concerns to ensure a focus on learning not blame.
- The leadership and boards of every organisation employing doctors should establish a key performance indicator for voice and influence and review feedback to assess performance.
- Systems regulators, improvement bodies and suggested partners should check that employers have and are using mechanisms for obtaining and reviewing feedback from doctors about their work.
- The GMC should work with partners listed[iii] to:
  - Support monitoring and assessment of engaging leadership, and just and fair cultures.
  - Assure progress across healthcare teams and organisations in both primary and secondary care.
- Healthcare providers should promote a workplace in which discrimination of any form is not tolerated, by ensuring prompt identification and addressing of issues.
- The GMC should work with partners listed[iv] to confront divisive cultures in healthcare organisations by reporting on progress with implementing the recommendations of the 'Fair to refer?' report.

Work conditions

Evidence from the review

Including private funding, the total cost of training a doctor is over half a million pounds[15], yet many workplace environments are not designed to make best use of their skills. Minor chronic frustrations multiply and steadily sap commitment.

In our conversations with doctors, they described absence of basic facilities and some of these appeared not only inadequate but out of step with employment law (e.g. access to toilets, food, water and taking breaks). Doctors also raised the issue of having somewhere to sleep before driving home after night shifts. We heard of doctors being involved in serious road accidents when sleep-deprived, including some that tragically resulted in death. Doctors told us about the impact of night working and the risks from fatigue, both to patient safety from errors and to personal safety. Yet, many hospitals do not have rest facilities or on call rooms. One doctor told us that they simply took naps on trolleys in the theatre recovery bay or on the floor.

[iii] See action plan in Annex 1.

[iv] See action plan in Annex 1.

The decision by the Department of Health in England to provide funding for doctors' rest rooms is therefore welcome. However, it's important that appropriate facilities are actually provided and that a similar commitment is followed through in all of the four

UK countries[82]. Doctors sometimes have a room but some told us the rooms available in some locations are unfit for purpose as the doors don't lock and they only contain dirty mattresses with used linen. But where good facilities were provided, doctors told us about them in glowing terms.

Doctors repeatedly mourned the loss of the doctors' mess. Such facilities offered a space for doctors to share their difficult experiences in the course of their work, to learn from each other, to provide social support and to laugh and relax. They ensured that doctors could eat well during the course of their work, rather than having to make do with fast food or no food at all – particularly on night shifts. With multidisciplinary working, we are not proposing a return to doctors' messes but a staff canteen, separate from facilities for patients, where doctors can eat with each other and other staff. This creates a sense of being valued, respected and supported by their organisations.

Another frequent complaint was that doctors did not have lockers to put their valuables in, such as coats, wallets, phones and keys. If they did, the lockers often did not lock. Doctors working in surgery told us that they often had to go in search for the right size of scrubs because of inadequate supplies.

There was widespread frustration about inadequate IT systems that meant doctors could not provide the care needed because so much of their time was spent battling with technology – slow systems with out of date or dysfunctional software. For example, doctors talked to us about having to try multiple passwords until they could login to a computer, having computers crash unexpectedly and software that did not communicate between primary and secondary care.

Such basic problems create persistent frustrations for hard-pressed doctors. Medicine is a demanding and stressful profession, so doctors need working conditions that provide them with the facilities to carry out their roles effectively and provide good quality care to patients.

Good practice and case examples

Good workplaces make provision for:

- break times and central locations to take breaks with access to nutritious food and drink, including during night shifts
- places to sleep where appropriate
- lockers to secure belongings
- effective IT systems or support with using them
- support for day-to-day work e.g. the right size, clean scrubs, and somewhere to change
- time and support for essential tasks, such as preparing for appraisal/ annual review of competence progression (ARCP) and revalidation.

This should apply equally in primary and secondary care.

4 Case study
Work conditions

Imperial College Healthcare NHS Trust identified concerns about the facilities available to junior doctors, their wellbeing and their lack of engagement while working in the organisation. The Trust focused on rest and eating facilities; poor involvement with the Junior Doctor Forum; the quality of the doctors' mess; and the sleeping accommodation for junior doctors when on-call, or when too tired to safely travel home.

A group was formed to address the issues, including a junior doctor and senior representation from Medical Education, the Medical Director's Office, Estates, Facilities, Accommodation, and Human Resources. A systematic approach was taken with each of the four main areas identified, using guidance such as the Fight Fatigue campaign materials and the BMA Fatigue and Facilities charter. The actions and consequences are shown in the figure below. Many trusts / boards have similar programmes.

Junior doctor wellbeing, facilities and engagement

Break and rest facilities

Actions
- Inspected each mess, logged all repairs and replaced items as necessary
- Installed reclining chairs on each site
- Purchased food preparation equipment such as microwaves, toaster, kettles
- Installed hot meal vending machines

Results
- Access to food out of hours
- Improved mess utilisation

Junior doctor forum

Actions
- Moved to lunchtime and provided food
- Advertised events in a variety of formats
- Requested executive attendance
- Publicised actions and outcomes
- Improved confidentiality e.g. annonymised minutes, allowed annonymous comments to be sent digitally

Results
- Improved attendance rates

Mess culture

Actions
- Establish a mess committee
- Upgraded bank account (debit card and digital banking)
- Supported committee with communication, finance and administration
- Mess joining process simplified

Results
- Several successful social events organised
- Rising mess membership levels

Sleeping accommodation

Actions
- Established an order of priority for bedrooms depending on shift type
- Reviewed accommodation booking process
- Bedroom reserved for staff too tired to travel home after a shift
- Alternatively taxis home can be authorised by site managers out-of-hours

Results
- Fair and transparent booking system
- Contractual requirements now met

Figure 1: Actions and results in the four areas of focus by the Task and Finish Groups for the facilities available to junior doctors at Imperial College Healthcare NHS Trust.

The group identified early stakeholder engagement, consulting relevant staff groups about changes, and taking an organised and strategic approach as crucial elements to their success. It created inspection checklists and gave joint responsibility to the mess committee and specific members of the medical education team. It produced guidance about how to create or upgrade rest and catering facilities, which has been communicated across the Trust.

Source: Imperial College NHS Trust Junior Doctor Wellbeing, Facilities and Engagement Task & Finish Group Project – AAGBI conference poster by Dr M O'Brien, Postgraduate Medical Education Fellow, Imperial College Healthcare NHS Trust

5 Case study
Managing fatigue effectively

Following the tragic death of an anaesthetist in training, who fell asleep while driving in 2016, the Association of Anaesthetists of Great Britain and Ireland (AAGBI) has worked to address issues of fatigue. It found that many doctors had been in accidents when driving home following a night shift. AAGBI has defined standards for rest facilities and cultural attitudes towards rest in hospitals. Dr Michael Farquhar, a consultant in sleep medicine at Guy's and St Thomas' NHS Foundation Trust has championed its "HALT: Take A Break" campaign. This campaign emphasises the importance of managing fatigue, especially at night. Dr Farquhar has provided guidance on managing night shifts, sleep and fatigue, which employers can use to better protect their staff by providing them with the time, resources and facilities they need to avoid excessive fatigue and stay safe. Suggestions include:

- Providing appropriate rest areas overnight, which allow staff to nap during breaks if they need to.
- Providing beds, free of charge, for post-nights staff who feel too tired to drive home.
- Offering regular screening of shift workers for primary sleep disorders in London.
- Using forward-rotating (day-evening-night) rota designs.
- Minimising frequent transitions between day and night shifts.
- Providing adequate recovery time after nights to re-establish normal wake/sleep patterns.
- Providing basic education for staff at induction regarding sleep and working nights.
- At least 30 minutes of continuous protected rest after approximately four hours duty.
- At least one 30 minute paid protected break for a shift rostered to last more than five hours and a second 30 minute paid protected break for a shift rostered to last more than nine hours .
- Encouraging a team-based 'hospital-at-night' approach, including bleep filtering and policies to permit consistent breaks.

Key recommendation two

Work conditions

To introduce UK-wide minimum standards for basic facilities in healthcare organisations.

- All healthcare employers should provide all doctors with places and time to rest and sleep, access to nutritious food and drink, the tools needed to do their job and should implement the BMA's Fatigue and Facilities charter.
- The leadership and boards of every organisation employing doctors should review facilities to ensure compliance with the BMA's Fatigue and Facilities charter.
- Systems regulators, improvement bodies and partners listed[v] should check that employers have implemented the BMA's Fatigue and Facilities charter in all working environments.
- The GMC should continue to work with partners via the insights and data obtained through their NTS to monitor, assess and support implementation. Where issues are identified, the GMC should work with postgraduate deans, medical royal colleges and employers to ensure they are promptly and fairly addressed.

Rotas and work schedules

Evidence from the review

During our engagement processes, many doctors complained about rotas and shift-work. Having control over your own life, whether in work or outside of work, is a fundamental need. The 2018 NTS found that those reporting low satisfaction with their rotas experienced more burnout and lower satisfaction than those who rated their rotas more positively[13]. Yet we heard accounts of trainee doctors being denied time off work, despite a partner experiencing stillbirth, being in intensive care, or in labour, not being able to book time for their wedding or to attend a relative's funeral. We heard accounts of doctors being told to produce marriage or death certificates to get such time off.

Dr Joanna Poole, an anaesthetic registrar, gathered many such examples from over 400 trainees across the UK[83]. Dr Poole reports sleeping in her car at service stations during rotations when she had a long drive home. She had to use annual leave to attend induction days when starting at a new trust.

Work schedule refers to shift work, night work, rotas, unpredictable hours, and long or unsociable hours. Shift work is known to cause strain to varying degrees[84] with a high level of sleep disturbance amongst those on rotating shifts[85-86]. Fatigue and sleep deprivation (associated with working long hours and shift pattern working) affect error rates and quality of care as well as personal safety[87].

Many doctors have to, or feel an obligation to, work outside their contracted hours in order to ensure patients are getting the care that they need – GP partners particularly. More than half (54%) of secondary care doctors in England say they work more than

[v] See action plan in Annex 1.

10% over their contracted hours in the 2018 NHS Staff Survey in England[8]. Those who reported working extra unpaid hours had lower levels of engagement, less satisfaction with their organisation and were 50% more likely to have been unwell as a result of stress at work during the previous year. Even doctors who worked extra paid hours reported higher levels of intentions to quit than those who did not work extra hours[8].

Doctors told us of widespread problems of poor rota design coupled with increased demand. There was a perception that arbitrary rota decisions are made by people who have no day-to-day contact with those affected by their decisions, and who did not understand the impact that shift work has. This adds to doctors' sense of loss of autonomy and control, and leads to anger and resentment.

Although their contracts state rotas must be available six weeks ahead of the schedule, many doctors told us this was not achieved routinely in their organisations.

We heard that doctors who wish to work flexibly are often treated as an inconvenience. Conflict between work and home life is a widespread problem in healthcare, which impacts on wellbeing[88]. Those experiencing such conflict are up to 30 times more likely to suffer depression or anxiety[89]. Employees who experience depression or anxiety also experience lower job satisfaction, high emotional exhaustion and are also more likely to quit their jobs[90].

And we heard many examples of trainees being posted far from their homes, partners or families. There is a need to review how trainees are allocated to organisations, not least because the current system means that those who perform best in exams tend to be allocated to the most in-demand hospitals, and those who are likely to need most support, struggle to perform or may not do well in an interview are placed furthest from their support network and can be at higher risk of poor wellbeing.

Good practice and case examples

Healthcare organisations need a consistent and enlightened approach to work scheduling and rota design. The BMA's guidance on rostering[91] sets out clear principles that include a transparent and collaborative process for rota design with equal opportunity for employers and doctors to provide input. There is good practice across our healthcare services – for example, we were told that some anaesthetic trainees in Newcastle get their rotas for the entire rotation in advance.

6 Case study
Effective rota management

Brighton and Sussex University Hospitals NHS Trust has a staff rota system that has created greater flexibility and enabled staff to choose their shifts to suit their other commitments, provided all the necessary clinical shifts are covered. As well as providing substantial benefits to patient care, the new approach to rotas has also improved educational opportunities throughout A&E. Benefits have included: being fully staffed, reduced turnover of staff, improved recruitment, reduced returns to A&E following discharge and reduced A&E waiting times throughout the day. The approach has helped the department win the Royal College of Emergency Medicine training Department of the Year 2018.

7 Case study
Locum's Nest app

The Locum's Nest app, which is in use at Western Health and Social Care Trust in Northern Ireland, publishes shift vacancies and allows doctors to volunteer to cover. We heard from doctors working at the Trust that they don't feel pressure to cover extra shifts and, since using the app, there has been a rise of up to 44% in shifts being filled through the use of Locum Nest.

8 Case study
E-Rostering

In Wales, Betsi Cadwaladr University Health Board provides E-Rostering for staff to manage their shifts. Key benefits include:

- Correct staffing levels at the right time to meet the demands for patient care.
- Ensures skill/competence of staff rostered meet service demand.
- Cross-ward visibility enables good management of peaks and troughs in demand.
- European Working Time Directive compliance, providing transparency of shift and rest times.
- Greater fairness and impartiality for staff.
- Enables clarity in relation to financial implications of staffing decisions.
- Automatic payroll feed to ESR to ensure accurate payments to staff.
- Full tracking of sickness, annual leave and training.

All of this is important for wellbeing and a range of other benefits. Analyses from the NHS Staff Survey showed that staff satisfaction with work-life balance was linked with better financial performance of trusts/ boards, lower staff absenteeism, higher patient satisfaction and lower risk of infection rates in hospitals. Such findings highlight the need for evidence-informed initiatives to promote work-life balance and recovery from work.

Key recommendation three

Work schedule and rotas

To introduce UK-wide standards for the development and maintenance of work schedules and rotas based on realistic forecasting that supports safe shift swapping, enables breaks, takes account of fatigue and involves doctors with knowledge of the specialty to consider the demands that will be placed on them.

- NHS England, NHS Wales, NHS Boards in Scotland and the Department of Health (Northern Ireland) should fully implement the BMA's and NHS Employers' Good Rostering Guide (see new deal monitoring guidance in Scotland) in all healthcare environments.
- Healthcare organisations across the UK should develop and maintain mechanisms to enable doctors to report rotas that are not compliant with the BMA's and NHS Employers' Good Rostering Guide (see new deal monitoring guidance in Scotland). Guardians of safe working hours in England should encourage doctors in training to raise exception reports about rostering issues and should monitor such exception reports and take steps to address the issues raised.
- Systems regulators, improvement bodies and partners listed[vi] should check employers have implemented the BMA's and NHS Employers' Good Rostering Guide (see new deal monitoring guidance in Scotland).
- The GMC should work with partners listed[vii] above to monitor implementation of the BMA's and NHS Employers' Good Rostering Guide (see new deal monitoring guidance in Scotland).

[vi] See action plan in Annex 1.

[vii] See action plan in Annex 1.

B – Belonging

B – Belonging

Medicine has always been stressful, and while the stressors have undoubtedly increased, some doctors told us that a key factor is the loss of aspects of a strong community as experienced by some hospital doctors in the past.

Collegial ties offer a significant buffer for doctors from the stresses of their work. But, such collegiate communities must be inclusive and embracing of all the diverse groups of doctors in modern healthcare, as well as other healthcare staff that doctors work with. Doctors work in multidisciplinary teams both in primary and secondary care but the development of those teams within supportive cultures has been slow and patchy[92].

Central to doctors' sense of belonging is the quality of team working and the culture and leadership within their teams and organisations. It is of critical importance that such cultures are inclusive and take account of the needs of all. We deal with each of these interrelated issues in turn.

Team working

Evidence from the review

Teamwork is fundamental to the effective delivery of healthcare and is associated with higher quality care, better staff wellbeing, higher levels of patient satisfaction, and lower levels of avoidable patient mortality. Team working in healthcare is often taken for granted, but we know that the quality of team and inter-team working in healthcare in the UK is often poor[5, 92-95].

We heard feedback from doctors about how modern workplaces with complex rotas often result in them working continually with people they don't know. This can mean nobody notices their presence or absence, except in how it relates to their function on the rota. Ward hopping, where doctors work across multiple wards simultaneously, is common in secondary care and creates feelings of isolation, alienation and vulnerability.

Doctors need the skills to work effectively across multiple teams, but dropping in and out of teams undermines coherence, community and belonging and can create a feeling of always being an outsider. A related observation was that the 'good old days were not that good' with long hours and some difficult consultants, but that doctors were happier because they were surrounded by a stable group of supportive colleagues and could talk about their challenges and difficulties. We heard that doctors sometimes feel easily replaceable, like cogs in the system, rather than valued professionals.

In secondary care, the 2018 NHS Staff Survey in England data suggests that only 40% of staff work in 'real teams' (teams with clear objectives that meet regularly to review performance) despite 96% of staff saying they work in teams[8]. Working in 'pseudo-teams' (that do not have these two basic characteristics – clear objectives and meeting regularly to review performance) is associated with worse staff mental health, poorer care quality, lower patient satisfaction, higher numbers of errors and injuries, and (in the acute sector) with higher levels of patient mortality[1, 5, 92, 94-95]. Our analysis of the data from the 2018 NHS Staff Survey in England, revealed that doctors who worked

in real teams had higher levels of work engagement, and more satisfaction with their organisation and work environment. They also had far lower intentions to quit and were less likely to be unwell from stress.

We must find new ways to enable doctors to work as part of effective and supportive multidisciplinary teams. This will be challenging, but clinical leads and other senior leaders and managers who respond positively to this challenge can make a profound difference to doctors' wellbeing, productivity and to patient care.

Quality of team working is a problem in all sectors of the healthcare system[92, 94-95]. Effective team working in primary care is central to the delivery of high-quality primary care services. Some GPs reported that they are so busy that time for team meetings, reviews of team performance and quality improvement initiatives are sacrificed. Others reported on the experience of working in a dynamic and well-functioning team, and how it makes a large positive difference to morale, wellbeing and practice effectiveness. In the Royal College of General Practitioners (RCGP) Scotland Workforce and Wellbeing survey, half (49%) of respondents felt that more opportunities for team building and learning within their practice would be the best approach to improving their wellbeing[12]. With the advent of more integrated systems in healthcare, inter-team working is increasingly central also. We also heard that GPs face significant communication challenges with managing the interface with secondary care, and those challenges reveal a lack of understanding of roles and skills between primary and secondary care. They valued support from system bodies to enable them to focus on effective team and inter team working and leadership, including peer coaching and mentoring. Some GPs felt the First Five programme run by the RCGP could be adapted, adopted and extended to include all GPs.

For trainees, multiple rotations were reported as having a significant impact on wellbeing, undermining their ability to be a member of any team or embedding into an employing organisation. Multiple rotations also fracture continuous supervision and prevent the development of stable peer networks. The impact may be greater on trainees from some groups, including BME and international medical graduates (IMG) but also disabled doctors, for whom forming relationships may take longer[42].

Good practice and case examples

Good practice would see all medical students, doctors and doctors in training belonging to a stable 'home team' or 'lead network' (where possible – multidisciplinary) that enables:

- involvement in quality improvement initiatives
- clarification of roles and responsibilities
- a sense of belonging and social support
- a space to discuss challenges, difficulties, frustrations
- a space for supportive supervision
- opportunity for appreciation and recognition

- peer coaching and mentoring
- professional development
- leadership development and teamwork training.

Face-to-face multidisciplinary team working should be the first choice. Teams need stability of membership to become cohesive, time for meetings on the rota, accessible space to meet and ways of involving all team members. Social interactions such as shared coffee breaks, meals and celebrations also build a sense of cohesion and psychological safety[96].

Doctors need training and on-going support to continuously develop their multidisciplinary team and team leadership skills from the beginning of their undergraduate education onwards. The Generic Professional Capabilities framework sets out the competencies for team working and leadership. Team leadership should be included as part of a doctor's appraisal/ARCP for developmental purposes. It is also essential that there is a strong focus on wellbeing and the support available to appraisees in annual appraisals.

9 Case study
Multidisciplinary 'board rounds'

Board rounds at Sandwell and West Birmingham Hospitals NHS Trust are scheduled daily. These are multidisciplinary team discussions on patient care that include as many members of the team as possible. Board rounds can be used to share information from relatives, prioritise tasks, delegate responsibilities and maximise the effectiveness of time spent with the patient. Each patient can be discussed in under a minute – including presenting complaint, diagnosis, management plan and expected discharge date – so most wards can complete them in 20 to 30 minutes. The board round discussion determines an integrated management plan with estimated discharge date and criteria for discharge. The ward round is punctual, held in a confidential space, well-chaired, and each member of the team leaves with clarity about their tasks. A large screen provides extensive patient information so that anyone can pick up mistakes or key information. All rounds are completed by 9.30am to provide information to other points in the hospital. The software package can be accessed from any Trust computer by clinical teams (to aid patient care) and by operational managers (to assist with bed capacity planning). Consultant job plans have been adjusted to account for these working arrangements as consultants are expected to attend board rounds four out of five days a week.

10 Case study
General practice team working

The general practitioners (GPs) working at Jubilee Medical Practice in Leicestershire make time to discuss cases and issues together as a team. This helps boost confidence and a sense of working inclusively, and their data suggests the approach has significantly reduced referral rates.

The Nuffield reports on a practice in Norfolk that created a team of nurse practitioners to manage urgent care and home visits, as well as substitute roles to shift workload away from GPs.

In the North West of England, GP practices facing a serious recruitment challenge came together and developed a new multidisciplinary team including pharmacists, paramedics and mental health workers. Their offer of sustainable, innovative, high-quality care has also led to an increase in numbers of GPs applying to work there.

11 Case study
Team working in a crisis

Hywel Dda University Health Board saw a reduction in cardiac arrest calls in acute adult general wards after integrating multidisciplinary team working principles into a medical simulation programme for support staff, nurses and junior doctors. This encouraged good team working and reflective discussions, where all contributions were valued. Resuscitation team leads reported that feedback and reflection among the clinical staff following incidents was a powerful learning process leading to more effective care.

12 Case study
Multidisciplinary team working

Barts Health NHS Trust is ensuring its leadership teams (combining nursing, AHP, scientific, managerial and medical staff) have protected time, skilled facilitation and team coaching to build team effectiveness. Aimed at both clinical and managerial staff, its ‘Super T’ team development programme has seen improvements in its staff survey scores, particularly in relation to engagement – the key staff survey predictor of trust performance in England. Space for reflection and learning is cited as a core benefit of the programme, and all teams continued to prioritise team time for reflection beyond the duration of the formal programme. A key benefit, identified by the organisation, was that the programme enabled much-improved matrix working and collaboration across the leadership teams of all parts of the Barts Health group of hospitals.

For GPs in small practices, team working may be challenging currently, but in primary care, there are clear links between the quality of team working, quality of patient care, patient satisfaction and staff wellbeing[97-98]. Professional forums are also needed to develop and sustain inter-professional relationships to address difficulties in working across primary and secondary care. With the advent of primary care networks in England, it should be a priority to develop supportive teams enabling peer coaching, social support, mentoring, quality improvement initiatives and action learning groups[99]. With the scale that Primary Care Networks will create, it will become easier to build effective multidisciplinary team working as the Haxby case example in the workload section below shows.

The new Scottish General Medical Services Contract came into force in 2018 and aims to reduce GP workload through the expansion of the primary care multidisciplinary team. This is supported by the Scottish Government's strategy for primary care. A key part of this is the introduction of GP clusters – professional groupings of GP practices, represented by practice quality leads feeding into cluster quality leads. The latter have responsibility to provide a quality improvement and leadership role, and they will liaise between practices and the NHS Board on quality improvement issues[100]. GP clusters have also been introduced in Wales, supported by Health Boards, and are designed to enable GPs and others within a locality to collaborate[101]. Northern Ireland has established GP Federations with two main aims, to support and protect GP practices and to help deliver the transformation agenda in Health and Social Care. There are currently 17 GP Federations owned entirely by GPs and covering all areas of Northern Ireland[102]. These changes should be accompanied by the provision of training for leaders in building effective team and inter-team working at every level.

NHS and primary care working arrangements must develop, prioritise and sustain effective team working, make provision for it (for example by ensuring high-quality support for team leaders) and provide areas where regular team meetings can take place. Teams that regularly take time out to review and improve their performance are far more effective and innovative – such timeouts increase productivity by an average of 38% and substantially improve doctors' health and wellbeing[103].

All must rise to the challenge of practising effective team working in medicine, given the evidence of the enormous benefits for doctors' productivity and wellbeing and for their patients.

Key recommendation four

Team working

To develop and support effective multidisciplinary team working across the healthcare service.

- All healthcare organisations should review team working and ensure that all doctors are working in effectively functioning and, ideally, multidisciplinary teams. The teams should have a shared purpose and clear objectives (one of which is team member wellbeing). Team members should be clear about their roles and meet regularly to review their performance, including inter-team/cross-boundary working. Quality improvement should be a core function of all teams.
- The leadership and boards of every organisation employing doctors should establish a key performance indicator for effective team working and obtain and review feedback to assess if all doctors are part of a well-functioning team.
- Systems regulators, improvement bodies and partners listed[viii] should check that employers are ensuring that doctors are working in well-functioning teams.
- The GMC should work with other professional regulators to develop guidance on multidisciplinary team working in modern healthcare environments.
- Healthcare systems should develop appropriate support and materials to ensure the continued development of teams in both primary and secondary care.

Culture and leadership

Evidence from the review

Organisational cultures can have a great impact on the wellbeing of staff[104]. Changes to work organisation such as restructuring, staff reductions and the introduction of temporary work, take their toll on staff[105-106]. 'Change fatigue' has also been highlighted as work intensifies and increases the risk of burnout that can lead to 'learned helplessness' and feelings of alienation from the healthcare system. The burden of the requirements of multiple regulators exacerbates this, particularly for GPs.

There are many positives reflecting doctors' commitment to their work: 65% of doctors in Wales[10] and 59% in Northern Ireland[9] reported looking forward to going to work always or often in the NHS Wales Staff Survey 2018 and HSCNI 2015 Staff Survey. This was higher than NHS staff as a whole – 60% and 57% in Wales and Northern Ireland respectively[9-10]. 73% in both countries were enthusiastic about their jobs. In the 2018 NHS Staff Survey in England, around two-thirds of doctors look forward to going to work, three-quarters are enthusiastic about their jobs and their ability to do their jobs to a standard they are personally pleased with[8].

On the other hand, data from these national surveys show concerns from doctors across the UK about the culture and leadership of their employing organisations. These findings suggest that the cultures of NHS organisations are not effectively meeting the needs for autonomy, competence and control among doctors.

[viii] See action plan in Annex 1.

- Restructuring: doctors in England told us they had concerns about repeated restructuring and reorganisation of NHS services at regional and national level.
- Organisational values: at the same time, only 62% of doctors in Wales and 56% in Northern Ireland would recommend their organisation as a place to work in the NHS Wales Staff Survey 2018 and HSCNI 2015 Staff Survey respectively. Only 65% felt that patient care was their organisation's top priority in both countries[9-10]. Only 36% of doctors in Wales believe their organisation is committed to helping staff balance their work and home life[10].
- Support from senior management: in the NHS Wales Staff Survey 2018, though 63% of doctors were satisfied with the support they received from their immediate manager, this still means that more than one in three were not satisfied[10]. 54% of doctors in Northern Ireland were satisfied[9]. In both countries, fewer than one in three say senior managers appreciate what it is like to work on the front line, that they lead by example, and that communication between staff and senior managers is effective[9-10].
- Other support: most doctors in Wales complain of lack of timely information to enable them to do their jobs well and of poor interdepartmental cooperation. Just over one in three (36%) can meet all the conflicting demands on their time at work and only 18% say there are enough staff for them to do their jobs properly[10]. Doctors in England in the 2018 NHS Staff Survey report a lack of involvement in changes affecting their work (55%), a lack of adequate materials, supplies and equipment (50%), and, as in Wales, one third say their teams do not meet frequently to discuss the team's effectiveness[8].

We heard consistent feedback about environments where leadership was remote from staff, where pressures fuelled by lack of resources led to bad behaviour that cascaded down the organisation from the top, and where staff did not feel valued by their leaders. There was widespread reporting that the standard response to safety failures was to blame individuals rather than develop systems to avoid recurrence.

For example, Scottish Government brought in the organisational duty of candour, which came into force in Scotland in April 2018, to implement consistent responses across health and social care providers to an unexpected event or incident that has resulted in death or harm[107].

These issues also relate to doctors working relationships with each other. In our engagement across the UK we heard of examples of a minority of doctors treating trainees and medical students aggressively or rudely. For example, following the Sturrock review on bullying and harassment at NHS Highland[108], the Secretary for Health and Sport set up a Ministerial Short Life Working Group for the learning to apply across Scotland to build supportive cultures that engender and encourage the right behaviours[109]. The report made specific proposals on leadership; peer support; and training management and HR work, to achieve a new behavioural and attitudinal approach. Whatever the pattern in the past, such behaviour is inconsistent with a modern compassionate healthcare workplace or with good medical and educational practice and can constitute bullying.

These are all issues of organisational culture, revealing some positives but many aspects of culture that undermine doctors' wellbeing. Changing such cultures is critical to transforming work environments and improving doctors' wellbeing.

Good practice and case examples

Doctors who reported feeling empowered and having supportive leaders, being part of a team, and having adequate job resources had dramatically higher levels of wellbeing.

How can the leadership of NHS organisations nurture such cultures of high-quality, continually improving and compassionate care and, at the same time, ensure the wellbeing and intrinsic motivation of all the diverse doctors that they lead (and of course all staff)? Research within the NHS suggests these are interdependent outcomes and that there are key cultural elements that must be present[110-111]. Compassionate and inclusive leadership are central and these too are described in Annex 4.

13 Case study
Changing cultures in the NHS

A programme of successful culture change is being implemented across all four UK countries.

NHS Improvement (NHSI), the Center for Creative Leadership and the King's Fund have developed a programme to enable healthcare organisations to develop cultures that enable and sustain continuously improving, safe, high-quality, compassionate care[ix]. All the materials are evidence-based, open-source and designed to be implemented by healthcare organisations rather than external consultants. The programme provides practical support to help healthcare organisations in primary and secondary care to diagnose their cultural issues, develop compassionate and inclusive leadership strategies to address them and implement any necessary changes. There are currently around 100 trusts and boards across the UK implementing the programme, including organisations in Wales (Aneurin Bevan), Scotland (Tayside) and Northern Ireland (Belfast). The resources are also being used internationally. Similar models have been developed in the US by the Mayo Clinic (Swensen et al., 2016; Swensen & Shanafelt, 2017). Many of the organisations involved have demonstrated success in changing culture.

Another example of success is Frimley Health NHS Foundation Trust, rated as good in 2019 by the CQC. It acquired the struggling Heatherwood and Wexham Park Hospital and initiated a culture change programme, after carefully assessing the culture of the new acquisition. The programme involved some 600 line managers training to focus on high quality, continually improving and compassionate patient care. More than 700 leaders went through a new training programme. 72% of staff recommend the hospitals managed under the Trust (Frimley Park, Heatherwood and Wrexham) as a good place to work.

[ix] https://improvement.nhs.uk/resources/culture-and-leadership/
https://improvement.nhs.uk/resources/culture-and-leadership-programme-phase-2-design/

14 Case study
Developing clinical leadership

The Newly Appointed Consultants (NACs) programme in Manchester University NHS Foundation Trust started in February 2013, with over 250 consultants attending the programme. Over 11 months, it provides newly appointed consultants with the skills, behaviours and mindset to lead and make improvements across the Trust. The programme is also designed to promote their wellbeing, by supporting their transition into leadership roles. Participants are encouraged to embark on service improvement projects, enabling them to directly influence working practices and implement change. One improvement project introduced new minimally invasive endoscopy to provide a walk-in-walk-out procedure under local anaesthesia. For patients, this eliminated the risk of general anaesthesia and enabled them to return to work and normal life on the same day. It also released beds and theatre space. The new procedure was recognised through an award and additional funding at the senior management level in the Trust.

The Clinical Leadership Programme (CLP), started in October 2018, is building on the principles in the NACs programme. It is aimed at senior clinicians who are able to shape culture, develop high-performing teams and work across boundaries. It looks at their approach to conflict and the management of professional relationships with colleagues. This supports clinicians by building positive relationships and creating a community of networks long after programme completion to sustain engagement.

Key recommendation five

Culture and leadership

To implement a programme to ensure healthcare environments have nurturing cultures enabling high-quality, continually improving and compassionate patient care and staff wellbeing.

- All UK healthcare organisations that have not already done so should commence and implement a programme of compassionate leadership across all healthcare sectors and obtain feedback from doctors and healthcare staff to evaluate its effectiveness. It should include mechanisms to ensure clinical leads and other leaders of doctors at all levels in the healthcare system are recruited, selected, developed, assessed and supported to model compassionate and collective leadership.
- Leadership and boards of every organisation employing doctors should introduce a key performance indicator for compassionate leadership and should review feedback from doctors and other healthcare staff to assess if leadership is compassionate and collective.
- System regulators, improvement bodies and funding and commissioning bodies should check that employers have in place mechanisms to support compassionate leadership. Regulators and quality improvement bodies to review how to improve regulatory alignment and ensure compassionate leadership is sustained in the longer term by integrating it as a priority into their regulatory models.
- The GMC should work with partners listed[x] to monitor and assess implementation and maintenance of such changes to cultures and leadership across the system.

[x] See action plan in Annex 1.

C – Competence

C – Competence

Doctors want to make a positive difference through their work by achieving valued outcomes, such as delivering high-quality care that improves patients' lives. The need for competence is met when workloads do not exceed the ability of staff to deliver this high-quality, safe and compassionate care. This also involves ensuring that doctors and students have enabling and supportive supervisory support focused on removing the obstacles in the workplace, rather than creating directive, controlling cultures that focus more on blame rather than on learning and accountability. Doctors need to be continually enabled to grow as practitioners, developing and learning so that their skills and competence are constantly improving.

We address each of these issues in turn below by reference to the evidence from the review, good practice, case examples and, finally, our key recommendations.

Workload

Evidence from the review

Excessive workload is the number one factor affecting poor patient satisfaction, low levels of staff engagement and failure to innovate. It is also the key factor determining doctors' stress levels[8, 112-113]. Previous research[30] has identified workload as the most consistent influence on strain amongst healthcare workers[xi].

Our research and the feedback we heard from doctors show that unmanageable workloads are damaging doctors' health and exposing patients to potential harm. The challenges doctors face relate to the pace of work, multiple concurrent demands, long hours, administrative burdens, role ambiguity and the emotional toll of working with illness and trauma in unsupportive environments. It is unsustainable to expect doctors to continue to take on ever-increasing demands when there is consistent evidence that they (and their fellow healthcare professionals) are, in many instances, unable to cope with a toxic cocktail of excessive demands and inadequate support.

Of the 4,605 responses to the iMatter staff survey in Scotland from medical and dental staff, only 37% agreed or strongly agreed they could meet all the conflicting demands on their time at work and only 31% said that there were enough staff to enable them to do their job properly[114]. In the most recent NHS Wales Staff Survey, the respective figures were 36% and 18%[10]; in the 2018 NHS Staff Survey in England, 37% and 29%[8]; and in the HSCNI 2015 Staff Survey, 33% and 24%[9].

Many trainers in the NTS reported heavy workloads, and that they regularly work beyond their rostered hours. 66.3% UK-wide describe the intensity of their work through the day as heavy or very heavy. This is twice as many as those who consider the intensity of their workload to be 'about right'. There is a strong correlation between how trainers rate the intensity of their workload and the provision of time to train[13].

[xi] Although this research was published some 20 years ago, it remains the highest quality study of staff stress in the NHS to date. The available evidence suggests that little has changed in that time in terms of levels of staff stress or the key factors that determine levels of stress.

The demands on GPs have increased substantially over recent years. They are treating more people with more complex problems than ever before and the number of GPs in the UK has has not kept pace with patient demand[, 115, 116]. We heard repeatedly that relentless seven to ten-minute consultation times are stressful for GPs and not productive for patients. The number of sessions that GPs undertake, often with no time for toilet or other breaks, increases intensity to unsustainable levels and, associated with the fear of making mistakes, leads to burnout. It has also damaged relationships with patients, some of whom feel they are being dealt with in a cursory way[116].

Around nine out of 10 GP trainers in the UK work beyond their normal hours on at least a weekly basis and more than half work beyond their hours daily[13]. This is a much higher proportion of trainers than in any other specialty. These heavy workloads have a negative effect on GP trainers' health and wellbeing. Two thirds (67%) often or always feel worn out at the end of the working day. Over half (52%) find their work emotionally exhausting, and over one in five (23.1%) report feeling exhausted at the thought of another day in work[13].

These findings are particularly concerning in the context of recent research by Mind[117], which found high levels of mental health concerns among GPs in England and Wales. The charity identified excessive workloads and long hours as two of the main drivers of these concerns.

When asked to rank the top five reasons for why the NHS was having difficulties retaining medical staff, the most commonly mentioned by doctors was excessive workload pressures (78%)[118]. In the 2018 NHS Staff Survey in England, among those doctors who said they would not always be confident in raising concerns about patient care, the main reason given was workload pressures making it difficult to find the time[8].

While volume of work is a key issue, there are also issues about excessive bureaucracy, unnecessary administration, unwarranted variation in practices and processes, and unnecessary hierarchical constraints[119]. For example, some doctors told us they were denied time to meet as teams in the fundamentally mistaken assumption that this will reduce rather than increase their productivity.

In secondary acute care, we heard about doctors being asked to carry multiple bleeps, cover multiple wards and simultaneously respond to life-threatening issues among their patients. The level of work overload, stress, anxiety and fatigue combine to reduce their cognitive function and produce decision fatigue thus further endangering their wellbeing and patient care[120].

Part of the problem is operational, and researchers have commented that good clinical workflow is the sum of a multitude of small processes which individually may seem insignificant or even trivial[81]. Together, they make the difference between a highly functional practice model and one that is chaotic, overloaded and stress-inducing. Clinical excellence depends on operational efficiency. In healthcare environments there is no team of engineers whose job it is to ensure a 'manageable cockpit' for clinicians, one that is free of information overload, distractions, interruptions, and cumbersome workflows that cumulatively contribute to a hazardous environment[121]. No one is responsible for analysing and minimising the aggregated administrative and cognitive burdens with the result that though the core work is satisfying, it is often simply crowded out[81, 121].

Related to work overload is work pace, especially where the clinician has little control over the number of patients (for example in emergency medicine); or time pressures, such as having to complete tasks within a specified period. Tasks with high repetition and short time cycles (as in general practice) are likely to result in high levels of stress (the combination of high demands and low control is particularly toxic). Other risks are repetitive strain and musculoskeletal disorders if office ergonomics are neglected[122]. What then are the solutions?

Good practice and case examples

A vital element of leadership is addressing courageously and persistently the key factors impacting upon the core mission of medicine and healthcare. This means senior management devoting attention to the most significant challenges, like workload. This will require a fundamental shift in the way we deliver medicine – transformational and innovative approaches. This is the responsibility not only of clinical leads but of all leaders and managers.

15 Case study
Jointly reducing workload

East London NHS Foundation Trust (ELFT) is a provider of mental health and community services, to a population of approximately 1.5 million people. In 2013, the Trust reviewed all clinical audits with a group of stakeholders, including service users and staff, to identify which really added value. This allowed it to stop 85% of all audit activity and led to a broader campaign to encourage people to identify non-value-adding activity. In May 2014, the Trust invited every team to identify activities that provided little value to patients or staff. The participation was high, and the Trust grouped the responses received into three themes: ideas related to duplication of meetings; unnecessary travel to Trust HQ for training; and duplication of recording clinical information. The Trust acted on those three areas, trialling combining meetings or even stopping them all together; having a group work on provision of training; and absorbing feedback into existing clinical transformation workstreams and systems configuration. The Trust then further encouraged all teams to have a discussion, using an introductory podcast from the senior management team to help identify something they spent time on that added little value. This involved discussing:

- What would you like to stop?
- Would you like to stop this completely, reduce it or change the way you do this to be more efficient?
- How much time do you estimate you will save (each day / week / month)?
- Have you involved patients and families in thinking about which activity to stop?
- Have you involved all your staff in thinking about which activity you might wish to stop?

In March 2017, a campaign at ELFT encouraged all staff to "break the rules". Staff were encouraged to highlight any bureaucratic and unnecessary rules that could be eliminated to focus more on what was important and valuable to service users, carers and staff work. Over 100 unique ideas were submitted. All of the ideas raised were shared with staff on the intranet, who were encouraged to vote for their favourite. Over 600 members of staff voted for their favourite suggestions (the biggest response seen in the Trust). The leadership team considered all of the suggestions and shared responses daily through the intranet on the ideas submitted and on how the system was being redesigned to make them possible.

Governments throughout the UK have made efforts to recruit and train more doctors and healthcare professionals. Recruiting more into the system will reduce workloads and allow greater role variation. This is necessary so that they can undertake the education, training, teambuilding, supervision, coaching, mentoring and academic research that is critical to their roles. Variation enhances wellbeing and job satisfaction and will sustain them in medical practice for the longer term[120].

As the think tanks the Nuffield Trust, The King's Fund and the Health Foundation have made clear, urgent action is needed to tackle severe staff shortages in the NHS[7]. This includes a big expansion in nurse training, deploying other staff to make up for the existing growing shortfall of GPs and accelerating the recruitment and training of physician associates.

In England, the People Plan is focused partly on ensuring more doctors are trained and recruited for primary and secondary care[123]. Similar efforts are underway in the other UK countries. For example, in Scotland, the aim of the Health and Care (Staffing) (Scotland) Act is helping to ensure appropriate staffing. The Act creates a new statutory duty on the geographical Health Boards, the Common Services Agency for the Scottish Health Service, and the four Special Health Boards that deliver clinical healthcare services to ensure that there are appropriate numbers of suitably qualified staff providing care, alongside guiding principles to be considered when carrying out this duty[124]. The Scottish Government's three-part National Health and Social Care Workforce Plan (preceding the integrated workforce plan and covering NHS Scotland, social care and primary care) sets out a range of short, medium and long-term measures[125]. And the National Clinical Strategy for Scotland published in 2016 made proposals for how clinical services need to change in order to provide sustainable health and social care services fit for the future[126].

Increasing the number of medical school places is a core issue being addressed across the UK. For example, in Northern Ireland, the Review of Medical School Places was one of the early actions of the Health and Social Care Workforce Strategy 2026: Delivering for Our People. The intent was to determine the future numbers of medical education training places that should be commissioned in Northern Ireland[127]. Wales is consulting on its workforce strategy until 2030, looking at supply and retention[128]. Train Work Live has been a successful campaign in Wales aimed at increasing recruitment of healthcare professionals[129].

Recruitment and retention of doctors is a problem that impacts most healthcare providers globally[130] and the NHS recruits globally to meet its staffing needs – more than 13% of the 2018 NHS workforce in England were not British[131].

We heard about schemes (Learn Earn Return and the Medical Training Initiative) that invite doctors from overseas for a specified period to develop key skills and then return to their country of origin. It is also vital that doctors recruited globally are supported in a way that enables successful transitions into the NHS and UK cultures.

We also heard about obstacles for doctors in the UK trying to return to work after a break, particularly for GPs needing a supported return to work after a break from practice due to ill health or regulatory intervention.

16

Case study
Recruit from other countries

Learn, Earn, Return is a collaboration between Health Education England (HEE), the Greater Manchester Health and Social Care Partnership, Edge Hill University and Wrightington, Wigan & Leigh NHS Foundation Trust. Doctors with at least four years' experience come to the UK for a master's degree. The course fee is paid by the doctor though other arrangements are sometimes available. Doctors will be employed full-time in NHS Hospitals. At the end of the course, they return to their country of origin with greater career opportunities. The programme has been offered since 2006, and the uptake is continuously increasing. Part of why the programme has been successful is the great attention paid to pastoral and cultural care of the doctors. NHS consultants, often from the same country, are personally involved in interviewing, recruiting, welcoming, teaching and looking after the participating doctors.

Training and recruiting more doctors needs to be supported by changes to the way medicine is delivered to increase the support for and thereby the productivity of doctors. There must also be a bolder move towards deploying alternative professionals in multidisciplinary teams to build a mixed skill set for use on the frontline of medicine, in both primary and secondary care. Many tasks that are currently done by doctors can be transferred to other professionals (such as physician associates and advanced nurse practitioners, pharmacists, physiotherapists, mental health practitioners, social prescribers, medical assistants and volunteers) working both in specialist units (e.g. phlebotomy teams) or in multidisciplinary teams[132]. There are potential benefits for all from more flexible ways of working, enabling skill development, task variety and reduced workload[133].

We heard about alternative professionals both overseas and in the UK being used to free up time for doctors by taking notes and preparing referral letters; running preventive programmes on diet, smoking and exercise; filtering patient requests; conducting multidisciplinary triage; dealing with normal screening results and repeat prescriptions; doing pre-appointment work to obtain information on medication, allergies, care gaps and reason for visit; and nurses treating some problems using standardised approaches. These changes allowed for longer consultations increasing doctor satisfaction and patient care.

17 Case study
Task shifting in primary care

In 2015, three GP practices serving St Austell in Cornwall decided to merge, absorbing 12,000 patients from the biggest practice in the locality, which had closed in 2014. The merged practice looked at every element of its work through an audit to fine-tune the doctors' workload.

This led to the recruitment of other healthcare professionals, including a community psychiatric nurse, a physiotherapist and a pharmacist. The merged practice aimed for people to be seen by the appropriate level of clinician for their concern, to ensure patients were seen in a timely manner due to lack of GPs in the area.

Recruitment also included administrators who managed its estates and premises, finances, governance, complaints, the practice website, and communications with patients and staff.

The wide range of skills among non-clinical staff supporting the clinicians enabled everyone to specialise in fewer areas of expertise rather than spread themselves across several roles and responsibilities. As a result, each GP is responsible for 3,800 patients vs. 2,200 patients in the rest of Cornwall.

This redesign process was managed by an executive group with one partner from each original surgery and the managing partner. Key decisions were taken at the partners' meeting once a month. Anyone from the practice could attend these meetings and the whole process has developed trust and strong collegiate relationships.

18 Case study
Task shifting in surgery

To combat issues surrounding workload, the Royal College of Surgeons of England developed the role of doctors' assistants. They successfully piloted the role at East Sussex Healthcare NHS Trust by employing five doctors' assistants on six-month secondments. These individuals, who were previously healthcare assistants, received a two-week induction, supervision and on going support. They undertook administrative and basic clinical tasks at the direction of doctors on-call or in acute clinical areas. Feedback from doctors, doctors' assistants and other staff was highly positive, with some doctors saying they would not have coped on a weekend shift without them.

Mrs Scarlett McNally, Consultant Orthopaedic Surgeon and RCS Council member who led the pilot, said the important aspects were excellent skills training, a clear task list, good communication, prior experience in a clinical area and support given for the change of role.

Important improvements can be made through clinicians undertaking workflow mapping, modifying work schedules to increase appointment times and reduce work intensity. Developing an ability to monitor time, volumes and administration demands within work processes (sometimes called 'manageable cockpits' after similar successful interventions in the aviation industry) provide a means to monitor workflow and effectiveness on an ongoing basis[121].

At the most basic level, we heard that this requires access to an up-to-date computer that can run the relevant software; computers on wheels that are working and fully charged; a system to report IT errors that ensures issues are dealt with promptly; WiFi without black spots; handheld devices (for observations etc) to be available and charged; a single sign-on password system; patients' case notes available; effective electronic prescribing; relevant stationery available prior to the successful introduction of the electronic patient record (EPR); equipment needed for clinical examinations such as tendon hammers, ophthalmoscopes and auroscopes; a desk to write notes and review test results; and some freedom from non-urgent interruptions from patients, families and other staff.

This suggests that deploying an administrator in clinical units on all shifts, with responsibility for these issues would significantly increase productivity and satisfaction among doctors and other healthcare staff.

19

Case study
Workload in General Practice

The Haxby Group[xii], which cares for 50,000 patients across York and Hull, found it was overwhelmed by excessive workloads. Its aim was to ensure a sustainable workload for GPs while maintaining high-quality patient care.

The solution was to develop the GP role to focus on complexity (with the time to do it) and become effective leaders of multi-disciplinary teams. The large size of the Group enabled it to focus on the governance required, to allow lower-risk investment, ensure good HR, finance and business intelligence and release GPs' time to manage the changes.

The Group now employs eight pharmacists, eight paramedics, five nurse practitioners and a physiotherapist. The tasks of prescription management, urgent care, home visits, reviewing letters and results, have been largely transferred to other professionals. GPs are available to discuss or review patients and provide mentorship and oversight to the rest of the team.

Quality of care and patient satisfaction is high and GPs now have 15 minutes for routine appointments.

[xii] While the size of the Haxby Group means that it does not reflect the usual UK primary care model, how it has tried to address workloads on a scale points to approaches that may be possible by collaborative working with the scale that Primary Care Networks will introduce in England (practice ongoing in Scotland and Wales through GP clusters and in Northern Ireland through GP Federations).

We also heard about innovative uses of technology to free up doctors' time to support more sustainable working. These include using automated chat services and phone and video consultations.

Case study 20
Releasing doctors' time

University Hospital Birmingham is using new technology to enable patients to access live and automated chat services, online symptom checkers and video consultations with doctors and nurses to dramatically reduce the pressure on services. Patients planning to go to A&E will be asked to do a two-minute online check of their symptoms before going to hospital. An artificial intelligence triage system will advise them if they need to seek treatment at A&E. This is intended to reduce workload in the A&E units at its four acute hospitals in Birmingham, by dramatically reducing the current 30% of 'avoidable attendances'. The Trust also plans to enable patients to talk to their consultant using their phones, and not have to attend physically for an outpatient appointment. It estimates it can implement this approach with 70% of its two million outpatient appointments within three years. Such innovations reflect similar practices in healthcare within the UK and internationally.

Other changes that appeared to have a great impact were those that enhance communication between healthcare professionals. Relocation of staff so teams are co-located, frequent team meetings, leader updates, regular doctor and leader meetings to discuss concerns and daily multi-professional team huddles to review the patient list appear to significantly improve productivity, staff satisfaction and wellbeing[81].

In the 2018 RCGP Scotland workforce and wellbeing survey, doctors made many suggestions for how to tackle GP workload, including improving IT, reducing bureaucracy, ensuring more time with patients, developing a culture that protects time for learning, having breaks, improving multidisciplinary team working, having time for reflective practice and increasing the say GPs have in their local health and social care system[12].

Key recommendation six

Workload

To tackle the fundamental problems of excessive work demands in medicine that exceed the capacity of doctors to deliver high-quality safe care.

- All organisations that oversee the work of doctors should undertake, in collaboration with doctors, a programme to review workload in their organisations. This will help them to use resources in the most efficient way, to ensure workloads do not exceed doctors' ability and capacity to deliver safe, high-quality care. Initiatives are underway across the UK to increase staffing numbers and this should be supported by additional solutions including, but not restricted, to:
  - A programme to deploy and develop alternative roles to enable doctors to work at the top of their competence, supported by effective multidisciplinary team working in all areas of healthcare, and to support doctors to return to work after a break in practice.
  - A review of new technologies being used in UK healthcare systems to increase efficiency (see case studies), working with the voluntary sector, and focusing on preventive care.
  - A programme of process improvements that increase productivity especially by supporting communication in regular team meetings between healthcare staff (see case studies).
  - Eliminating tasks and activities that do not add value to patient care or doctors' wellbeing.
  - Engaging communities, community representatives and patients in taking shared responsibility for their health services.
  - Identifying services that cannot be provided in a resource-constrained system and unnecessary processes that do not add value.
- The leadership and boards of every organisation employing doctors should review programmes to address excessive workload and monitor their impact.
- Systems regulators, improvement bodies and partners listed[xiii] should check that employers have in place programmes to address excessive workloads and to monitor them to ensure improvement.

Management and supervision

Evidence from the review

Unlike other healthcare staff (and people working in organisations generally), doctors often do not have a line manager. For many doctors, including doctors in training and some specialty and associate specialists (SAS) we spoke to in England, they are disempowered within the existing hierarchical system. A picture emerged of isolated working patterns, not being part of a team, a lack of connection to clinical leads and seniors, absence of line management and inaccessible rota managers. Consequently, many doctors have nowhere to go with the day-to-day challenges of their working lives. This fundamentally weakens their sense of belonging, feelings of competence and their sense of control.

[xiii] See action plan in Annex 1.

Doctors' need for autonomy/control does not imply independence or lack of accountability. At the same time, being managed by people who are challenging, aggressive, intimidating and who cause conflict has a detrimental impact on the mental health of doctors. Compassion and encouragement from clinical leads, line managers and senior management has direct benefits for the mental health of doctors and for wise allocation of workload, control of access to resources and the provision of appropriate supervision[133].

For example, the system of exception reporting introduced in England after the junior doctors' strike in 2015-2016 does not appear to be enabling doctors to manage their work time effectively. Out of 33,000 exception reports in the year to September 2018, only 2.5% led to service or rostering changes. Half of these were made at just three trusts – Barts Health, The Newcastle Upon Tyne Hospitals Foundation Trust and Royal United Hospitals, Bath[134]. Exception reporting is a process that exists only in England, and, while the GMC has consulted doctors in training about rota monitoring in Scotland, Wales and Northern Ireland, the data demonstrating how it is working in practice isn't available. In Scotland, the BMA and the Scottish Government jointly agreed the New Deal Monitoring Guidance for doctors in training. This aims to implement an accurate, fair, robust, and consistent approach to monitoring the hours that trainees work[135].

In a pressured modern workplace, lack of support of and no access to a line manager has a negative impact on the work experience of doctors in relation to their core work needs. As one doctor commented: "…there are times when the senior support does not exist, and that's when it can become stressful, when you're searching for consultants and registrars you don't know, and they don't know you."

Good practice and case examples

There is considerable evidence of the importance of good supervision for care quality and for doctor wellbeing[136-138]. The GMC NTS data reveals that having a good educational supervisor both in primary care and secondary care buffers the negative effect of working beyond contracted hours on burnout. Trainees experienced the least burnout when they worked only their contracted hours and were satisfied with their supervisor[13].

Because many clinicians across the UK reported difficulties in finding the time to fulfil their supervision roles, supervision time must be allocated in job plans of clinical/educational supervisors and in the job plans of line managers. Their workloads must be balanced to ensure that supervision time is not crowded out by other demands. Effective clinical supervision increases efficiency and productivity and will repay the time allocated[139-140].

In the NHS Staff Survey in England, doctors who reported having supportive line managers experienced higher levels of work engagement, more satisfaction with their organisation, and more satisfaction with their immediate work conditions. They were less likely to be intending to leave their organisations or the NHS[8].

Provider organisations (both in primary and secondary care), clinical leads and senior colleagues must provide supportive and compassionate supervision. This should include ensuring that local requirements for appraisal are proportionate. There

also needs to be a close relationship between doctors in training and their clinical supervisors, involving regular contact so that trainees can get timely, supportive and helpful feedback, as well as visible and inspirational role modelling.

For example, Project Lift is a leadership programme across health and social care in Scotland, supported by the Scottish Government, offering multi-professional development opportunities to established and potential leaders[141].

Case study 21
Improving appraisal

The acquisition of new appraisal software allowed all Manchester University Foundation Trust staff to move to a single appraisal platform, enabling Managed Clinical Services working across sites to have all their staff within one system. Medical directors and other clinical managerial staff can view and report on the staff within their hierarchy level and monitor appraisal progress directly. The system has allowed Manchester University Foundation Trust to tailor the system for its specific requirements, providing a tailored appraisal portfolio for each clinician according to their role and specialty. Moreover, it is designed so that only the required information is asked to be completed.

Dedicated supervision

NHS Lothian appointed its first cohort of chief registrars in 2018. They have 20% of their time dedicated to personal leadership and management alongside clinical commitments. They are a voice for doctors in training across the health board and are tasked with being a link between doctors in training and management in the organisation. Chief registrars chair the Lothian Trainee and Management Forum, the primary purpose of which is to provide a regular forum for two-way communication between doctors in training and management representatives. Other activities include co-ordinating a wellbeing survey of all doctors in training and organising a conference on ‘Being Human: valuing our workforce’.

Poor quality supervision and feedback impacts on both trainers and trainees[13]. This can particularly affect doctors from some groups[42, 142]. It is important that supervisors, at all levels of seniority, are adequately trained to enable them to fulfil their roles effectively. This requires evaluation of training to determine its effectiveness, and regular assessment of the quality of their supervision based on the principles of compassionate and inclusive leadership.

There is a collective aspiration across the four health systems to develop compassionate and inclusive/collective leadership. This is done through the People Plan by NHS England; in Northern Ireland, through the HSC Collective Leadership Strategy launched in 2017; in Scotland through Project Lift; and in Wales through the new Health & Social Care Workforce Strategy. The challenge is to ensure that these commitments are translated into practice. The development of supervision skills should also be part of continuing professional development throughout the supervisors’ tenure in the role. Ensuring organisations provide resources (training, time on schedule etc) for appropriate supervision could be further reinforced via

systems regulators and improvement bodies, GMC evaluations and reflections by team members. This is a clear route to enhancing productivity, engagement and commitment of doctors across our health services.

Key recommendation seven

Management and supervision

To ensure all doctors have effective clinical, educational and pastoral support and supervision to thrive in their roles

- All organisations that employ doctors should make sure:
  - Each has a well-trained line manager supporting them to perform their roles effectively and ensuring their basic work needs are met. They should also obtain feedback to ensure this is in place (in primary care, this might be a peer mentor or coach).
  - Management, support, educational and clinical supervision are included in the job plans of those in such roles, and their workloads are balanced to ensure protected time to provide these functions.
- The leadership and boards of every organisation employing doctors should review feedback to check all doctors have well-trained line managers with protected time to carry out their functions.
- Organisations responsible for education and training of doctors and medical students should ensure they have an appropriate level of high-quality educational and clinical supervision provided by well-trained and compassionate supervisors.
- Systems regulators, improvement bodies and partners listed[xiv], including postgraduate training organisations, should work with the GMC to implement and monitor this recommendation, including via quality management and assurance mechanisms.

Learning, training and development

Learning, training and development are central to a sustained sense of competence from medical education at undergraduate level all the way through a doctor's career journey. The GMC sets the standards for providers of formal medical education and training, and regularly checks to ensure those standards are met. But, the issues are wider than only formal development[143]. We consider these issues in relation to undergraduate, postgraduate and post-qualification training below.

Evidence from the review

Undergraduate medical education

Our focus groups with UK medical students identified factors similar to those of other undergraduates, including the transition from home/school to university life; the lack of a support network (family, friends); fear of disclosing mental health issues; competition with peers reinforced by social media; and self-care issues (e.g. with nutrition or sleep[144]). More specifically, however, medical students said that university-wide support services

[xiv] See action plan in Annex 1.

were rarely tailored to the specific stressors they experience, such as witnessing ill or dying patients or being part of a serious untoward incident. We heard that in some circumstances minimum requirements for attendance were too rigid and didn't allow for life events during training. We have also received feedback that, for some students, re-taking a year was in their best interests and meant they were not struggling to keep up going forward. Although students may not be keen to take time out or re-take a year, medical schools should be assisting students to consider what is best and consistent with achieving GMC outcomes and meeting the demands of the course.

Some interactions with other professionals made medical students feel at the 'bottom of the ladder' undermining their confidence and wellbeing. There were anxieties about the planning of, and the time and cost of travel to placements. Placement providers were also not always adequately prepared to receive students, and it was difficult to access consultant time and get exposure to and sign off for competences.

Finally, the combination of tuition fees, university expenses, course length, and limited ability to work to earn while at medical school can accumulate into financial pressures affecting students' wellbeing (many accumulate debts of over £80,000).

Postgraduate training

So far in the report, we have explored factors affecting doctors' wellbeing at work, and we want to look at these more specifically in the context of training. Doctors in training repeatedly expressed frustration at the current approach to training. Doctors' wellbeing must be supported at the start of their careers, when they face a steep learning curve. The doctors in training we spoke to described challenges that have the combined effect of significantly reducing autonomy/control, belonging and competence. Indeed, the role of doctors in training seems perversely designed to prevent the fulfilment of all three needs. Doctors in training are also particularly vulnerable to the workplace factors that impact on all doctors, including workload, poor rota design and management, inadequate supervision and a lack of basic facilities.

We heard about a tension between the education and training of doctors and the pressures of service provision with concerns that some employers by default see trainees primarily as service providers rather than as doctors in training. While service provision is an important part of training, it can have a negative impact if trainees are required to undertake high levels of rota gap cover work that may not be educationally useful or if they are inadequately supervised. While this did not appear to be true for all SAS doctors, in focus groups we heard from some SAS doctors that the pressures of service provision also made it difficult for them to access development opportunities.

The rigidity of the training framework itself makes stepping off or getting experience gained elsewhere recognised, and this does not support doctors in relation to their wider life circumstances.

Concerns about differential attainment in exams are well known and, while the causes are complex, we know that some groups are likely to be less familiar with assessment structures and expectations. This is not only true for those coming from overseas but also for those who may be the first in their household to go to university/medical school/become a doctor. Doctors who fail exams face increased financial pressures from paying for examination retakes.

Some trainers avoid giving feedback, particularly where the person receiving it is from a different ethnic background to the trainer. Consequently, some doctors miss out on coaching. These experiences add to the other pressures for those on training programmes[143]. They undermine a sense of growing competence and do not suggest supportive learning environments consistent with the core health service values of compassion and inclusion.

The frequency of placement changes makes it difficult for doctors in training to build and maintain supportive relationships with peers and seniors, leaving them isolated at a time when they are undergoing frequent transitions and need support. Placement changes also result in repeated changes of employer, causing significant practical challenges for overseas trainees in relation to visas but also for the wider trainee population, for example, in relation to repeated mandatory training requirements[142].

Remote postings remove doctors in training (usually those who are already struggling and have failed to get their placements of choice) from their families for prolonged periods[146]. This diminishes the extent to which all three core work needs are met – the needs for autonomy/control, belonging, and growing competence.

Placing doctors with lower attainment, often with the highest need for additional support, away from their friends and family, leads to difficulties. By creating a hierarchy of attainment in which there is a small proportion of outright winners and a large group of relative losers, the system undermines a sense of competence[142].

The system of allocating the best performers to their organisations of choice also tends to strengthen the impact of inverse care trends[145] with the areas most in need being poorly served while the most attractive locations can take their pick from a large number of well-qualified applicants.

Later career development

Many GPs are planning to retire early, which will increase burden on those that remain in the profession. The feedback we heard suggests one of the underlying causes may be the limited opportunities GPs have to learn or develop, particularly when they wish to reduce their patient-facing roles. GPs are in effect asked to do the same tasks without opportunities for development for often well over 30 years. Some GPs have responded by taking part-time or locum positions in other care settings or becoming educators, leaders or mentors[35, 146-147]. At the other end of their careers, we heard that GPs struggle with the transition to the demands of GP practice following postgraduate training. The First Five programme run by the RCGP, detailed in the below case study, is a programme to support newly-qualified GPs' transition to general practice but this could also be adapted, adopted and extended to include all GPs to allow for ongoing GP development and training.

22 Case study
Support for GP development

Organisations representing GPs make clear that those who are newly-qualified often need support beyond their clinical training to help them transition into their new role. First Five is an initiative run by the Royal College of General Practitioners (RCGP) designed to support GPs in their first five years post MRCGP qualification through to revalidation. The initiative has been warmly welcomed because it helps GPs develop networks that can provide peer and professional support.

A similar trend is seen in secondary care, with senior consultants planning to take early retirement. We heard that at the later stages of their career, many wish to stop acting down to cover rota gaps and to reduce the impact of demanding shift patterns on their wellbeing. We know that pensions regulations play a part, but many doctors are highly motivated to stay in or return to the NHS if there were attractive roles that made good use of their experience and skills.

Good practice and case examples

Undergraduate medical education

Student wellbeing is a shared responsibility of the individual learner, the school, and the placement providers. It is good practice to provide tailored support services at medical school level and some schools have implemented student-led peer support/ mentoring programmes and wellbeing elements in the curriculum. They promote students' wellbeing through extracurricular activities, and are flexible when students need time away for health/welfare issues.

Students in the Scottish Graduate Entry Medicine programme (ScotGEM) are allocated a personal tutor at the school (with a pastoral role) and a General Clinical Mentor (GCM) who supervises their clinical placements. During the GMC 2018/19 quality assurance review of the programme the students were very positive about their experience, describing the GCMs as generally approachable and available for clarification or advice[148].

23 Case study
Clinical placement facilitators

Lancashire Teaching Hospitals NHS Foundation Trust introduced clinical placement facilitators (CPFs), band six – seven nurses, who work closely with medical students and clinical placement supervisors (CPS) in identifying struggling students and supporting, guiding and teaching them within each placement. Students say they are excellent mentors who help organise their placements based on their needs.

Quotes from medical students about the CPF team at Lancashire Teaching Hospital NHS Foundation Trust:

> "CPFs make a huge difference and invaluable for learning and support. They go out of their way to make your placement run smoothly. I feel lucky I got a placement at Preston."
>
> "Excellent CPFs in organising medical students' learning, so we can make the most out of our placement."

The undergraduate curricula can be designed to ensure that students have the tools to support their own wellbeing, develop a compassionate approach to care, work effectively in multidisciplinary teams, and develop their compassionate and inclusive leadership skills. This could be part of the ongoing review of undergraduate curricula that will be completed by 2020, to align with the revised outcomes that newly qualified doctors must meet by the end of their medical degree (Outcomes for graduates 2018).

Education providers can ensure that students, like doctors, have membership of a stable 'home team' that meets regularly and provides the student with a sense of belonging. Changes in the way clinical placements are run can also help with that. Placement providers play a key role in ensuring that they support students' wellbeing with appropriate cohort sizes, collaboration with other providers to ensure a good distribution of students, and providing pre-briefings for the teams that students will be shadowing.

Good education providers work with students to understand their needs and address them. They provide compassionate and inclusive supervision that offers reasonable flexibility for students with mitigating circumstances. They also support students and ensure that the culture enables them to speak up about concerns.

To address the performance pressures on students, good education providers are seeking to develop a culture of learning that shifts the focus to enabling every student to become an excellent doctor, rather than competing with their peers to determine who is best. Conversations with colleagues at the American Association of Medical Colleges (AAMC) suggested that a pass-fail system where students are encouraged to achieve a high level, and all are supported to succeed is very successful.

Postgraduate training

In relation to the rigidity of the training framework, the step-on step-off principle could provide practical solutions to some of the problems identified. The GMC's new guidance Excellence by design and the introduction of the General professional capabilities framework will better enable trainees to switch specialty. The Curricula Review already underway will also ensure curricula are aligned to assessments and the reality of medical practice.

24 Case study
Improving Surgical Training

Improving Surgical Training (IST) is a project led by the Royal College of Surgeons of England and HEE. It includes a range of evidence-based initiatives to improve the quality and quantity of training for surgical trainees, following the issues identified by the Improving Surgical Training report. The pilot is running in several sites to allow early years trainees to develop competencies at an accelerated pace, with opportunities to gain skills usually acquired in more advanced training. Pilot training placements will usually be of twelve months' duration, to allow the development of a more settled learning environment, and an improved relationship between trainees and their supervisors. This will be achieved by:

- Providing training opportunities for approximately 60% of the working week, often through a minimum 1:10 on-call rota.
- Providing pilot trainees with simulation-based training through dedicated induction programmes ('boot camps') and having specific opportunities within their posts for both supervised and unsupervised activities.
- Requiring protected supervision time for training in pilot trainers' job plans and a minimum of one hour per trainee per week to provide feedback and reflection. Trainers have been offered additional training and will support trainees in obtaining the appropriate opportunities to gain the curriculum-defined skills for their stage.
- Supporting the 'modern firm' structure in the working environment, comprising trainer, trainee, peer colleagues and the surgical care team. Where present, the latter will work closely with pilot trainees to provide clinical support and reduce administrative responsibilities.

A key feature of IST is that progression will be based on the acquisition of curriculum-defined competencies, ensuring the product at the end of training meets current and future patient needs. The project is being independently evaluated, where issues including trainee satisfaction and wellbeing will be explored.

Concerns about differential attainment are being addressed in some places by ensuring early, honest feedback and the use of mechanisms to address diverse needs, including the use of personal development plans based on formative assessment, and exam preparation support[149].

Placement change problems have been addressed in some areas of the UK through single lead employer schemes and other positive initiatives[150-152]. Similar moves towards supporting placement transitions are being mooted across England and there are already successful 'streamlining/passporting' schemes[152].

25 Case study
Integrated foundation training

The North West of England Foundation School piloted several Longitudinal Integrated Foundation Training (LIFT) programmes in 2016 across eight acute trusts. The LIFT programme, run by HEE North West, aims to connect several such integrated placements in a coherent two-year programme. The LIFT programmes have six, four-month placements in acute specialties with an attachment to a general practice for the duration of the two years. The latter provides continuity and a 'home team'. All the LIFT programmes have the expected standards of teaching and learning, as well as clinical and educational supervision focused on longitudinal competency themes such as values, leadership, self-management, patient safety and quality improvement. Surveys showed that LIFT trainees felt more valued, supported and satisfied in their roles, had a lower sickness absence rate and tended towards more compassionate reflections than standard trainees. In the programme evaluation, doctors in training fed back that the time spent in primary care was one of the most positive aspects of the LIFT programme. Participants reported improved communication and consultation skills, a greater ability to deal with complex, diverse and uncertain situations. Participants reported being better prepared to make an informed career choice.

Later career development

With the move towards wider role development and task shifting to address workloads, there will be a significant need for teaching, training, mentoring and support for multidisciplinary team working. Experienced staff are well-placed to provide this; newly-qualified GPs also need access to programmes that will support them to transition into their new role. Some programmes enable experienced GPs to continue to contribute without doing only patient-facing sessional work, and others in secondary care enable consultants to continue to contribute in a way that reduces the impact of shift work and rota gap cover.

Key recommendation eight

Training, learning and development

To ensure the systems and frameworks for learning, training and development:

- Promote fair outcomes
- Are sufficiently flexible to enable doctors and medical students to grow and develop throughout their careers and to better manage their wider life circumstances.

Undergraduate medical education

- Medical schools should work collaboratively with students to:
  - Get feedback and meet their specific needs.
  - Measure and improve student well-being as a routine performance metric.
  - Ensure a culture of interdisciplinary learning within the faculty and integrate wellbeing, compassion and multidisciplinary team working into student training within ongoing curriculum review.
  - Offer confidential services tailored to the needs of medical students and a package of support for those seeking mitigating circumstances/ taking time out, including additional ways to complete attendance and curriculum requirements.
  - Ensure an effective feedback mechanism for medical students to speak up about concerns such as bullying and undermining.
  - Ensure clinical placement providers are well prepared to receive students and work with other schools to address issues like capacity.
  - Consider benefits of a pass/fail grading system at least for some course components.
- Medical schools should establish a key performance indicator for student wellbeing across all learning environments and review feedback to assess performance.
- The GMC, through its quality assurance functions, should check and monitor the improvements made by medical schools on student wellbeing.

Postgraduate training

- The GMC and system leaders across education and training, including postgraduate training organisations, should support a review of the impact of the allocation of training placements[xv].
- System leaders across education and training should improve the programme of assessment, including curricula, to ensure:
  - Early and ongoing formative assessment of learning outcomes and provide opportunities to improve and evaluate performance prior to high-stakes assessment.
  - The development of a personal development plan.
- The GMC should continue to monitor differential attainment with a view to achieving continuous reduction in differential outcomes.
- The organisations responsible for postgraduate medical education and training across the UK should, where they have not already done so, address administrative burdens placed on doctors in training such as by establishing a Single Lead Employer (as in Scotland, Wales and Northern Ireland) or by cross-organisation passporting (where a Single Lead Employer system is not practicable).
- Postgraduate training organisations should review feedback to assess performance with addressing administrative burdens placed on doctors in training.
- The GMC, through its quality assurance functions, should check and monitor improvements made by postgraduate training organisations to address administrative burdens placed on doctors in training.

Ongoing development

- The GMC should work with UK national governments to develop strategies to better support the ongoing development of all doctors outside or after formal postgraduate training, and, in particular, GPs. This should establish new ways of working to improve the capacity and confidence of newly-qualified GPs and specialists and the retention of experienced doctors in the NHS.
- The GMC to review the findings of its survey of specialty and associate specialist (SAS) and locally employed (LE) doctors to work with partners to consider what steps need to be taken to better develop and support this group of doctors and their different challenges across the UK.

[xv] This is one of the recommendations in HEE's report on NHS Staff and Learners' mental wellbeing in England. The GMC's Promoting Excellence standards give the GMC a responsibility for the fairness of recruitment processes.

Conclusion

Conclusion

Our aim should be to ensure that the UK's health services are a model for the world in creating work places that promote doctors' wellbeing, through meeting their core work needs. This is a moral issue but is also consistent with the core purpose of the service to ensure the health of our population. Doctors' health and wellbeing is critical to the quality of care they can provide for patients and communities.

We have repeatedly referred to compassion or kindness in interactions with those we work with, those we lead and those for whom we provide services. There is a convincing evidence base for the beneficial effects of compassion on patient outcomes and the wellbeing of health and care professionals. Neglect, incivility, bullying and harassment of staff have quite opposite effects[154]. Lawrence and Maitlis (2012) describe an ethic of care in effective teams and organisations, which is more likely to occur in those 'that foster integration, nurture trust and respect the emotional lives of members, and where members have the opportunity to become competent carers'[155]. When our focus is on understanding and helping others in service of the healthcare systems' shared vision, collaboration and teamwork will be much more effective, productivity markedly higher and patient safety and satisfaction much improved.

Our call to action is for all health service leaders to practise the skills of compassionate and inclusive leadership to create the cultures that the health service needs for the future. Where organisations are founded on values and cultures of compassion and inclusion, they will foster individual, team, inter-organisational, and community wellbeing characterised by fairness, trust, thriving and wellbeing. In that way, we will effectively meet doctors' needs for autonomy, belonging and competence at work and thereby better serve the wellbeing of the patients and communities we serve. That is not only our challenge, it is our imperative.

Annex 1 – Action plan

Action plan

The General Medical Council (GMC) should work with UK national governments and those coordinating and leading the following programmes to ensure collaborative action to guarantee the wellbeing of the medical profession as a priority:

- The NHS People Plan in England
- The Health and Social Care Workforce Strategy 2026: Delivering for Our People in Northern Ireland
- The Ministerial Short Life Working Group on Culture and Project Lift in Scotland
- Health and Social Care Strategy and the Health and Social Care Leadership Framework in Wales

This action plan sets out detailed recommendations. It also highlights potential partners and proposes some practical solutions.

Autonomy and control

Aim: to give doctors control over their work lives

Potential partners – national and local organisations across the four countries of the UK including:

- National Health Service (NHS) organisations
- Employers - including local health service Trusts, Boards and primary care providers
- Employers - representative organisations
- Systems regulators and quality improvement bodies
- Postgraduate medical education and training organisations
- The GMC
- Doctor representative organisations – including the British Medical Association (BMA)
- Medical royal colleges and faculties
- Medical leadership organisations

1. Voice, influence and fairness – to introduce mechanisms for doctors to influence the culture of their healthcare organisations and decisions about how medicine is delivered.

Clinical leaders and managers should consult doctors (and other healthcare staff) and gather feedback about how healthcare teams are established and maintained, how their work is organised and delivered and the response to concerns to ensure a focus on learning not blame.

Approach and practical solutions to include:

- Employers making sure concerns are listened to and addressed by working with doctors to:
  - Encourage and gather feedback from all healthcare staff via psychologically safe mechanisms, including staff working in isolated roles or at risk of being perceived as 'outsiders'.
  - Assess and identify concerns, including the extent to which teams and organisations are working in ways that are fair and just. This should be part of the core work of any environment that doctors work in.
  - Continuously develop and deliver an action plan to address concerns and suggestions.
  - Prioritise time and resources to deliver culture transformation programmes and training as required.
  - Provide timely feedback on if and how concerns have been addressed.

1. Voice, influence and fairness – to introduce mechanisms for doctors to influence the culture of their healthcare organisations and decisions about how medicine is delivered (continued)

The leadership and boards of every organisation employing doctors should establish a key performance indicator for voice and influence and review feedback to assess performance.

Systems regulators, improvement bodies and suggested partners should check that employers have and are using mechanisms for obtaining and reviewing feedback from doctors about their work.

The GMC should work with partners listed to:
- **Support monitoring and assessment of engaging leadership, and just and fair cultures.**
- **Assure progress across healthcare teams and organisations in both primary and secondary care.**

Approach and practical solutions to include:

- Monitoring using established (academic, peer-reviewed) measures of voice, influence, justice and fairness.
- Improvement, development and implementation of the following to ensure high-quality measurements across all areas:
  - The GMC's national training surveys (NTS)
  - NHS staff surveys[xvi]
  - National surveys of primary care staff[xvii]

Healthcare providers should promote a workplace in which discrimination of any form is not tolerated, by ensuring prompt identification and addressing of issues.

Approach and practical solutions to include:

- Employers ensuring quality, positive diversity and inclusion across all areas of healthcare by:
  - Providing a timely and sensitive engagement or feedback process that staff can use to report concerns or issues.
  - Taking appropriate steps to address any issues identified.

[xvi] Such as the NHS Staff Survey in England, Health and Social Care Northern Ireland Staff Survey and Scotland Dignity at Work Survey, NHS Wales Staff Survey

[xvii] Such as the National GP Worklife Surveys in England and RCGP Scotland Workforce and Wellbeing survey

1. Voice, influence and fairness – to introduce mechanisms for doctors to influence the culture of their healthcare organisations and decisions about how medicine is delivered (cont.)

The GMC should work with partners listed to confront divisive cultures in healthcare organisations by reporting on progress with implementing the recommendations of the 'Fair to refer?' report.

Approach and practical solutions to include:

- Progress reporting to include the proportionality of referrals by employers to the GMC.

2. Work conditions – to introduce UK-wide minimum standards for basic facilities in healthcare organisations.

All healthcare employers should provide all doctors with places and time to rest and sleep, access to nutritious food and drink, the tools needed to do their job and should implement the BMA's Fatigue and Facilities charter.

Approach and practical solutions to include:

- Ensuring basic facilities include, but are not limited to:
  - Removing barriers to and promoting the importance of taking breaks.
  - Physical spaces to take breaks.
  - Access to nutritious food and drink for all shifts.
  - Suitable places to rest.
  - Lockers to secure belongings.
  - Effective IT systems and support with using them.
  - Time to take breaks and undertake essential activities such as appraisal, training and supervision.
- Employers to seek feedback from staff on any obstacles to the access to basic facilities and to address concerns raised.
- Employers, where necessary, to reinforce the importance of accessing basic facilities, rests and breaks to those responsible for day-to-day supervision of medical staff:
  - Through the delivery of culture transformation programmes and training.
  - By promoting the importance of breaks and time for essential tasks, such as supervision, line management and appraisal.

The leadership and boards of every organisation employing doctors should review facilities to ensure compliance with the BMA's Fatigue and Facilities charter.

Systems regulators, improvement bodies and partners listed should check that employers have implemented the BMA's Fatigue and Facilities charter in all working environments.

The GMC should continue to work with partners via the insights and data obtained through their NTS to monitor, assess and support implementation. Where issues are identified, the GMC should work with postgraduate deans, medical royal colleges and employers to ensure they are promptly and fairly addressed.

3. Work schedule and rotas - To introduce UK-wide standards for the development and maintenance of work schedules and rotas based on realistic forecasting that supports safe shift swapping, enables breaks, takes account of fatigue and involves doctors with knowledge of the specialty to consider the demands that will be placed on them.

NHS England, NHS Wales, NHS Boards in Scotland and the Department of Health (Northern Ireland) should fully implement the BMA's and NHS Employers' Good Rostering Guide (see new deal monitoring guidance in Scotland) in all healthcare environments.

Approach and practical solutions to include:

- Ensuring doctors' work schedules enable them to be:
  - Well
  - Healthy
  - Effective in their work
  - Able to sustain their contribution to high-quality patient care.
- Healthcare organisations to ensure that rotas are designed and managed based on accurate data, taking account of the available staff rather than being designed on the basis of a notional workforce.

Healthcare organisations across the UK should develop and maintain mechanisms to enable doctors to report rotas that are not compliant with the BMA's and NHS Employers' Good Rostering Guide (see new deal monitoring guidance in Scotland). Guardians of safe working hours in England should encourage doctors in training to raise exception reports about rostering issues and should monitor such exception reports and take steps to address the issues raised.

Systems regulators, improvement bodies and partners listed should check employers have implemented the BMA's and NHS Employers' Good Rostering Guide (see new deal monitoring guidance in Scotland).

The GMC should work with partners listed above to monitor implementation of the BMA's and NHS Employers' Good Rostering Guide (see new deal monitoring guidance in Scotland)

Approach and practical solutions to include:

- Undertaking monitoring until good practice is standard practice within all healthcare organisations in the UK, with the aim to achieve this within 12 months.

Belonging

Aim: to help doctors be connected to, cared for and caring of others around them, so they feel valued, respected and supported

Potential partners – national and local organisations across the four countries of the UK including:

- NHS organisations
- Employers - including local health service Trusts, Boards and primary care providers
- Employers - representative organisations
- Systems regulators and quality improvement bodies
- Healthcare professional regulators
- Postgraduate medical education and training organisations
- The GMC
- Doctor representative organisations – including the BMA
- Medical royal colleges and faculties
- Medical leadership organisations

4. Team working – to develop and support effective multidisciplinary team working across the healthcare service.

All healthcare organisations should review team working and ensure that all doctors are working in effectively functioning and, ideally, multidisciplinary teams. The teams should have a shared purpose and clear objectives (one of which is team member wellbeing). Team members should be clear about their roles and meet regularly to review their performance, including inter-team/cross-boundary working. Quality improvement should be a core function of all teams.

Approach and practical solutions to include:

- Employers working with clinical leads to ensure doctors are working in such teams and that these are working cohesively, supportively, inclusively and compassionately.

The leadership and boards of every organisation employing doctors should establish a key performance indicator for effective team working and obtain and review feedback to assess if all doctors are part of a well-functioning team.

4. Team working – to develop and support effective multidisciplinary team working across the healthcare service (continued)

Systems regulators, improvement bodies and partners listed should check that employers are ensuring that doctors are working in well-functioning teams.

Approach and practical solutions to include:

- Monitoring to include using established (academic, peer-reviewed) measures.
- Improvement, development and implementation of the following to ensure high-quality measurements across all areas:
  - The GMC's NTS
  - National staff surveys[xviii]
  - National surveys of primary care staff[xv]

The GMC should work with other professional regulators to develop guidance on multidisciplinary team working in modern healthcare environments.

Approach and practical solutions to include:

- Guidance that is evidence-based, appropriate and developed in a way that:
  - Improves team and inter-team working.
  - Improves healthcare for the communities the NHS serves.
  - Improves staff wellbeing.
  - Is focussed on clinical effectiveness, innovation and quality improvement.

Healthcare systems should develop appropriate support and materials to ensure the continued development of teams in both primary and secondary care.

Approach and practical solutions to include:

- Materials that are evidence-based, appropriate and developed in a way that:
- Improves team and inter-team working.
- Improves healthcare for the communities the NHS serves.
- Improves staff wellbeing.
- Team development to be focussed on clinical effectiveness, patient experience, team member wellbeing, innovation and quality improvement, and quality of inter-team working.

[xiv] Such as the NHS Staff Survey in England, Health and Social Care Northern Ireland Staff Survey, Scotland Dignity at Work Survey and NHS Wales Staff Survey

[xv] Such as the National GP Worklife Surveys in England and RCGP Scotland Workforce and Wellbeing survey

5. Culture and leadership – to implement a programme to ensure healthcare environments have nurturing cultures enabling high-quality, continually improving and compassionate patient care and staff wellbeing.

All UK healthcare organisations that have not already done so, should commence and implement a programme of compassionate leadership across all healthcare sectors and obtain feedback from doctors and healthcare staff to evaluate its effectiveness. It should include mechanisms to ensure clinical leads and other leaders of doctors at all levels in the healthcare system are recruited, selected, developed, assessed and supported to model compassionate and collective leadership.

Approach and practical solutions to include:

- Leaders across all healthcare organisations reviewing their organisational cultures using the evidence-based resources available for the four UK countries. The key leadership and cultural development programme, being implemented in around 100 Trusts and Boards across the UK, is the open source culture and leadership programme developed by NHS Improvement in partnership with The King's Fund. The King's Fund is leading also on developing compassionate leadership with national partners in all four UK countries.
- These steps should help the development of high-quality care cultures and the modelling of compassionate and collective leadership in every part of the healthcare system. This will support high-quality, continually improving and caring approaches for doctors and patients.

Leadership and boards of every organisation employing doctors should introduce a key performance indicator for compassionate leadership and should review feedback from doctors and other healthcare staff to assess if leadership is compassionate and collective.

Systems regulators, improvement bodies and funding and commissioning bodies should check that employers have in place mechanisms to support compassionate leadership. Regulators and quality improvement bodies to review how to improve regulatory alignment and ensure compassionate leadership is sustained in the longer term by integrating it as a priority into their regulatory models.

Approach and practical solutions to include:

- Monitoring using established (academic, peer-reviewed) measures.
- Improvement, development and implementation of the following to ensure high-quality measurements across all areas:
  - The GMC's NTS
  - National staff surveys[xx]
  - National surveys of primary care staff[xxi]

5. Culture and leadership – to implement a programme to ensure healthcare environments have nurturing cultures enabling high-quality, continually improving and compassionate patient care and staff wellbeing (continued)

The GMC should work with partners listed to monitor and assess implementation and maintenance of such changes to cultures and leadership across the system.

Approach and practical solutions to include:

- Monitoring bodies to assess implementation of initiatives and monitor improvements to culture and leadership across the system. All four UK countries to ensure that this is a central element of performance management frameworks.
- Monitoring bodies to ensure their own organisations are exemplars of such healthy cultures.

[xx] Such as the NHS Staff Survey in England, Health and Social Care Northern Ireland Staff Survey, Scotland Dignity at Work Survey and NHS Wales Staff Survey

[xxi] Such as the National GP Worklife Surveys in England and RCGP Scotland Workforce and Wellbeing survey

Competence

Aim – to improve doctors' ability to experience effectiveness and deliver quality care

Potential partners – national and local organisations across the four countries of the UK including:

- NHS organisations
- Employers – including local health service Trusts, Boards and primary care providers
- Employers – representative organisations
- Systems regulators and quality improvement bodies
- Healthcare professional regulators
- Postgraduate medical education and training organisations
- Medical schools
- The GMC
- Doctor representative organisations – including the BMA
- Medical royal colleges and faculties
- Medical leadership organisations

6. Workload – to tackle the fundamental problems of excessive work demands in medicine that exceed the capacity of doctors to deliver high-quality safe care.

All organisations that oversee the work of doctors should undertake, in collaboration with doctors, a programme to review workload in their organisations. This will help them to use resources in the most efficient way, to ensure workloads do not exceed doctors' ability and capacity to deliver safe, high-quality care. Initiatives are underway across the UK to increase staffing numbers and this should be supported by additional solutions including, but not restricted, to:

- **A programme to deploy and develop alternative roles to enable doctors to work at the top of their competence, supported by effective multidisciplinary team working in all areas of healthcare, and to support doctors to return to work after a break in practice.**
- **A review of new technologies being used in UK healthcare systems to increase efficiency (see case studies), working with the voluntary sector, and focusing on preventive care.**
- **A programme of process improvements that increase productivity especially by supporting communication in regular team meetings between healthcare staff (see case studies).**

6. Workload – to tackle the fundamental problems of excessive work demands in medicine that exceed the capacity of doctors to deliver high-quality safe care (continued)

- **Eliminating tasks and activities that do not add value to patient care or doctors' wellbeing.**
- **Engaging communities, community representatives and patients in taking shared responsibility for their health services.**
- **Identifying services that cannot be provided in a resource-constrained system and unnecessary processes that do not add value.**

Approach and practical solutions to include:

- Healthcare systems and bodies to work collaboratively with staff across all working environments, including primary care, to address issues of excessive workload and identify appropriate solutions. This includes close communications between employers, leaders in primary care, system bodies and staff to ensure prompt identification of issues and potential solutions.
- Integrated approaches to ensuring doctors' workloads do not exceed their ability and capacity to deliver safe, high-quality care to be collaboratively and continuously developed.
- Identifying activities that do not add significant value in doctors' work and eliminating them.
- Increased use of quality improvement approaches to reduce work that does not add significant value to the core mission of healthcare.
- Effective use of new technologies to reduce excessive, chronic workload.
- Multi-disciplinary team-working and appropriate task-shifting across all environments to support more effective role development and task allocation making the best use of team skills.
- Governments and healthcare organisations in the four countries to facilitate national conversations to engage the community about priorities for the NHS. This must include a focus on the workload burden on the NHS and the need for systemic prevention and for better healthcare self-management in communities.

The leadership and boards of every organisation employing doctors should review programmes to address excessive workload and monitor their impact.

6. Workload – to tackle the fundamental problems of excessive work demands in medicine that exceed the capacity of doctors to deliver high-quality safe care (continued)

Systems regulators, improvement bodies and partners listed should check that employers have in place programmes to address excessive workloads and to monitor them to ensure improvement.

Approach and practical solutions to include:

- Monitoring using established (academic, peer-reviewed) measures.
- Improvement, development and implementation of the following to ensure high-quality measurements across all areas:
  - The GMC's NTS
  - National staff surveys[xxii]
  - National surveys of primary care staff[xxiii]

[xxii] Such as the NHS Staff Survey in England, Health and Social Care Northern Ireland Staff Survey, Scotland Dignity at Work Survey and NHS Wales Staff Survey

[xxiii] Such as the National GP Worklife Surveys in England and RCGP Scotland Workforce and Wellbeing survey

7. Management and supervision – to ensure all doctors have effective clinical, educational and pastoral support and supervision to thrive in their roles.

All organisations that employ doctors should ensure:

- **Each has a well-trained line manager supporting them to perform their roles effectively and ensuring their basic work needs are met. They should also obtain feedback to ensure this is in place (in primary care, this might be a peer mentor or coach).**
- **Management, support, educational and clinical supervision are included in the job plans of those in such roles, and their workloads are balanced to ensure protected time to provide these functions.**

Approach and practical solutions to include:

- Management for doctors focussed on better meeting their basic work needs for autonomy and control, belonging and competence. Such management should model compassionate and inclusive leadership.

The leadership and boards of every organisation employing doctors should review feedback to check all doctors have well-trained line managers with protected time to carry out their functions.

Organisations responsible for education and training of doctors and medical students should ensure they have an appropriate level of high-quality educational and clinical supervision provided by well-trained and compassionate supervisors.

Approach and practical solutions to include:

- Quality and accessibility of education and clinical supervision ensuring training and working environments are safe for patients and supportive for learners and educators. They should adhere to the GMC's 'Promoting excellence – standards for medical education and training'.

Systems regulators, improvement bodies and partners listed , including postgraduate training organisations, should work with the GMC to implement and monitor this recommendation, including via quality management and assurance mechanisms.

8. Training, learning and development – to ensure the systems and frameworks for learning, training and development:

- **Promote fair outcomes.**
- **Are sufficiently flexible to enable doctors and medical students to grow and develop throughout their careers and to better manage their wider life circumstances.**

Undergraduate medical education

Medical schools should work collaboratively with students to:

- **Get feedback and meet their specific needs.**
- **Measure and improve student wellbeing as a routine performance metric.**
- **Ensure a culture of interdisciplinary learning within the faculty and integrate wellbeing, compassion and multidisciplinary team working into student training within ongoing curriculum review.**
- **Offer confidential services tailored to the needs of medical students and a package of support for those seeking mitigating circumstances/ taking time out, including additional ways to complete attendance and curriculum requirements.**
- **Ensure an effective feedback mechanism for medical students to speak up about concerns such as bullying and undermining.**
- **Ensure clinical placement providers are well prepared to receive students and work with other schools to address issues like capacity.**
- **Consider the benefits of pass/fail grading system at least for some course components.**

Approach and practical solutions to include:

- Supporting supervisors to give prompt, tailored and ongoing feedback to all learners. Exam preparation support should particularly provide candidates less familiar with assessment structures and expectations or candidates who have failed an exam with additional support.

Medical schools should establish a key performance indicator for student wellbeing across all learning environments and review feedback to assess performance.

The GMC, through its quality assurance functions, should check and monitor the improvements made by medical schools on student wellbeing.

8. Training, learning and development – to ensure the systems and frameworks for learning, training and development:

- **Promote fair outcomes.**
- **Are sufficiently flexible to enable doctors and medical students to grow and develop throughout their careers and to better manage their wider life circumstances** (continued)

Postgraduate training

The GMC and system leaders across education and training, including postgraduate training organisations, should support a review of the impact of the allocation of training placements[xxiv].

System leaders across education and training should improve the programme of assessment, including curricula, to ensure:

- **Early and ongoing formative assessment of learning outcomes and provide opportunities to improve and evaluate performance prior to high-stakes assessment.**
- **The development of personal development plans.**

The GMC should continue to monitor differential attainment with a view to achieving a continuous reduction in differential outcomes.

The organisations responsible for postgraduate medical education and training across the UK should, where they have not already done so, address administrative burdens placed on doctors in training such as by establishing a Single Lead Employer (as in Scotland, Wales and Northern Ireland) or by cross-organisation passporting (where a Single Lead Employer system is not practicable).

Postgraduate training organisations should review feedback to assess performance with addressing administrative burdens placed on doctors in training.

The GMC, through its quality assurance functions, should check and monitor improvements made by postgraduate training organisations to address administrative burdens placed on doctors in training.

Approach and practical solutions could include:

- Monitoring using established (academic, peer-reviewed) measures.
- Improvement, development and implementation of the GMC's NTS to ensure high-quality measurements across all areas.

[xxiv] This is one of the recommendations in HEE's report on NHS Staff and Learners' mental wellbeing in England. The GMC's Promoting Excellence standards give the GMC a responsibility for the fairness of recruitment processes.

8. Training, learning and development – to ensure the systems and frameworks for learning, training and development:

- **Promote fair outcomes.**
- **Are sufficiently flexible to enable doctors and medical students to grow and develop throughout their careers and to better manage their wider life circumstances** (continued)

Ongoing development

The GMC should work with UK national governments to develop strategies to better support the ongoing development of all doctors outside or after formal postgraduate training, and, in particular, GPs. This should establish new ways of working to improve the capacity and confidence of newly-qualified GPs and specialists and the retention of experienced doctors in the NHS.

The GMC to review the findings of its survey of specialty and associate specialist (SAS) and locally employed (LE) doctors to work with partners to consider what steps need to be taken to better develop and support this group of doctors and their different challenges across the UK.

Annex 2 – Approach to review

Approach to UK-wide review of doctors' and medical students' wellbeing

At the start of 2018, the GMC commissioned a UK-wide review of doctors' and medical students' wellbeing. The review, which forms part of the GMC's wider *Supporting a profession under pressure* portfolio of work, considered the wellbeing of all medical students and doctors in the UK across all specialties, grades, employment arrangements and demographics.

The findings from the review have been fed into the report and recommendations. They will enable the GMC to work together with organisations across the UK to agree priority areas for collaborative action, to tackle the causes of poor wellbeing and improve support for doctors and medical students.

The review was co-chaired by Professor Michael West and Dame Denise Coia. Unfortunately, in May 2019, Dame Denise Coia had to step down due to ill-health. Professor Michael West continued to chair the review.

For Professor Michael West's and Dame Denise Coia's biographies see page 10.

Evidence based approach to research and engagement

The review was based on a research and engagement strategy designed to ensure a robust evidence base.

Engagement

As part of the engagement strategy, a detailed stakeholder mapping exercise was carried out. Dame Denise Coia, Professor Michael West and the GMC review team supporting them with their work ('the review team') met with a wide range of external stakeholders. These included organisations within the healthcare system and others with an interest in the wellbeing of people at work. A full list of the organisations involved with the review is included at the end of this annex.

Awareness of the review was raised through a number of channels, including engagement events, meetings with stakeholders and social media.

The review team also used these channels to undertake an initial exploration of possible partnerships and sought to establish whether organisations held any information and/or data that could be useful for the purposes of the review. This resulted in an overwhelmingly positive response from organisations and individuals who offered to share data and their support. A number offered to pilot interventions as part of the review.

The review team worked with the Scottish Wellbeing Advisory Group, co-chaired by Dame Denise Coia and David Garbutt at NHS Education Scotland, to support early intervention pilots in two Scottish health boards. Further information can be found in a case study on the work in Annex 3. The review team also worked with groups in Northern Ireland and Wales who were linked with the Scottish working group.

A number of events were held with doctors and medical students across all four countries of the UK. The groups included medical students across all year groups, doctors in training across different specialties and grades, general practitioners, specialty and associate specialists (SAS) and consultant grade doctors working in community settings, mental healthcare and acute hospitals.

These events were designed to obtain doctors' and students' feedback in relation to the emerging evidence and recommendations in the review, in advance of the final report being published. The sessions lasted between one and two hours, and were informal in order to encourage participants to speak freely. Participants were given background information on the review and asked to discuss the three themes identified in the review (autonomy/ control, belonging, competence). They also discussed potential solutions to issues raised and offered feedback on emerging ideas for recommendations.

The engagement activities provided opportunities to compare this feedback and seek input and learn from doctors and medical students directly.

Research methodology

Aims and objectives

The aim of the research component of the review was to build a structured evidence base to inform the review's conclusions and key policy recommendations on the mental health and wellbeing of medical students and doctors in the UK. The focus was to build a comprehensive picture of the key issues, using a range of sources of evidence given the time and resources available.

The review chairs asked four research questions:

- What is the prevalence and incidence of adverse mental health among medical students and doctors in the UK, and how does this compare with other countries, others in the working population and others working in health and care services?
- What is the impact of poor wellbeing on medical students and doctors and on quality of care?
- What factors have most influence on the wellbeing of people at work, and specifically on medical students and doctors?
- What primary interventions (focused on workplace factors identified in the above) are effective for ensuring medical students' and doctors' health and wellbeing?

Methods

To answer the four research questions, the review involved qualitative and quantitative research:

Qualitative research

1. The chairs and the review team held meetings with individuals working in universities, hospitals, general practices and in each of the national organisations within the four countries of the UK holding relevant data. The meetings focused on gathering their views on the mental health and wellbeing of medical students and doctors and identifying information they could share with the review team. The review team kept written notes of the meetings, which were analysed using inductive and deductive content analysis with the QSRI NVivo 12 Pro software.

2. The review team reviewed a series of reports and articles focusing on mental health and wellbeing. The material was identified by the chairs of the review, the engagement meetings, and through correspondence with individuals with a specialist interest, knowledge or expertise in the field. These publications were also analysed using inductive and deductive content analysis using with QSRI NVivo 12 Pro in relation to the four research questions.

3. The review team conducted a literature review, focusing specifically on primary interventions to support medical students' and doctors' wellbeing. Primary interventions were defined as interventions that are aimed at modifying or eliminating stressors in the work environment which could impact on an individual's health and wellbeing. Three databases were searched for published literature on mental health and wellbeing of doctors and medical students, primary interventions for medical students' and doctors' wellbeing: MEDLINE/ PubMed, CINAHL Plus, and PsycINFO. The specific databases were chosen because of their international coverage and their relevance to healthcare; PsycINFO was selected because of the relevance of organisational psychology to the review. It did not involve a systematic literature review or broader coverage of databases due to the limited timescale for the review.

   The search concepts used were intervention; wellbeing and doctor/medical student. In addition to the database searches for published literature, a number of internationally recognised experts in the field were contacted for advice on publications they were aware of that focused on primary interventions.

Inclusion / exclusion criteria

The review focused on publications that discussed a specific intervention meeting our definition of 'primary' intervention. The intervention had to be directed at students or healthcare professionals, but not exclusively medical students or doctors. Papers had to be published in the English language, within the last 10 years (2009-present), to capture more recent developments in the field. Papers discussing secondary (e.g. mindfulness training) and tertiary interventions (e.g. counselling services) were noted (since some were tangentially relevant) but generally not included.

Data extraction

The articles identified through the database searches and correspondence with experts were critically appraised by two members of the review team through a screening process. This was necessary because of the very large number of entries found in the database searches, (the terms 'doctor' and 'wellbeing' frequently appeared together). The first stage involved reading the publication titles and/or abstracts to determine relevance to the topic. The second stage involved reading the abstract / summary or specific sections of publications (introduction, results and discussion / conclusions) selected through the first stage, to determine whether the inclusion criteria had been met. All publications screened in the second stage of the process were recorded in Microsoft Excel with a brief explanation of the reasons why the inclusion criteria were or were not met.

The two researchers met three times to discuss the papers they had selected, which led to a final list of publications. The full text of publications meeting the screening criteria was retrieved and saved, and documents shared from the organisations contacted were added to the list. The publications in the final list were divided between three members of the review team, and information recorded in a Microsoft Excel template, using key fields that had been agreed between the review team and Professor Michael West. A summary of the interventions discussed was extracted from the template, and categorised according to the three themes governing the review; autonomy/ control, belonging and competence. The relevant interventions were incorporated into the rest of the research findings to inform the final report. The process followed is shown on Figures 1 and 2.

Literature search on physician wellbeing

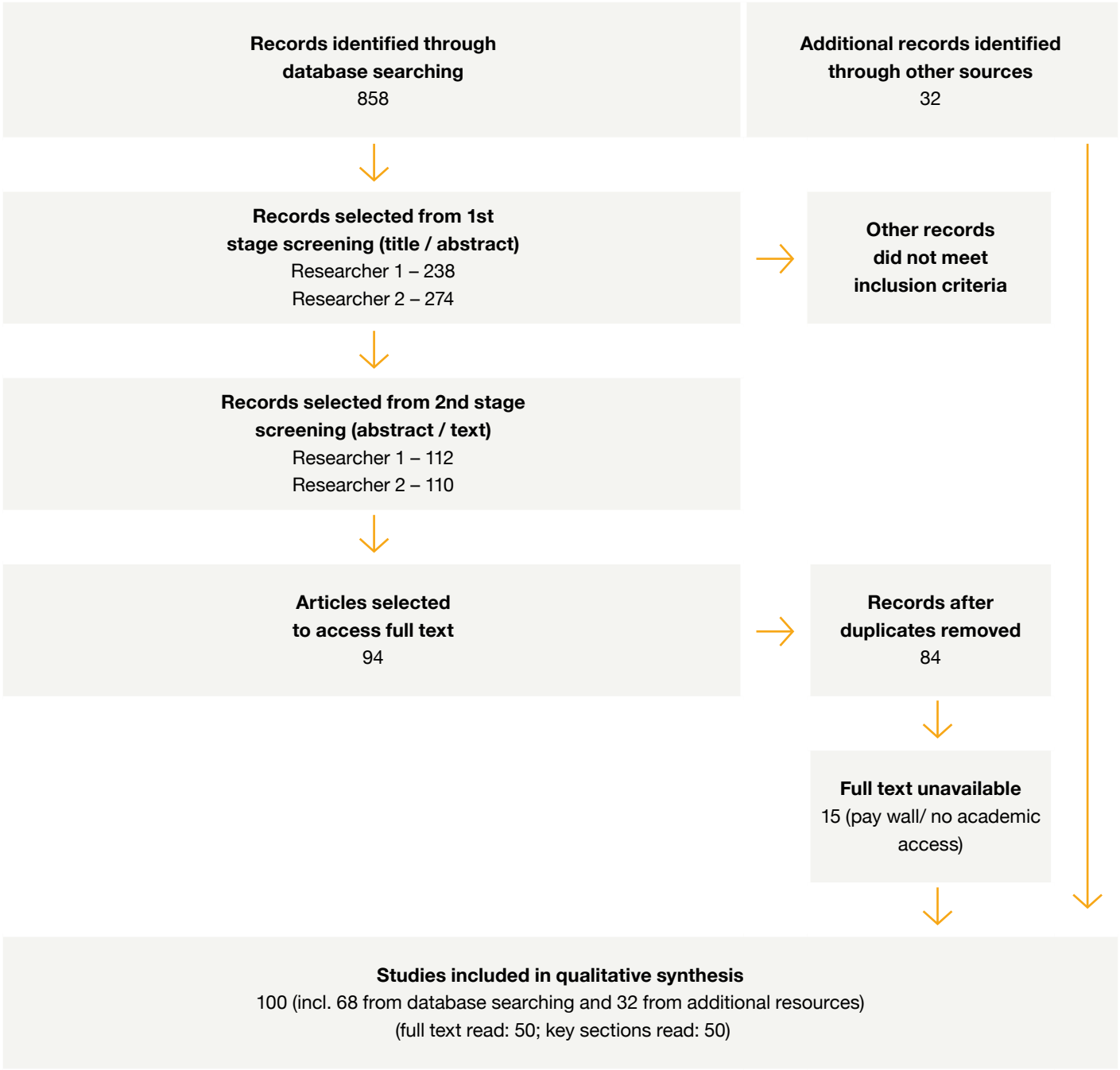

Figure 1: Flow chart for literature review component (doctor wellbeing).

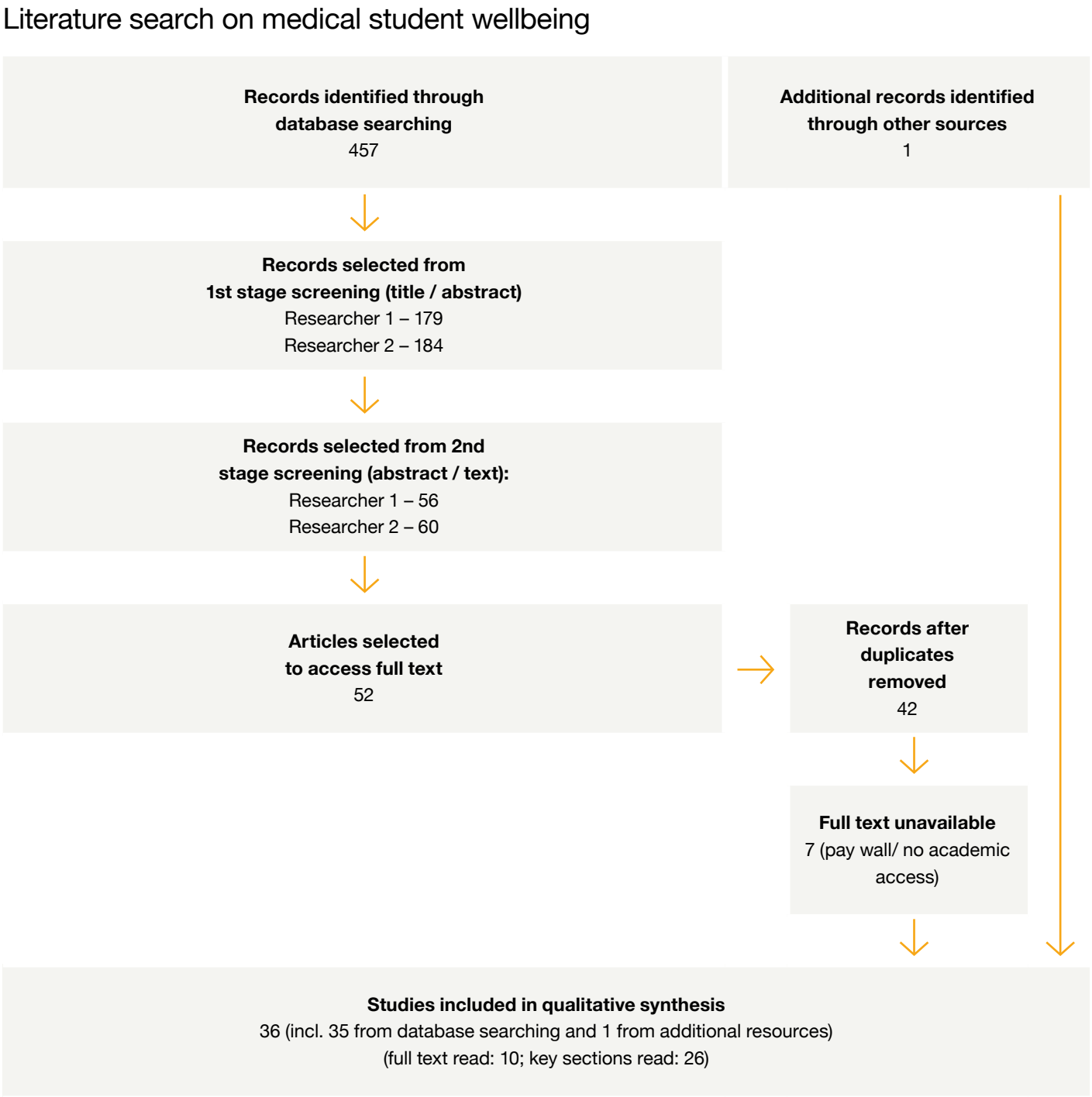

Figure 2: Flow chart for literature review component (medical student wellbeing).

4. Members of the review team attended two international conferences on the mental health and wellbeing of doctors that took place during the initial stages of the review; the WellMed Conference in Thessaloniki, Greece (9-13 May 2018); and the International Conference on Physician Health in Toronto, Canada (11-13 October 2018). The review team contacted the conference organisers after the events, and requested copies of the presentations given on initiatives to support doctors' and medical students' wellbeing. Three review team members read through the presentations and populated a standardised Excel template with key information on the initiatives.

Quantitative research

5. The national training surveys (NTS) are the GMC's annual surveys of doctors in training and trainers. They are used to monitor and report on the quality of postgraduate medical education and training in the UK. In 2018 the GMC introduced new questions on wellbeing and burnout into the surveys, and analysis of this data has been used as a key evidence source for this review. The questions were taken from the Copenhagen Burnout Inventory section on work-related burnout. Responses from the 2018 NTS were used in three strands of analysis:

    a. To measure the prevalence of burnout within the UK trainee and trainer populations – from an overall perspective, but also between different groupings of the population, including medical specialty, training level, age, ethnicity, and gender.

    b. To explore associations between burnout and other measures within the NTS. An independent researcher, Dr Pascale Daher, was commissioned to look at relationships among factors associated with doctors' reporting of stress and burnout, using structured equation modelling. Factors included workload, whether doctors in training and trainers felt supported or prepared for their role, or whether their training was disrupted by work environment factors.

    c. To understand what factors in the workplace impact on doctors' wellbeing (burnout and overall satisfaction), Dr Daher tested a series of models that looked at the impact of a set of job demands. This included workload, working hours and rota design and job resources such as teamwork, supportive environment and educational supervision on doctors' wellbeing. Dr Daher also tested models that explored whether the association between these job demands and wellbeing is contingent on the availability of job resources and, when there was an association, probed the nature of the relationship.

6. The review team accessed publicly available data from NHS England's 2018 National Staff Survey; the 2018 NHS Wales' Staff Survey; and the Scottish Government's iMatter Staff Experience Continuous Improvement model. The GMC also entered into a data sharing agreement with NHS England which enabled the team to analyse anonymised raw data from NHS England's National Staff Survey.

a. Publicly available data: The surveys were used, dependent on what was publicly available in each, to compare results between medical staff groups and other NHS staff groupings. Changes in responses for the medical staff group's results across multiple years were also examined to identify trends.

b. The review team used the anonymised raw data from NHS England's National Staff Survey from 2014 to 2018 to explore the factors that impact on doctors' wellbeing. The team also set out to understand how workplace factors might affect doctors' wellbeing both positively and negatively. Two main indicators of wellbeing were used – the first looked at positive forms of wellbeing, namely engagement and satisfaction. The second indicator focused on turnover, physical health, stress, and presenteeism. As in the NTS, Dr Daher explored the impact of a range of factors including workload, working extra hours (paid and unpaid) and a bundle of workplace support factors such as teamwork, leadership, and the availability of job resources on each of the indicators of wellbeing. To better understand how these factors interact in the workplace, Dr Daher tested a series of moderation models and where a significant interaction was found, probed for the direction of the interaction.

The GMC review team

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Anna Rowland – Assistant Director

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Adam Troughton – Data Reporting Officer

Nilla Varsani – Project Manager

Dr Catherine Walton – GMC Clinical Fellow 2019-20

Organisations the Chairs and GMC review team met with and attendees of relevant events held during the review

Academy of Medical Royal Colleges

Academy of Trainee Doctor's Group

Associates of Surgeons in Training

Black and Minority Ethnic Forum attended by:

- Association of Pakistani Physicians and Surgeons of UK
- Association of Pakistani Physicians of Northern Europe
- Jewish Medical Association UK
- British International Doctors Association
- British Association of Physicians of Indian Origin
- Pakistan Medical Association
- British Islamic Medical Association
- Muslim Doctors Association

British Industrial Design Association

British Medical Association (BMA)

BMA's Staff, Associate Specialist and Speciality Doctors (SAS) Committee

British Orthopaedics Trainees' Association

Care Quality Commission

Care Under Pressure

Chartered Institute of Personnel and Development

Confederation of Health and Social Care

Conference of Postgraduate Medical Deans

Doctors in Distress

Doctors in training roundtable event attended by:

- Chair of the BMA's Junior Doctor's Committee
- Chair of the RCGP's Associates in Training Committee
- Co-chair of the BMA's Medical Schools Committee
- Co-chair of the RCP London Trainees Committee

Doctors Support Network

Faculty of Leadership and Management

Faculty of Intensive Care Medicine

Family Doctor's Association

Government departments throughout the UK and devolved countries

KPMG

Medical Schools Council

Medical Women's Federation

MIND

NHS Confederation
NHS Employers
NHS Improvement
NHS Practitioners Programme
NHS Providers
Royal College of Anaesthetists
Royal College of Emergency Medicine
Royal College of General Practitioners
Royal College of Obstetricians and Gynaecologists
Royal College of Paediatrics and Child Health
Royal College of Pathologists
Royal College of Psychiatrists
Royal College of Radiologists
Royal College of Veterinary Surgeons
Society of Occupational Medicine
The Association of LGBT Doctors and Dentists (GLADD)
The Kings Fund

England

Association of Surgeons, England
BMA England
Charlie Waller Memorial Trust
East Lancashire Hospitals NHS Trust – focus group
Health Education England
Lancashire Teaching Hospitals NHS Foundation Trust – focus group
Leicester Medical School – focus group
Liverpool Medical School – focus group
Manchester Medical School – focus group
NHS England
NHS Practitioner Health Programme
Northamptonshire Healthcare NHS Foundation Trust – focus group
Royal Blackburn Hospital – focus group
Royal College of Physicians of London
Royal College of Surgeons of England
University Hospital Coventry & Warwickshire NHS Trust – focus group
University Hospitals of Leicester NHS Trust – focus group
Warwick Medical School – focus group
Wrightington, Wigan and Leigh NHS Foundation Trust

Northern Ireland

Department of Health Northern Ireland
Northern Health and Social Care Trust – focus group
Northern Ireland Medical and Dental Training Agency
Public Health Agency (NI)
Regulation and Quality Improvement Authority

Scotland

Academy of Medical Royal Colleges, Scotland
BMA GP Committee
BMA Junior Doctors Committee
BMA Scotland
Health and Safety Executive in Scotland
Healthcare Improvement Scotland
NHS Education for Scotland
NHS Greater Glasgow and Clyde
NHS Lothian, Edinburgh – focus group
NHS Tayside, Dundee – focus group
Royal College of General Practitioners, Scotland
Royal College of Physicians of Edinburgh
Royal College of Physicians of Edinburgh Trainee Committee
Royal College of Psychiatrists
Royal College of Surgeons of Edinburgh
Royal College of Surgeons of Edinburgh Trainee Committee
Scottish Academy Trainee Doctors Group
Scottish Association of Medical Directors
Scottish Clinical Leadership Fellows
Scottish Deans Medical Education Group
Scottish Directors of Medical Education
Scottish Government
Scottish Medical Students Committee

Wales

Academy of Medical Royal Colleges Wales
BAPIO Wales
BMA Cymru
Cardiff Medical School – focus group
Community Health Council in Wales
Healthcare Inspectorate Wales
Health Education and Improvement Wales
NHS Wales
NHS Wales Confederation
NHS Wales Employers
Powys Community Health Council
Public Health Wales
Royal College of Psychiatry, Wales
Swansea Medical School – focus group
Wales Audit Office
Welsh medical students committee

Overseas

Mayo Clinic, USA
National Academy of Medicine
The Cleveland Clinic

Annex 3 – Additional case studies

Multiple themes

Case study
Scottish wellbeing advisory group

The Scottish wellbeing advisory group, co-chaired by Dame Denise Coia and David Garbutt, has coordinated a large programme of work focused on promoting doctors' wellbeing. The group has provided leadership, built a community of good practice, and created influence and collaboration between Territorial Health Boards, NHS Education for Scotland (NES), professional bodies and the Scottish Government to bring about change across NHS Scotland.

The group's aim has been to deliver change across all Health Boards in NHS Scotland, in order to promote and improve doctors' wellbeing, system productivity and patient experience. The work is consistent with the Scottish Government's workforce strategy of a 'once for Scotland' approach, where changes are consistent within Scotland and learning is shared across geographies.

Current initiatives include:

Developing and testing early intervention pilots in two Scottish Health Boards

The GMC review team has worked with Scottish colleagues on early intervention pilots in NHS Lothian and NHS Greater Glasgow and Clyde, involving testing of interventions designed to support doctors[xi] and improve their wellbeing. With the support of senior leaders in the Boards, doctors' accounts of their working lives were mapped using a consistent survey instrument. Survey data (across domains of engagement, stress/burnout, workload) revealed that younger doctors (aged between 20-24) were more burnt out on average than older colleagues; this was also the case for Foundation Year 1 (FY1) trainees, whether this was due to FY1 doctors more likely being in the 20-24 age group, or vice versa is difficult to determine. Both surveys also showed that males in general were less burnt out than their female colleagues, significantly so when it came to personal burnout. Working nights was also shown to have a significant negative impact on results across all domains in both Health Board pilots.

The surveys undertaken in the two Health Boards included qualitative questions on workplace factors that positively contribute to wellbeing and those that could be changed to improve wellbeing at work.

Themes emerging from NHS Lothian following analysis of the qualitative responses included:

- Colleagues and teams were the most mentioned factor contributing to their wellbeing at work, followed by 'interesting work', 'time on rota', 'saying thank you' and 'rest'.

[xi] The NHS Lothian pilot surveyed only doctors in training. The NHS Greater Glasgow and Clyde pilot surveyed all doctors below consultant grade.

- Respondents often used the terms ‘friendly’, ‘supportive’, ‘caring’, and ‘approachable’ to describe their colleagues.
- Positive feedback from colleagues and patients, including patients saying ‘thank you’, boosted respondents’ wellbeing and made them feel valued.
- Respondents highlighted ‘facilities’, ‘peer and senior support’, ‘rota planning’, ‘staffing’, ‘task shifting and appropriate escalation’, ‘time for other activities including family life’, ‘shifts’ and ‘training’ as areas that could be changed to improve wellbeing at work.
- Several suggestions were made to improve facilities ranging from improving technology systems to dedicated rooms to enable private conversations when seeing patients.
- Despite identifying colleagues and their teams as positive influences to wellbeing at work, respondents also gave several constructive examples of helpful improvements to peer and senior support, including acknowledging the pressure more junior staff were under, prioritising breaks, speaking to colleagues respectfully and giving motivational and positive feedback.

The Scottish wellbeing advisory group has worked with NHS Lothian senior leaders, chief registrars, departmental teams and doctors in training to co-design an improvement programme and interventions based on the survey findings.
This has included:

- Further development of local peer mentoring programmes.
- Personal wellbeing and resilience workshops in association with local experts.
- Tests of change to facilities provided including access to hot food out of hours, rest facilities and transport solutions.
- Rota management and monitoring masterclasses to support shared understanding and engagement of managers/ senior medical staff/ doctors in training with this core process.
- Access to group structured reflective practice in more clinical areas like psychiatry, medicine of the elderly, acute medicine and the emergency department, including testing of Balint groups.
- Increasing use of positive event (e,g, GREATix and Learning from Excellence) reporting and culture change around adverse event reporting in service of a just culture.
- A full day conference organised by the chief registrars focused on supporting and valuing the medical workforce aligned to the principles of realistic medicine.
- A quality improvement showcase to value and promote the input of doctors in training in improving clinical services.

Engagement conversations have also been held with clinical teams and system leaders to facilitate change and ensure team understanding. This has included:

- Informal and formal feedback conversations with clinical teams using the data from the wellbeing survey.
- A trainee-management forum facilitating two-way communication between doctors in training and site and system management.
- Teaching fellow and chief registrar involvement in end of rotation feedback and listening conversations.
- Introduction of an electronic engagement platform for all doctors in training to allow sharing of concerns, ideas for change and facilitate open and transparent communication.
- A network of medical education coordinators that engaged formally and informally with all doctors in training, to promote engagement and highlight concerns.

The same qualitative questions were included in the NHS Greater Glasgow and Clyde survey, themes emerging following recent initial qualitative analysis of responses included:

- 'Colleagues and teams' were again by far the most mentioned factor contributing to their wellbeing at work, followed by 'saying thank you', 'working atmosphere and culture' and 'interesting work'.
- Respondents highlighted 'rota planning', 'peer and senior support', 'staffing' and 'facilities' as areas that could be changed to improve wellbeing at work the most.

The Health Board will be developing a similar programme following analysis of the qualitative responses to offer a complete picture along with the quantitative findings.

- **Providing support for doctors who are facing work-related mental health and wellbeing problems, by developing a specialist practitioner health programme.**
  Scottish Clinical Leadership fellows, with the support of the advisory group, have proposed that a doctors' specialist health service should be developed in Scotland.
- **Enhancing educational governance for doctors in training as valued members of clinical staff.**
  A review of educational governance has been undertaken by NHS Education Scotland and is being incorporated in the new NHS Scotland Blueprint for Governance, with the support of the group. They are in the process of drawing up development packages that fit under the theme of governance in general.

The Scottish wellbeing advisory group has brought together stakeholders and the Scottish Government with a desire to influence change. The group has focused on providing leadership, a mechanism for community building and helped create a critical mass to build internal momentum and external negotiating power across NHS Scotland.

Team working

Case study
Wellbeing and peer support

WARD (Well and Resilient Doctors) is an organised peer support group, comprised of registrar and above doctors in training.

WARD teams host education workshops to improve wellbeing on topics such as mindfulness, sleep and fatigue and physical health. The team currently work with foundation doctors but hope to support all doctors in training in the future.

WARD teams are placed in eight trusts in Severn at the moment, and they wish to expand the service so that it is available in every trust in the deanery. Beyond the central service, each trust has a dedicated local team who also highlight other support services offered by the trust on their website.

Voice, influence and fairness

Case study
Listening to doctors in training – University Hospitals of Leicester (UHL) NHS Trust

In November 2017, an online survey was sent to 943 junior doctors working at UHL, with 402 doctors responding. The Trust designed the survey to produce a comprehensive picture of junior doctor morale. The results highlighted many factors influencing morale, including team working and relationships, feedback, training and workload. The findings sparked a dialogue between doctors in training, senior clinicians and managers. This led to the development of a Junior Doctor Morale working group, formed in January 2018, to improve the working lives of both doctors in training and locally employed junior doctors at the Trust.

The working group introduced a number of changes, including:

- Guidance for raising concerns while on shift.
- Interventions to recognise doctors' efforts, for example monthly local junior doctor awards, and annual trust-wide educator awards.
- Workshops on having challenging conversations, to improve feedback from consultants to trainees.
- Free post-shift rest facilities for junior doctors, when they feel too tired to travel home safely.
- Allocation of 100 extra car parking passes for junior doctors.
- Creation of divisional / local junior doctor forums to give junior doctors an opportunity to express their views.

Training

Medical students

Case study iv
Inter-professional education and team-based learning – King's College London Medical School.

King's College London has a range of inter-professional workshops for medical students and other students from King's faculties as part of their curriculum. This inter-professional programme provides learning opportunities throughout students' training, and encourages the multi-disciplinary team working expected by many professional bodies.

Year 1 medical students join students from dietetics, midwifery, nursing, pharmacy and physiotherapy in learning about patient safety and team behaviour. They also undertake a programme of clinical skills simulations (involving recognition of an unwell patient) with nursing and midwifery students.

Year 2 medical students report (as part of their portfolio assessment) on their observations of inter-professional team working and communication encountered on placement.

Year 3 medical students (brought together with Year 2 nursing, midwifery and pharmacy students) complete an inter-professional education workshop on pain assessment and management, to consider how effective inter-professional collaboration enhances patients' pain management.

In Year 4 of the programme, medical students take part in an inter-professional simulation session (involving a mannequin) and de-brief to improve patient safety and care through awareness and reflection on practice with adult/child nursing and midwifery peers.

In Year 5 the students participate in a medication error prevention workshop to discuss individual and team responsibilities in the delivery of safe medicines management with colleagues from other disciplines. They also participate in a multi-disciplinary Schwartz Round during their Transition to Practice module.

Further, medical students can sign up voluntarily to take part in a half-day workshop on collaborative teamwork in mental health where medical students form small groups. They work in partnership with a patient educator and clinical psychology, mental health nursing, pharmacy and occupational therapy students. This workshop aims to develop the skills required for person-centred care planning within a mind-body approach.

There are also several inter-professional learning programmes in development, including medication review, e-prescribing, and experiential learning in maternity care.

Workload

Case study
Workforce initiatives – Royal College of Emergency Medicine (RCEM)

RCEM has highlighted evidence that working in highly pressurised healthcare environments damages the health and wellbeing of clinical staff. Emergency physicians are amongst those at the highest risk of mental ill health, compassion fatigue and career burnout. The College also highlighted the imbalance between consultant numbers and the growth in attendance at the Emergency Department.

The College has provided guidance on system design, job planning and wellbeing strategies for emergency medicine. The key principles from this guidance are to:

- Maximise safe working practices for emergency medicine consultants working a significant part of their time out of hours to allow more proportionate time off, so that they have time to rest, recover and recuperate from the intensity of the working environment.
- Actively support the development of portfolio and less than full time (LTFT) working careers, where appropriate.
- Develop job plans for the older emergency physicians, so that they can balance their clinical and non-clinical work. The proposals should allow for opting out of onerous on call and night time clinical duties.

The College also made staffing recommendations in relation to size of service and shift. It defined the desirable ratio between a consultant and new attendances as one whole time equivalent (WTE) Consultant to between 3,600-4,000 new attendances. This would depend upon the complexity of workload and associated clinical services for which an Emergency Department is responsible.

The College also published a workforce plan with several commitments, including:

- Increased growth and recruitment into the specialty, through ‘expansion cohorts’ with Health Education England (HEE), the defined route of entry into emergency medicine (DRE-EM) training programme, international recruitment, particularly as part of ‘earn, learn and return’ schemes, and other routes.
- Investment into the growth of the advanced clinical practitioner (ACP) workforce in emergency care.
- Investment in a leadership/personal development training programme for every emergency medicine trainee.
- Providing funding to and working with a third of the trusts highlighted in the GMC's NTS as having the biggest problems with their training environment, to develop and implement clinical educator strategies.

- Piloting LTFT training for all higher specialty training year 4 (ST4) and above trainees in emergency medicine.
- Development of post Certificate of Completion of Training (CCT) fellowships.
- Joint publication of a best practice guide with NHS Improvement, that trusts will be expected to use to improve their recruitment and retention in emergency departments.

These commitments have been designed to address the issues of growing a multi-professional workforce, reducing attrition in medical training, and improving retention.

Culture and leadership

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Case study

Buddying agreement between organisations – Guy's and St Thomas' Hospital NHS Foundation Trust and Medway NHS Foundation Trust

Buddying was introduced in 2013 by the Department of Health to support NHS organisations in special measures. These partnering arrangements differ from other regulatory measures, in that they embed a team of senior clinicians and managers from a high performing organisation into a struggling hospital. A 2014 review by the Foundation Trust Network has suggested that buddying arrangements are well-received by most organisations, with clear opportunities for peer-based learning.

Senior clinical and managerial teams from a high-performing organisation, Guy's and St Thomas' Hospital NHS Foundation Trust (GSTT), provided buddying support to colleagues from an organisation in difficulty, Medway NHS Foundation Trust (MFT). This was to rapidly improve safety and quality of care and help a recently appointed management team to improve performance. In March 2015, a buddying partnership was agreed for 18 months, subsequently extended to 28 months.

The aim was to promote close working partnerships, compassionate leadership and improve patient quality of care, safety and efficiency. Equally important was the emotional and pastoral support for staff at the trust in difficulty, which helped them enact change during periods of scrutiny, perceived failure and low team morale.

A review published on the programme† cites the beneficial impact of two interventions:

- Firstly, the value of a buddying arrangement, in which staff from GSTT provided advice, operational assistance, compassionate leadership and pastoral support to colleagues at MFT during planning and implementation of a new medical pathway.
- Secondly, the effectiveness of a whole system medical pathway transformation, in which physical estate (i.e. ambulatory emergency care, acute admissions wards) and medical processes (i.e. medical rotas, staffing, handovers, board rounds and specialist referral) were changed.

GSTT appointed project managers and clinical leads with defined responsibilities and seconded nursing, medical and managerial staff to provide targeted input (e.g. leadership support) and mentoring for MFT staff. In total, 113 GSTT staff contributed to the buddying programme, of whom 19 (including three contract managers) were involved in the medical pathway. The buddying team worked closely with MFT's local improvement programme, operational teams, NHSI and the Emergency Care Improvement Support Team (ECIST). Progress was communicated to MFT's board, external agencies (ie NHSI) and operational managers at regular team meetings.

The authors of the programme review noted the programme demonstrated that significant improvement in performance, safety, quality of care and patient/staff experience can be achieved at pace (<10 weeks) if supported by effective team working and appropriate external and regulatory input. The authors also noted their experience suggests that buddying can be an effective way to promote change and support a trust in difficulty, when included within a comprehensive improvement programme.

† Leach R, Banerjee S, Beer G, Tencheva S, Conn D, Waterman A et al. Quality Improvement: Supporting a hospital in difficulty: experience of a 'buddying' agreement to implement a new medical pathway.

Case study
Leadership interventions – Mayo Clinic

The Mayo Clinic is a non-profit integrated multi-specialty group practice in the US which has 4,500 physicians (242 of them are in titled leadership positions). It has developed and validated two leadership interventions that led to significant increases in professional satisfaction and reductions in professional burnout.

'Listen-ask-develop'

The practice of 'Listen-ask-develop' is a team-based approach to eradicate the root causes of professional burnout. It works in teams of doctors and with integrated care teams. The model directs the removal of frustrations one at a time and engages professionals as partners in co-creation activities to identify and solve problems. The technique begins with the assumption that systems and behaviours are the problem, not people.

The 'Listen-ask-develop' model is intended to:

- Identify drivers of burnout.
- Foster healthy clinician-leadership relationships.
- Engender teamwork and camaraderie.
- Support development of clinician leaders.
- Alleviate burnout by improving team dynamics, processes, and systems of care.

The work unit leaders ensured action was taken in partnership with members to address points raised by doctors following the 'listen' stage of the model to ensure its success. Issues outside of the control of the work unit were communicated to appropriate leaders in the organisation and timely feedback was given regarding the action plan (Swensen et al, 2017).

Using the technique to identify and remove local frustrations, teams at Mayo Clinic reduced burnout and improved satisfaction. In 217 clinical units with approximately 11,000 staff, satisfaction improved by 17%, burnout decreased by 21%, and teamwork increased by 12% (Swensen et al, 2016).

'The Leader Index'

A team at the Mayo Clinic has identified five Leader Index Behaviours that positively impact physicians' professional fulfilment, satisfaction and burnout. These are:

- Include: Nurture a culture where all are welcome and psychologically safe.
- Inform: Transparently share what you know with the team.
- Inquire: Consistently solicit input and ideas of associates.
- Develop: Support professional development and career aspirations of staff.
- Recognise: Express appreciation and gratitude in a meaningful way to colleagues.

The team at the Mayo Clinic has developed a way to evaluate these behaviours, and develop and select leaders for them. The leadership qualities, behaviours and actions are also teachable.

The Clinic formally assesses the performance of physician leaders each year through the Leader Index, using a 12-question staff-wide survey evaluating the five key leader behaviours (Swensen et al, 2016). The results are shared with leaders, who are supported to improve with workshops, training and dedicated coaching sessions. If leaders could not or did not wish to improve, they were moved on from their positions because of the degree of impact on the morale of their workforce.

The Mayo Clinic has succession pools for all leadership positions, which are rated for readiness, competence, and ethnic and gender diversity. Individuals holding these positions rotate after two four-year terms so no leader is in position longer than eight years.

Based on the success of the work with physicians, the Clinic scaled the Leader Index management to include all (over 3,300) point of care leaders such as nurse managers and social worker supervisors.

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Case study

Collective Leadership project – Belfast Health and Social Care Trust

The Collective Leadership project at the Belfast Trust started with a new structure aimed at creating high levels of medical participation and medical and clinical engagement. The new triumvirate structure means each division is led by a team of three, chaired by a doctor. This aims to give formal senior leadership roles to doctors, makes doctors professionally accountable for the medical leadership in the division, drives multi-disciplinary working at senior levels and encourages medical involvement in decision making. In 2018, the Trust started its culture programme to create a baseline of the current culture and change culture. By the middle of 2019, when the Change Team presented its results to the Board, 2,000 staff had participated.

Other organisational development approaches are aimed at creating the behaviours and culture needed for collective leadership to be effective. A culture in which people relate to each other differently and with more compassion. Of these, staff report that they value:

- Role modelling a more intentional, compassionate, appreciative and visible leadership by senior leaders, including the Chief Executive and Medical Director.
- Development of a medical engagement strategy focusing on quality improvement. Care was taken to implement it thoughtfully in such a way it was clear thought had been given to reducing the extra burden. For example, during out of hours QI training doctors were encouraged to bring their children if they wished. QI programs have given doctors the skills to create a positive sense of influence over the quality of the service.
- Embedding a different style of leadership through a medical development programme through The King's Fund and increasing doctors' voice through focus groups and open sessions.
- Creating a more compassionate culture through the adoption of Schwartz Rounds, listening events which tackle fear cultures where they exist in pockets or are created by changes in the wider context, and workshops on just culture.
- Encouraging team-based working across the integrated care model.

Case study
Wellbeing initiatives – The Cleveland Clinic

The Cleveland Clinic is a non-profit, multi-specialty academic medical centre, which provides clinical services and conducts academic research. The Clinic has taken multiple approaches to improve the wellbeing of their clinicians and staff, including:

- Communicating **vision and leadership principles** by expressing to staff that they are part of a team of compassionate caregivers that aim to transform healthcare. This is also expressed through the values of the organisation that every person has to meet: quality, safety, empathy, innovation, teamwork, inclusion and integrity.
- Running **town hall meetings**, where senior leaders from the Clinic spoke to staff using a standardised toolkit to understand their perspective on the Clinic's strengths and deficits. This effort ran with leadership support across 60,000 members of staff and a key goal was to create a culture of safety and an environment of listening and respect. The feedback from the town hall meetings allowed leaders in each department to identify three or four things to tailor. A key characteristic was the 'strength and deficit approach', where departments focus was not just on improving deficits, but also concentrated on enhancing strengths.
- Conducting an **engagement survey** achieving staff engagement of 68%.
- Running a **learning academy** in the Clinic's Global Centre for Learning. This includes a healthcare leadership course, a management programme, and a course on empathy and its importance in clinicians' roles. Every doctor in the Clinic went offline for half a day to attend a communications course on how to interact with patients and make sure that interactions are meaningful. The management programme also asked managers to go to lunch together once a month to share their experiences and learning.
- Running a **coaching and mentoring programme**, which included training for staff on how to be coaches and mentors. The programme started with an orientation at the beginning of the year where staff could approach potential mentors. In addition to affecting the sense of belonging to the organisation, mentors can help their mentees with specific advice for career development and fulfilling their goals.
- Providing **mindfulness resources** to staff and a **wellbeing day** once a year.
- Addressing the 'pebbles in the shoes' to remove **small frustrations** that can have a big impact, and enable staff to fully concentrate on supporting patients:
  - Conscious efforts to make Electronic Medical Records (EMRs) easier for doctors, including creating a secure app to put EMRs on doctors' phones.
  - Developing a 'tap and go' option to sign into systems in the clinic instead of entering a password. This saves time as it needs to be done multiple times each day
  - Giving the ability to park near to the ward where doctors' patients are located.

Case study

Professional Compliance Analysis Tool (PCAT) – Scottish Government Health Workforce and Strategic Change Directorate

The Scottish Government Health Workforce and Strategic Change Directorate developed a quality improvement framework: the Professional Compliance Analysis Tool. PCAT was designed to improve working patterns, quality of training, clinician wellbeing and patient safety. It offers a way for teams and departments to celebrate good practice and identify areas for improvement. PCAT is locally owned and led by those who experience and see its impact directly. Local teams are able to tailor questions asked in surveys, this has helped participation levels and recipients remain anonymous. Combined with quantitative data collected, PCAT has provided a robust tool that accurately reflects trainees' views of their experiences, which can then inform meaningful discussions around potential areas of improvement. Entire teams discuss findings to agree on QI processes, accountabilities and timelines. Trainees have reported this process has engaged and empowered them as it has allowed them to see real changes being implemented as a direct result of their feedback.

PCAT has been successfully rolled out across Scotland, providing whole-system data collection but also offering in-depth and specific analysis of individual departments' strengths and opportunities. Using locally owned data to inform QI conversations can effect genuine improvement and enhance staff experience in a way that may be unachievable by centrally administered surveys.

Management and supervision

Case study xi
GP appraisal report

The focus of the Medical appraisal: Feedback from GPs in 2018-19 report by NHS England and NHS Improvement was to look at GPs' perspective of their annual appraisal across different areas of the country, to understand whether it's necessary, offers value for money and is beneficial to doctors and patients. Feedback was provided by a total of 13,440 GPs (estimated 30% of the GP workforce in England), supplied by 10 of 16 NHS England Local Offices. The feedback was very positive, with 88% of respondents agreeing that their appraisal contributes to improvements in patient care, and 91% agreeing it was useful for promoting quality improvement. Many GPs commented specifically about being supported by their appraiser through difficult times. The results were more positive than the equivalent results in the 2017 survey by the Royal College of General Practitioners (RCGP), which had a smaller sample (1,100 respondents). Despite the positive feedback on annual appraisals in this report, areas for ongoing improvement were minimising the burden of less valuable activities for doctors, and optimising the platform or product used for recording supporting information for appraisals.

The Royal College of General Practitioners in Scotland surveyed its members in 2018, in relation to how they felt about working in general practice, what motivated them, what worried them, what impact working had on their wellbeing, and their views on the future. The survey received 355 responses from practising GPs and those who had recently left the profession, representing a cross-section of approximately 8% of Scotland's GP workforce. Almost 70% of GPs reported spending time face-to-face with patients, working as part of a team and improving patient outcomes as their primary motivations. At the same time however:

- 57% said they think working in general practice will get worse over the next few years and 26% said that they're unlikely to be working in general practice in five years' time.
- 37% feel so overwhelmed by their daily tasks that they feel they cannot cope at least once per week.
- 44% said stress had impacted their mental health and 29% their physical health. 39% of respondents thought stress had impacted their decision making and patient care, and 35% reported it impacted their personal life.

GPs considered more opportunities for team building and learning within their practice and longer consultation times as the most attractive approaches to address the issues.

Case study
Supporting doctors in difficulty – Wrightington, Wigan and Leigh NHS Foundation Trust

In recent years Wrightington, Wigan and Leigh NHS Foundation Trust has worked jointly with other trusts to offer remediation services. The services supported doctors encountering difficulties with their clinical competencies, communication, behaviour or relationship difficulties with their colleagues. This has involved the development of an intensive remediation plan, the establishment of supervision and mentorship support, and the direct involvement of the Medical Director to oversee the process. A clinical supervisor was appointed in each case to support the doctor.

Interventions to support staff mental health

The Trust has brought in initiatives to support staff mental health, including:

- Development of the Critical Incident Stress Management service (CISM). This is a coordinated response to support staff following a distressing incident, offering debrief sessions to support staff with the after effects, their stress reaction and levels of resilience.
- Power Pause – an emotional first aid kit to support staff during times of high pressure. It is designed to help staff to rest, as and when they need to, throughout their working day and recharge through taking breaks.
- Take 10's – to reflect on stress levels and the impact on health and wellbeing. The Trust takes this proactively out to staff, establishing a temporary base when required, to encourage people to attend.
- Giving staff the 'gift of time' on their birthday – with a complementary day off work.
- Running a range of financial wellbeing schemes to ease the stress of money worries, including debt consolidation, loan services, pay advances, savings through payroll and support and advice.

Case study xiii
Medical Peer Support – NHS Ayrshire & Arran

A medical peer support program for consultants and SAS doctors was launched in NHS Ayrshire & Arran in spring 2018 as a result of a self-directed initiative. Trained consultants and SAS grade clinicians (peer supporters) offer support to colleagues who struggle from the emotional impact of an adverse event or a difficult professional or personal experience. Reactions can include sadness, shame, anger, fear, guilt and isolation. Unresolved these can result in depression, anxiety, burnout, sickness absence and suicide. The adverse effect on others such as family, colleagues, team and the quality of patient care can be significant. A prevalent culture of invulnerability and perfectionism makes it very difficult for clinicians to share their emotions. Evidence, however, suggests that senior grade doctors prefer to talk with a peer. Peer support is not therapy but offers temporary social support as empathic and non-judgemental listening from a colleague in a safe space. It is entirely confidential and voluntary.

A lot of evidence about medical peer support originates from Jo Shapiro, an Otolaryngologist at the Brigham and Women's Hospital in Boston who initiated a peer support programme[††]. The NHS Ayrshire & Arran peer support group was inspired by that programme to implement the model. There are now 14 peer supporters offering support to consultant and SAS doctor colleagues. In the first year, 23 one-to-one peer support conversations took place. A confidential system of self-referral or referral by clinical or associate medical directors offers any senior clinician direct access to peer support. Contact can also be made via a confidential mailbox. A list of all 14 peer supporters and details of the program are available on the Ayrshire & Arran internal website. Close links exist with mental health, psychology and occupational health for advice and onward referral if necessary. The peer supporters meet every two months for mutual support and updates. A twice-yearly training day maintains and enhances peer support skills. To ensure utmost confidentiality no paper or electronic records are kept. An annual activity report without any personal details is generated. Local management has been very supportive of the program. A need to expand peer support to senior specialist trainees in NHS Ayrshire & Arran has been identified.

Other health boards in Scotland are now developing peer support programs. Plans are also afoot to create a Scottish peer support network.

In times where social interaction at work has diminished as a result of changes in work patterns in healthcare, peer support offers a safe space for conversation and listening for clinicians who struggle to go through a difficult period. According to Jo Shapiro, peer support is 'one way forward toward a culture of community that truly values a sense of shared organisational responsibility for clinician wellbeing and patient safety'[††].

[††] Shapiro J, Galowitz P. Peer Support for Clinicians. Academic Medicine. 2016;91(9):1200-1204.

Case study
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Learn Not Blame Campaign – Doctors' Association UK

Doctors' Association UK's 'Learn Not Blame' campaign aims to empower individual doctors to be part of a transformational change process working towards a revolution in the culture of the NHS. The campaign encourages individuals to commit to action within their own sphere of influence, and join together as a movement to put pressure on NHS leadership to mirror that change and commit at a Trust or Health Board level to an open, learning and just culture.

Equality, Diversity and Inclusion

Case study
Ethnic Minority Network – North East London Foundation Trust

North East London NHS Foundation Trust has been making continued improvements for BME doctors alongside the wider organisation. The Trust's ethnic minority network (EMN) ambassadors include representatives from medical staffing, to ensure issues affecting medical colleagues are included in the implementation of the EMN's strategy.

This has involved adopting an NHS Equality Delivery System, a framework to help them continually improve their performance on equality. Actions have included:

- Development programmes for BME staff.
- Developing more targeted adverts to attract under-represented sections of the community.
- Rolling out 'fair treatment' panels to triage disciplinary cases.
- Appointing another BME-origin member to the Trust's board voting membership.
- Appointing a medical consultant EMN network ambassador, who works directly with the executive medical director to raise any issues.
- Planning to deliver a 'cultural intelligence' training session for all medical staff across the trust.
- The Trust's focus for the EMN Strategy is to have a key objective to support medical staff around formal disciplinary processes.

Annex 4 – Compassionate and inclusive leadership

Compassionate and inclusive leadership

There is a collective aspiration across the four UK health systems to develop compassionate and inclusive/collective leadership. This is done through:

- The People Plan by NHS England;
- The HSC Collective Leadership Strategy in Northern Ireland;
- Project Lift in Scotland and
- A Healthier Wales, the new Health and Social Care strategy in Wales.

The challenge is to ensure that these commitments are translated into practice.

Compassionate leadership comprises four elements:

Attending: The first element of compassionate leadership is being present with and attending to those we lead. Leaders who attend will model being present with those they lead and 'listening with fascination' (Kline, 2002).

Understanding: The second component involves leaders appraising the situation those they lead are struggling with to arrive at a measured understanding. Ideally, leaders arrive at their understanding through dialogue with those they lead and perhaps have to reconcile conflicting perspectives rather than imposing their own understanding.

Empathising: The third component of compassionate leadership is empathising. Compassionate leadership requires being able to feel the distress or frustration of those we lead without being overwhelmed by the emotion and therefore unable to help.

Helping: The fourth and final component is taking thoughtful and intelligent action to help the other. Probably the most important task of leaders in healthcare is to help those they lead to deliver the high-quality, compassionate care they want to provide.

What compassionate leadership does not mean is:

- loss of commitment to purpose, high-quality performance or good performance management
- difficult conversations being labelled as bullying
- always taking the easy, consensus way forward rather than putting patients and communities first
- not being able to challenge the status quo and make the radical changes patients and communities need or
- team work and system working being controlled by whoever has the most power and is most ruthless (see https://www.kingsfund.org.uk/blog/2019/05/five-myths-compassionate-leadership).

If we are to create compassionate cultures in organisations it is also vital to have inclusive leadership. The Fair to refer? report identified steps that need to be taken to ensure that the needs of all doctors, including those in isolated roles or perceived as 'outsiders', are understood and addressed. Without shifts in power, compassionate leadership could be a fig leaf for controlling others.

Compassionate leadership can be seen as including key aspects of leadership in our national health services.

Compassionate leadership

Attending	Understanding	Empathising	Helping
Effective leadership • *Direction* A clear, shared, inspiring purpose or vision • *Alignment* Clear goals for people and teams aligned and springing from the vision • *Commitment* Developing trust and motivation amongst all	**Inclusive leadership** • Clear, shared, inspiring purpose or vision • Positively valuing difference • Frequent face to face contact • Continuous commitment to equality and inclusion • Clear roles and strong teams	**Collective leadership** • Everyone has leadership responsiblity • Shared leadership in teams • Interdependent leadership = working together across boundaries • Consistent leadership style across the organisation	**System leadership** • Shared vision and values • Long term objectives • Frequent face to face contact • Constructive and ethical conflict management • Mutual support and altruism across organisational and sector boundaries

In more detail, attending includes:

- noticing suffering at work
- inquiring about suffering or distress
- recognising time pressure, overload and performance demands that distract us from noticing suffering
- challenging policies, rules, and norms of conduct oriented to blame and punishment

Understanding includes:

- seeing that suffering is often masked by missed deadlines, errors or difficult work situations
- learning to be curious about the causes of difficult or ambiguous work situations
- cultivating the default assumption that others are good, capable and worthy of value
- withholding blame by focusing on learning
- giving others dignity and worth whatever their role or difference

Empathising includes:

- being present
- remaining calm and steady in the face of suffering
- developing empathic listening, allowing leaders to be present without needing to fix, solve or intervene necessarily
- identifying with others by feeling similar

Helping includes:

- focusing on what is most useful for the other
- taking action that addresses suffering
- creating flexible time to cope with suffering, buffering others from overload
- avoiding legalistic approaches that deny human connection
- addressing corrosive politics, toxic interactions, underperformance via 'fierce compassion'
- empathising, integrity and confidentiality
- recognising that compassion is neither weak nor vulnerable

For more detail, see:

West, M. A. & Chowla, R. (2017). Compassionate leadership for compassionate health care. In Gilbert, P. (ed.). *Compassion: Concepts, Research and Applications*. (pp. 237-257). London: Routledge.

West, M., Collins, B., Eckert, R. and Chowla, R. (2017). Caring to change. [online] Available at: https://www.kingsfund.org.uk/publications/caring-change [Accessed 24 Oct. 2019].

Annex 5 – Sources of support

Sources of support

During the review we identified a number of excellent services providing support and advice to doctors and medical students.

The British Medical Association have compiled a list of support services that doctors and medical students may find useful. This includes a directory of wellbeing support services around the UK, specifically for those looking for local support.

This list can be accessed at www.bma.org.uk/advice/work-life-support/your-wellbeing/sources-of-support.

Bibliography

Bibliography

1. NHS staff management and health service quality [Internet]. GOV.UK. 2019. Available from: https://www.gov.uk/government/news/nhs-staff-management-and-health-service-quality

2. NHS Employers. Staff experience and patient outcomes: What do we know? [Internet]. 2014. Available from: https://www.nhsemployers.org/~/media/Employers/Publications/Research%20report%20Staff%20experience%20and%20patient%20outcomes.pdf

3. The King's Fund. Employee engagement and NHS performance [Internet]. 2012. Available from: https://www.kingsfund.org.uk/sites/default/files/employee-engagement-nhs-performance-west-dawson-leadership-review2012-paper.pdf

4. NHS England. Links between NHS staff experience and patient satisfaction: analysis of surveys from 2014 and 2015 [Internet]. 2018. Available from: https://www.england.nhs.uk/wp-content/uploads/2018/02/links-between-nhs-staff-experience-and-patient-satisfaction-1.pdf

5. West M, Markiewicz L. Effective team work in health care. In: Ferlie E, Montgomery K, Reff Pedersen A, ed. by. The Oxford handbook of health care management. Oxford University Press; 2016. p. 231-252.

6. West C. Association of Resident Fatigue and Distress With Perceived Medical Errors. JAMA [Internet]. 2009 [cited 29 October 2019];302(12):1294. Available from: https://jamanetwork.com/journals/jama/article-abstract/184625

7. The King's Fund. Closing the gap: key areas for action on the health and care workforce [Internet]. 2019. Available from: https://www.kingsfund.org.uk/sites/default/files/2019-03/closing-the-gap-health-care-workforce-overview_0.pdf

8. NHS England. National NHS Staff Survey 2018 [Survey]. Data accessed 30 October 2019. Additional analysis conducted on data provided by NHS England.

9. 2015 HSC staff survey regional report | Department of Health [Internet]. Health Available from: https://www.health-ni.gov.uk/publications/2015-hsc-staff-survey-regional-report

10. NHS Wales. NHS Wales Staff Survey 2018: National report [Internet]. 2018. Available from: http://www.wales.nhs.uk/sitesplus/documents/866/4.3b%20National%20Staff%20Survey%20Report.pdf. Additional analysis conducted on data provided by NHS Wales.

11. Manchester Centre for Health Economics, Policy Research Unit in Commissioning and the Healthcare System. Eighth National GP Worklife Survey [Internet]. 2019. Available from: http://www.population-health.manchester.ac.uk/healtheconomics/research/Reports/EighthNationalGPWorklifeSurveyreport/EighthNationalGPWorklifeSurveyreport.pdf

12. The Royal College of General Practitioners Scotland. From the Frontline: The changing landscape of Scottish general practice [Internet]. 2019. Available from: https://www.rcgp.org.uk/-/media/Files/RCGP-Faculties-and-Devolved-Nations/Scotland/RCGP-Scotland/2019/RCGP-scotland-frontline-june-2019.ashx?la=en

13. General Medical Council. National Training Surveys 2019 [Survey]. Data accessed 30 October 2019. Additional analysis conducted on internal data.

14. General Medical Council. Internal registration data. 17 June 2019

15. British Medical Association. How much does it cost to train a doctor in the United Kingdom? [Internet]. 2013. Available from: https://www.bma.org.uk/-/media/files/pdfs/working%20for%20change/policy%20and%20lobbying/welsh%20council/nhs%20wales%20workforce%20review.pdf?la=en

16. Statistics - Industries [Internet]. Health and Safety Executive. 2019 [cited 29 October 2019]. Available from: http://www.hse.gov.uk/statistics/industry/index.htm

17. Health and Social Care Northern Ireland Quarterly Workforce Bulletin June 2019 [Internet]. Health-ni.gov.uk. 2019 [cited 29 October 2019]. Available from: https://www.health-ni.gov.uk/sites/default/files/publications/health/hscwb-key-facts-june-2019.pdf

18. NHS National Services Scotland, Information Services Division. NHS Scotland Workforce: Quarter ending 30 June 2019 [Internet]. 2019. Available from: https://www.isdscotland.org/Health-Topics/Workforce/Publications/2019-09-03/2019-09-03-Workforce-Summary.pdf

19. BMA Cymru Wales. CALL FOR EVIDENCE BY THE NHS WALES WORKFORCE REVIEW: Response from BMA Cymru Wales [Internet]. Available from: https://www.bma.org.uk/-/media/files/pdfs/working%20for%20change/policy%20and%20lobbying/welsh%20council/nhs%20wales%20workforce%20review.pdf?la=en

20. Sickness absence falls to the lowest rate on record - Office for National Statistics [Internet]. Office for National Statistics. 2019 [cited 29 October 2019]. Available from: https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/articles/sicknessabsencefallstothelowestratein24years/2018-07-30

21. Welsh Government. Sickness absence in the NHS in Wales, quarter ended 31 March 2019 [Internet]. 2019. Available from: https://gov.wales/sites/default/files/statistics-and-research/2019-08/sickness-absence-nhs-wales-quarter-ended-31-march-2019-549.pdf

22. NHS National Services Scotland, Information Services Division. NHS Scotland Workforce: Quarter ending 30 June 2019 [Internet]. 2019. Available from: https://www.isdscotland.org/Health-Topics/Workforce/Publications/2019-09-03/2019-09-03-Workforce-Summary.pdf

23. Committee for Finance and Personnel. Report on Sickness Absence in the Northern Ireland Public Sector, Volume 1 [Internet]. 2015 p. 26. Available from: http://www.niassembly.gov.uk/globalassets/documents/reports/finance/report-on-sickness-absence-vol1.pdf

24. Oliver D. David Oliver: Moral distress in hospital doctors. BMJ [Internet]. 2018 [cited 29 October 2019];:k1333. Available from: https://www.bmj.com/content/360/bmj.k1333

25. Forde R, Aasland O. Moral distress among Norwegian doctors. Journal of Medical Ethics [Internet]. 2008 [cited 29 October 2019];34(7):521-525. Available from: https://jme.bmj.com/content/34/7/521.long

26. Penfold R. Why junior doctors need more autonomy. 2019. BMA - Quarterly survey Q2 2017 [Internet]. Bma.org.uk. 2019 [cited 23 October 2019]. Available from: https://www.bma.org.uk/collective-voice/policy-and-research/education-training-and-workforce/quarterly-survey/quarterly-survey-results/quarterly-survey-q2-2017

27. Moberly T. Sickness absence rates across the NHS. BMJ [Internet]. 2018 [cited 29 October 2019];:k2210. Available from: https://www.bmj.com/content/361/bmj.k2210

28. Mitchell K, Vayalumkal J. Sickness presenteeism: The prevalence of coming to work while ill among paediatric resident physicians in Canada. Paediatrics & Child Health [Internet]. 2017 [cited 29 October 2019];22(2):84-88. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5804915/

29. Aysun K, Bayram Ş. Determining the level and cost of sickness presenteeism among hospital staff in Turkey. International Journal of Occupational Safety and Ergonomics. 2017;23(4):501-509.

30. Wall T, Bolden R, Borrill C, Carter A, Golya D, Hardy G et al. Minor psychiatric disorder in NHS trust staff: Occupational and gender differences. British Journal of Psychiatry. 1997;171(6):519-523.

31. British Medical Association. Fatigue and sleep deprivation – the impact of different working patterns on doctors [Internet]. 2018. Available from: https://www.bma.org.uk/collective-voice/policy-and-research/education-training-and-workforce/fatigue-and-sleep-deprivation

32. Salminen S. Shift Work and Extended Working Hours as Risk Factors for Occupational Injury. The Ergonomics Open Journal [Internet]. 2010 [cited 29 October 2019];3(1):14-18. Available from: https://www.researchgate.net/publication/228708597_Shift_Work_and_Extended_Working_Hours_as_Risk_Factors_for_Occupational_Injury

33. General Medical Council. Fitness to practise matters that UK medical graduates declared to the GMC. 2018.

34. Osborn R e. Primary Care Physicians In Ten Countries Report Challenges Caring For Patients With Complex Health Needs. - PubMed - NCBI [Internet]. Ncbi.nlm.nih.gov. 2019 [cited 3 October 2019]. Available from: https://www.ncbi.nlm.nih.gov/pubmed/26643631

35. British Medical Association. Caring for the mental health of the medical workforce [Internet]. 2019. Available from: https://www.bma.org.uk/collective-voice/policy-and-research/education-training-and-workforce/supporting-the-mental-health-of-doctors-in-the-workforce

36. National training surveys reports [Internet]. Gmc-uk.org. 2019 [cited 29 October 2019]. Available from: https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/national-training-surveys-reports

37. Manchester Centre for Health Economics, Policy Research Unit in Commissioning and the Healthcare System. Ninth National GP Worklife Survey [Internet]. 2017. Available from: http://blogs.lshtm.ac.uk/prucomm/files/2018/05/Ninth-National-GP-Worklife-Survey.pdf

38. Royal College of Physicians. Bring a junior doctor: Experiences from the front line of the NHS [Internet]. 2016. Available from: https://www.rcplondon.ac.uk/guidelines-policy/being-junior-doctor

39. Royal College of Physicians. Doing things differently: Supporting junior doctors in Wales [Internet]. 2019. Available from: https://www.rcplondon.ac.uk/projects/outputs/doing-things-differently-supporting-junior-doctors-wales

40. Oskrochi Y, Maruthappu M, Henriksson M, Davies A, Shalhoub J. Beyond the body: A systematic review of the nonphysical effects of a surgical career. Surgery [Internet]. 2016 [cited 29 October 2019];159(2):650-664. Available from: https://www.surgjournal.com/article/S0039-6060(15)00656-X/fulltext

41. Society of Occupational Medicine and The Louise Tebboth Foundation. What could make a difference to the mental health of UK doctors? A review of the research evidence [Internet]. 2018. Available from: https://www.som.org.uk/sites/som.org.uk/files/What_could_make_a_difference_to_the_mental_health_of_UK_doctors_LTF_SOM.pdf

42. Atewologun D, Kline R. Fair to Refer? Reducing disproportionality in fitness to practise concerns reported to the GMC [Internet]. 2019. Available from: https://www.gmc-uk.org/-/media/documents/fair-to-refer-report_pdf-79011677.pdf

43. Williams D, Mohammed S. Discrimination and racial disparities in health: evidence and needed research. Journal of Behavioral Medicine [Internet]. 2008 [cited 29 October 2019];32(1):20-47. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2821669/

44. GP Health Service, Practitioner Health Programme. The Wounded Healer: Report on the First 10 Years of Practitioner Health Service [Internet]. 2018. Available from: http://php.nhs.uk/wp-content/uploads/sites/26/2018/10/PHP-report-web.pdf

45. Meerten M, Rost F, Bland J, Garelick A. Self-referrals to a doctors' mental health service over 10 years. Occupational Medicine [Internet]. 2014 [cited 29 October 2019];64(3):172-176. Available from: https://academic.oup.com/occmed/article/64/3/172/1438214

46. Imo U. Burnout and psychiatric morbidity among doctors in the UK: A systematic literature review of prevalence and associated factors. BJPsych Bulletin [Internet]. 2017 [cited 29 October 2019];41(4):197-204. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5537573/

47. NHS England. Employee engagement, sickness absence and agency spend in NHS trusts [Internet]. 2018. Available from: https://www.england.nhs.uk/wp-content/uploads/2018/03/wres-engagement-absence-agency-spend.pdf

48. West M, Dawson J. NHS Staff Management and Health Service Quality [Internet]. 2011. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/215454/dh_129658.pdf

49. Cooper C, Quick J. The handbook of stress and health. 2017.

50. Firth-Cozens J. Cultures for improving patient safety through learning: the role of teamwork. Quality and Safety in Health Care [Internet]. 2001;10(Supplement 2):ii26-ii31. Available from: https://qualitysafety.bmj.com/content/qhc/10/suppl_2/ii26.full.pdf

51. Trzeciak S, Booker C, Mazzarelli A. Compassionomics. 2019.

52. Shanafelt T, Bradley K, Wipf J, Back A. Burnout and Self-Reported Patient Care in an Internal Medicine Residency Program. Annals of Internal Medicine [Internet]. 2002;136(5):358. Available from: https://annals.org/aim/article-abstract/715151/burnout-self-reported-patient-care-internal-medicine-residency-program

53. Shanafelt T, Balch C, Bechamps G, Russell T, Dyrbye L, Satele D et al. Burnout and Medical Errors Among American Surgeons. Annals of Surgery. 2010;251(6):995-1000.

54. Welp A, Meier L, Manser T. Emotional exhaustion and workload predict clinician-rated and objective patient safety. Frontiers in Psychology [Internet]. 2015;5. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4302790/

55. Dasan S, Gohil P, Cornelius V, Taylor C. Prevalence, causes and consequences of compassion satisfaction and compassion fatigue in emergency care: a mixed-methods study of UK NHS Consultants. Emergency Medicine Journal [Internet]. 2014;32(8):588-594. Available from: http://emj.bmj.com/cgi/pmidlookup?view=long&pmid=25248545

56. Maslach C, Leiter M. The Truth About Burnout: How Organizations Cause Personal Stress and What t. John Wiley & Sons; 2013.

57. Maslach C, Schaufeli W, Leiter M. Job Burnout. Annual Review of Psychology. 2001;52(1):397-422.

58. Vela-Bueno A, Moreno-Jiménez B, Rodríguez-Muñoz A, Olavarrieta-Bernardino S, Fernández-Mendoza J, De la Cruz-Troca J et al. Insomnia and sleep quality among primary care physicians with low and high burnout levels. Journal of Psychosomatic Research. 2008;64(4):435-442.

59. Fahrenkopf A, Sectish T, Barger L, Sharek P, Lewin D, Chiang V et al. Rates of medication errors among depressed and burnt out residents: prospective cohort study. BMJ. 2008;336(7642):488-491.

60. Shirom, Nirel, & Vinokur, 2006 Shirom A, Nirel N, Vinokur A. Overload, autonomy, and burnout as predictors of physicians' quality of care. Journal of Occupational Health Psychology. 2006;11(4):328-342.

61. Vahey D, Aiken L, Sloane D, Clarke S, Vargas D. Nurse Burnout and Patient Satisfaction. Medical Care [Internet]. 2004;42(Suppl):II-57-II-66. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2904602/

62. Krantz and McCeney, 2002 1. Krantz D, McCeney M. Effects of Psychological and Social Factors on Organic Disease: A Critical Assessment of Research on Coronary Heart Disease. Annual Review of Psychology. 2002;53(1):341-369.

63. Levy R, Cain K, Jarrett M, Heitkemper M. Journal of Behavioral Medicine. 1997;20(2):177-193.

64. Heitkemper M, Jarrett M, Levy R, Cain K, Burr R, Feld A et al. Self-management for women with irritable bowel syndrome. Clinical Gastroenterology and Hepatology [Internet]. 2004;2(7):585-596. Available from: https://www.cghjournal.org/article/S1542-3565(04)00242-3/fulltext

65. Cohen S, Herbert T. HEALTH PSYCHOLOGY: Psychological Factors and Physical Disease from the Perspective of Human Psychoneuroimmunology. Annual Review of Psychology. 1996;47(1):113-142.

66. Stress effects on the body [Internet]. Apa.org. 2019 [cited 30 October 2019]. Available from: https://www.apa.org/helpcenter/stress-body

67. Mental Health Foundation. Stress: are we coping? [Internet]. 2019. Available from: https://www.mentalhealth.org.uk/publications/stress-are-we-coping

68. Goh J, Pfeffer J, Zenios S, Rajpal S. Workplace stressors & health outcomes: Health policy for the workplace. Behavioral Science & Policy. 2015;1(1):43-52.

69. Baillien E, De Cuyper N, De Witte H. Job autonomy and workload as antecedents of workplace bullying: A two-wave test of Karasek's Job Demand Control Model for targets and perpetrators. Journal of Occupational and Organizational Psychology. 2011;84(1):191-208.

70. NHS Scotland. Dignity at work survey 2017 (Survey data)

71. Stone D, Deci E, Ryan R. Beyond Talk: Creating Autonomous Motivation through Self-Determination Theory. Journal of General Management [Internet]. 2009;34(3):75-91. Available from: http://selfdeterminationtheory.org/SDT/documents/2009_StoneDeciRyan_JGM.pdf

72. Fredrickson B. Positivity. New York: MJF Books.; 2012.

73. Lyubomirsky, King and Diener, 2005 Lyubomirsky S, King L, Diener E. The Benefits of Frequent Positive Affect: Does Happiness Lead to Success. Psychological Bulletin. 2005;131(6):803-855.

74. Cameron K, Spreitzer G. The Oxford handbook of positive organizational scholarship. Oxford University Press; 2012.

75. Lee R, Seo B, Hladkyj S, Lovell B, Schwartzmann L. Correlates of physician burnout across regions and specialties: a meta-analysis. Human Resources for Health [Internet]. 2013;11(1). Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3849515/

76. Van den Broeck A, Ferris D, Chang C, Rosen C. A Review of Self-Determination Theory's Basic Psychological Needs at Work. Journal of Management. 2016;42(5):1195-1229.

77. The King's Fund. Caring to change: How compassionate leadership can stimulate innovation in health care [Internet]. 2017. Available from: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Caring_to_change_Kings_Fund_May_2017.pdf

78. Guillaume Y, Dawson J, Priola V, Sacramento C, Woods S, Higson H et al. Managing diversity in organizations: An integrative model and agenda for future research. European Journal of Work and Organizational Psychology. 2013;23(5):783-802.

79. Cropanzano R, Bowen D, Gilliland S. The Management of Organizational Justice. Academy of Management Perspectives. 2007;21(4):34-48.

80. Naqvi H. Email sent to: Michael West. 6 September 2019.

81. Sinsky C, Willard-Grace R, Schutzbank A, Sinsky T, Margolius D, Bodenheimer T. In Search of Joy in Practice: A Report of 23 High-Functioning Primary Care Practices. The Annals of Family Medicine. 2013;11(3):272-278.

82. Rimmer A. Government commits £10m to doctors' rest facilities. BMJ [Internet]. 2019 [cited 30 October 2019];:l2233. Available from: https://www.bmj.com/content/365/bmj.l2233

83. Campbell D. Dossier reveals 'petty tortures' of NHS trainee doctors denied leave [Internet]. the Guardian. 2019. Available from: https://www.theguardian.com/society/2019/mar/28/nhs-trainee-doctors-denied-leave-dossier-hospitals

84. Folkard and Monk, 1979 1. FOLKARD S, MONK T. Shiftwork and Performance. Human Factors: The Journal of the Human Factors and Ergonomics Society. 1979;21(4):483-492.

85. Barton J. Choosing to work at night: A moderating influence on individual tolerance to shift work. Journal of Applied Psychology. 1994;79(3):449-454.

86. Smith C, Robie C, Folkard S, Barton J, Macdonald I, Smith L et al. A process model of shiftwork and health. 2019.

87. British Medical Association. Fatigue and sleep deprivation – the impact of different working patterns on doctors [Internet]. 2018. Available from: https://www.bma.org.uk/collective-voice/policy-and-research/education-training-and-workforce/fatigue-and-sleep-deprivation

88. Grant-Vallone E, Donaldson S. Consequences of work-family conflict on employee well-being over time. Work & Stress. 2001;15(3):214-226.

89. Frone M. Work–family conflict and employee psychiatric disorders: The national comorbidity survey. Journal of Applied Psychology. 2000;85(6):888-895.

90. Hoonakker P, Carayon P, Schoepke J, Marian A. Job and Organizational Factors as Predictors of Turnover in the IT Work Force: Differences between Men and Women. [Internet]. 2004 [cited 30 October 2019];. Available from: https://www.researchgate.net/publication/253790639_Job_and_Organizational_Factors_as_Predictors_of_Turnover_in_the_IT_Work_Force_Differences_between_Men_and_Women

91. British Medical Association and NHS Employers. Good Rostering Guide [Internet]. 2018. Available from: https://www.nhsemployers.org/-/media/Employers/Publications/NHSE-BMA-Good-rostering-170518-final.pdf?dl=1&dl=1

92. West M, Lyubovnikova J. Illusions of team working in health care. Journal of Health Organization and Management. 2013;27(1):134-142.

93. Borrill C, Carletta J, Carter A, Dawson J, Garrod S, Rees A et al. The Effectiveness of Health Care Teams in the National Health Service Report [Internet]. 2001. Available from: https://www.researchgate.net/publication/238686262_The_Effectiveness_of_Health_Care_Teams_in_the_National_Health_Service_Report

94. Lyubovnikova J, West M, Dawson J, Carter M. 24-Karat or fool's gold? Consequences of real team and co-acting group membership in healthcare organizations. European Journal of Work and Organizational Psychology. 2014;24(6):929-950.

95. Lyubovnikova J, West M. Why teamwork matters: Enabling health care team effectiveness for the delivery of high quality patient care. In: Salas E, Tannembaum S, Cohen D, Latham G, ed. by. Developing and enhancing teamwork in organizations. San Francisco: Jossey Bass; 2013. p. 331-372.

96. West M. Effective teamwork. Chichester, West Sussex: John Wiley & Sons; 2012.

97. Borrill C, West M, Shapiro D, Rees A. Team working and effectiveness in health care. British Journal of Healthcare Management. 2000;6(8):364-371.

98. Poulton B, West M. Effective multidisciplinary teamwork in primary health care. Journal of Advanced Nursing. 1993;18(6):918-925.

99. Primary care networks explained [Internet]. The King's Fund. 2019 [cited 30 October 2019]. Available from: https://www.kingsfund.org.uk/publications/primary-care-networks-explained

100. A National Framework for Quality and GP Clusters in Scotland [Internet]. Gov.scot. 2019 Available from: https://www.gov.scot/publications/improving-together-national-framework-quality-gp-clusters-scotland/pages/4/

101. GP-one | Clusters [Internet]. Gpone.wales.nhs.uk. 2019. Available from: http://www.gpone.wales.nhs.uk/clusters

102. HSCB [Internet]. HSCB. 2019 Available from: http://www.hscboard.hscni.net/our-work/integrated-care/gps/gp-federations/

103. Tannenbaum S, Cerasoli C. Do Team and Individual Debriefs Enhance Performance? A Meta-Analysis. Human Factors: The Journal of the Human Factors and Ergonomics Society. 2012;55(1):231-245.

104. Dixon-Woods M, Baker R, Charles K, Dawson J, Jerzembek G, Martin G et al. Culture and behaviour in the English National Health Service: overview of lessons from a large multimethod study. BMJ Quality & Safety [Internet]. 2013 [cited 30 October 2019];23(2):106-115. Available from: https://qualitysafety.bmj.com/content/23/2/106.long

105. de Jong T, Wiezer N, de Weerd M, Nielsen K, Mattila-Holappa P, Mockałło Z. The impact of restructuring on employee well-being: a systematic review of longitudinal studies. Work & Stress. 2016;30(1):91-114.

106. Greenglass E, Burke R. Hospital restructuring and burnout. Journal of health and human services administration. 2002;25(1):89-114.

107. Duty of Candour [Internet]. Www2.gov.scot. 2019. Available from: https://www2.gov.scot/Topics/Health/Policy/Duty-of-Candour

108. Sturrock J. Cultural issues related to allegations of bullying and harassment in NHS Highland: independent review report [Internet]. 2019. Available from: https://www.gov.scot/publications/report-cultural-issues-related-allegations-bullying-harassment-nhs-highland/

109. Improving NHS workplace culture - gov.scot [Internet]. Gov.scot. 2019. Available from: https://www.gov.scot/news/improving-nhs-workplace-culture

110. Dixon-Woods M, Baker R, Charles K, Dawson J, Jerzembek G, Martin G et al. Culture and behaviour in the English National Health Service: overview of lessons from a large multimethod study. BMJ Quality & Safety. 2013;23(2):106-115.

111. A. West M, Lyubovnikova J, Eckert R, Denis J. Collective leadership for cultures of high quality health care. Journal of Organizational Effectiveness: People and Performance. 2014;1(3):240-260.

112. NHS Employers. Staff experience and patient outcomes: What do we know? [Internet]. 2014. Available from: https://www.nhsemployers.org/-/media/Employers/Publications/Research-report-Staff-experience-and-patient-outcomes.pdf

113. Chandler G, Keller C, Lyon D. Unraveling the Determinants and Consequences of an Innovation-Supportive Organizational Culture. Entrepreneurship Theory and Practice. 2000;25(1):59-76.

114. Scottish Government, Health Workforce, Leadership and Service Transformation Directorate. Health and social care staff experience: report 2017 [Internet]. 2017. Available from: https://www.gov.scot/publications/health-social-care-staff-experience-report-2017/pages/3/

115. Palmer B. Is the number of GPs falling across the UK? [Internet]. 2019 [cited 30 October 2019]. Available from: https://www.nuffieldtrust.org.uk/news-item/is-the-number-of-gps-falling-across-the-uk

116. The King's Fund. Understanding pressures in general practice [Internet]. 2016. Available from: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Understanding-GP-pressures-Kings-Fund-May-2016.pdf

117. Two in five GPs have a mental health problem [Internet]. Mind.org.uk. 2019 . Available from: https://www.mind.org.uk/news-campaigns/news/two-in-five-gps-have-a-mental-health-problem/

118. British Medical Association. Caring, supportive, collaborative: a future vision for the NHS [Internet]. 2019. Available from: https://www.bma.org.uk/collective-voice/policy-and-research/nhs-structure-and-delivery/future-vision-for-the-nhs

119. NHS Confederation. Challenging bureaucracy [Internet]. 2013. Available from: https://www.nhsconfed.org/~/media/Confederation/Files/Publications/Documents/challenging-bureaucracy.pdf

120. Bakker A, Demerouti E. The Job Demands-Resources model: state of the art. Journal of Managerial Psychology. 2007;22(3):309-328.

121. Sinsky C, Privitera M. Creating a “Manageable Cockpit” for Clinicians. JAMA Internal Medicine. 2018;178(6):741.

122. McCoy J, Evans G. Physical work environment. In: Barling J, Kelloway K, Frone M, ed. by. Handbook of Work Stress. London: SAGE Publications; 2005. p. 219-266.

123. NHS. Interim NHS People Plan [Internet]. 2019. Available from: https://www.longtermplan.nhs.uk/wp-content/uploads/2019/05/Interim-NHS-People-Plan_June2019.pdf

124. Health and Care (Staffing) (Scotland) Bill. 2019.

125. NHS Scotland. National Health and Social Care Workforce Plan Part 3 – Improving workforce planning for primary care in Scotland [Internet]. 2018. Available from: https://www.gov.scot/binaries/content/documents/govscot/publications/strategy-plan/2018/04/national-health-social-care-workforce-plan-part-3-improving-workforce/documents/00534821-pdf/00534821-pdf/govscot%3Adocument/00534821.pdf

126. The Scottish Government. A national clinical strategy for Scotland. 2016. Available from: https://www.gov.scot/publications/national-clinical-strategy-scotland/

127. Department of Health, Northern Ireland. Health and Social Care Workforce Strategy 2026. 2018. Available from: https://www.health-ni.gov.uk/publications/health-and-social-care-workforce-strategy-2026

128. Health Education and Improvement Wales (HEIW). A Healthier Wales: A Workforce Strategy for Health and Social Care [Internet]. 2019. Available from: https://socialcare.wales/cms_assets/file-uploads/HEIW_SCW_Draft_Workforce_Strategy_for_consultation_July-Sept_2019-English-v2.pdf

129. This is Wales. #TrainWorkLive Medical - HEIW [Internet]. Heiw.nhs.wales. 2019 Available from: https://heiw.nhs.wales/programmes/this-is-wales-train-work-live-medical/

130. Britnell M. Human: Solving the global workforce crisis in health care [Internet]. Nuffield Trust. 2019 Available from: https://www.nuffieldtrust.org.uk/news-item/human-solving-the-global-workforce-crisis-in-health-care

131. Baker C. NHS staff from overseas: statistics [Internet]. Researchbriefings.parliament.uk. 2019 Available from: https://researchbriefings.parliament.uk/ResearchBriefing/Summary/CBP-7783

132. World Health Organisation. Task Shifting: Global Recommendations and Guidelines [Internet]. 2008. Available from: https://apps.who.int/iris/bitstream/handle/10665/43821/9789241596312_eng.pdf?sequence=1&isAllowed=y

133. De Dreu C, West M, Fischer A, MacCurtain S. Origins and consequences of emotions in organizational teams. In Payne RL, Cooper CL, editors, Emotions at Work: Theory, Research and Applications for Management. Chichester: Wiley. 2001. p. 199-217

134. Collins A. Revealed: Junior doctors 'losing faith' in long hours safeguards [Internet]. 2019 [cited 30 October 2019]. Available from: https://www.hsj.co.uk/workforce/revealed-junior-doctors-losing-faith-in-long-hours-safeguards/7025250.article

135. The Scottish Government, Health Workforce and Strategic Change Directorate. Doctors in training – New Deal Monitoring Guidance. 2016. Available from: https://www.sehd.scot.nhs.uk/pcs/PCS2016(DD)02.pdf

136. West M. Leading cultures that deliver high quality care. 2015

137. West M, West T. Leadership in healthcare: a review of the evidence. Health Management. 2015;15:123-125.

138. Swensen S, Kabcenell A, Shanafelt T. Physician-Organization Collaboration Reduces Physician Burnout and Promotes Engagement: The Mayo Clinic Experience. J Healthc Manag. 2016 Mar-Apr;61(2):105-27

139. Kilminster S, Jolly B. Effective supervision in clinical practice settings: a literature review. Medical Education [Internet]. 2000;34(10):827-840. Available from: https://onlinelibrary.wiley.com/doi/full/10.1046/j.1365-2923.2000.00758.x

140. Care Quality Commission. Supporting information and guidance: Supporting effective clinical supervision [Internet]. 2013. Available from: https://www.cqc.org.uk/sites/default/files/documents/20130625_800734_v1_00_supporting_information-effective_clinical_supervision_for_publication.pdf

141. Project Lift | Live your potential [Internet]. Projectlift.scot. 2019 [cited 17 October 2019]. Available from: https://projectlift.scot/

142. Woolf K, Rich A, Viney R, Rigby M, Needleman S, Griffin A. Fair Training Pathways for All: Understanding Experiences of Progression [Internet]. 2016. Available from: https://www.gmc-uk.org/-/media/documents/2016-04-28-fairpathwaysfinalreport_pdf-66939685_pdf-67089434_pdf-70345187.pdf

143. How we quality assure [Internet]. Gmc-uk.org. 2019 [cited 17 October 2019]. Available from: https://www.gmc-uk.org/education/how-we-quality-assure

144. Cardiff University. Factors that impact on medical student wellbeing -- Perspectives of risks [Internet]. 2013. Available from: https://www.gmc-uk.org/-/media/about/factors_that_impact_on_medical_student_wellbeing.pdf?la=en&hash=4F939939EF74AD5E29EEAB8283B27A9537C2ABF8

145. NHS Health Education England. NHS Staff and Learners' Mental Wellbeing Commission [Internet]. 2019. Available from: https://www.hee.nhs.uk/sites/default/files/documents/NHS%20(HEE)%20-%20Mental%20Wellbeing%20Commission%20Report.pdf

146. Watson N. GP Partnership Review [Internet]. 2019. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/770916/gp-partnership-review-final-report.pdf

147. Legraien L. Over half of GPs plan to stop practising before retirement age [Internet]. 2019 [cited 30 October 2019]. Available from: http://www.pulsetoday.co.uk/your-practice/special-reports/retirement/over-half-of-gps-plan-to-stop-practising-before-retirement-age/20038994.article

148. General Medical Council. Visit Report on Report on Report on Scottish Graduate Entry to Medicine programme (ScotGEM) [Internet]. 2019. Available from: https://www.gmc-uk.org/-/media/documents/scotgem---end-of-year-report---2018-19_pdf-79504295.pdf

149. Experiences shared [Internet]. Gmc-uk.org. 2019 [cited 30 October 2019]. Available from: https://www.gmc-uk.org/education/standards-guidance-and-curricula/projects/differential-attainment/experiences-shared

150. Department of Health, Northern Ireland. Single lead employer for postgraduate doctors and dentists in training. 2019. Available from: https://www.health-ni.gov.uk/sites/default/files/publications/health/hsc-TC8-4-2019.pdf

151. BMA - Single lead employer arrangements [Internet]. Bma.org.uk. 2019 Available from: https://www.bma.org.uk/advice/employment/contracts/juniors-contracts/juniors-scotland/single-lead-employer-arrangements

152. NHS Wales Shared Services Partnership (NWSSP) | About Us [Internet]. Nwssp.wales.nhs.uk. 2019 [cited 30 October 2019]. Available from: http://www.nwssp.wales.nhs.uk/about-gp-specialty-registrar/

153. NHS Streamlining Resource Hub [Internet]. Nhsemployers.org. 2019 [cited 30 October 2019]. Available from: https://www.nhsemployers.org/your-workforce/recruit/streamlining-programme

154. Pearson C, Porath C. The cost of bad behavior. 2009.

155. Lawrence T, Maitlis S. Care and Possibility: Enacting an Ethic of Care Through Narrative Practice. 2012.

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