Dear Acting Convenor

Thank you for inviting the GMC to contribute to the committee’s work on the leadership and workforce challenges across the health and social care sectors, particularly in relation to the Covid-19 pandemic. We have included a number of data sources in our response; for succinctness these have been listed in Annex B.

Leadership is an area of particular interest to the GMC, and was one of the important themes of the three independent reports we published in 2019: Caring for doctors, caring for patients; Fair to refer?; and the Independent Review of Gross negligence manslaughter and culpable homicide in medical practice. These reports evidenced the impact of poor culture on staff burnout, retention and patient care.

Addressing these areas is a priority for the GMC. Following on from the publication of these reports, we held a roundtable with our Scottish partners where we explored how to build on the good work already taking place to support the medical profession. At the meeting we agreed we should collaborate on a programme of work on leadership, collective workforce challenges (including induction), team-based working and regulatory alignment.

Another of our priorities is the development of a sustainable medical workforce. This is one of the four themes of our corporate strategy 2021-2025, and we recognise that the ongoing shortage of healthcare professionals in the UK poses a threat to patient care and professionals’ wellbeing and progression. Following the pandemic and as the system moves towards recovery and renewal, we will refocus our work to respond to the challenges ahead. We’ll be proportionate in our regulation and responsive to workforce needs. We’ll continue contributing to developing supportive, inclusive, fair and well led healthcare environments. And we will offer our data and insight to inform decision-making that delivers for the public, the profession and the healthcare system.
Part of this includes using our position to help shape medical education and training to better support the development of medical students and professionals. In particular, we are working with partners to consider the changes that have already been made as a result of the pandemic, and where education and training systems could go further and faster in promoting greater cross-specialty learning and developing and recognising generic skills across specialties.

**Q1. How has the pandemic impacted on leadership and workforce challenges in the health and social care sectors?**

*Leadership challenges*

Overall, we saw evidence of an increased focus on inclusive leadership, wellbeing and team working for healthcare staff during the first wave of the pandemic. Whilst we don’t have direct evidence to support this, we have, however, heard informal stakeholder feedback that not all of this has been sustained into the second wave. These things need to continue to be prioritised going forward as healthcare professionals will need time and support whilst they and the healthcare system recovers from the pandemic.

As outlined in Annex B our national training survey (NTS) was carried out during the first wave and showed positive signs of cultures of teamwork between all healthcare professionals improving. We were also pleased to report evidence of supportive workplace environments, and that clinical leaders and senior doctors were more visible and accessible.

*Workforce practice challenges*

The ability of the health service to deliver safe patient care depends on recruitment, retention and the ongoing development of all doctors. The medical workforce continues to grow, with a 3% growth in the number of licensed doctors in Scotland between 2019 and 2020.

Whilst this is a positive trend, we want to understand why some doctors choose to leave the medical register. Ahead of the pandemic we completed research to look at the number who leave after two key career milestones. We have found that doctors of a non-UK nationality were disproportionately high amongst those leaving after their Foundation 2 year and that doctors who first qualified outside the UK were more likely to leave soon after completing their specialty training. As outlined in Annex B, we know one of the drivers to leaving practice can be a dissatisfaction with previous roles/places of work/NHS culture. This underlines the importance of ensuring good medical leadership not just for the wellbeing of staff, but for the impact it can have on the workforce.

Annex B also outlines the significant and rapid changes to their personal and professional lives that doctors have experienced as a result of the pandemic (as we
outline in further detail in our report [The state of medical education and practice in the UK 2020](#). These include the proportion of doctors who were redeployed, and how the pandemic impacted on mental health and wellbeing, culture and teamwork. Worryingly a smaller percentage of BME doctors reported positive impacts on teamwork as a result of the pandemic, as opposed to their white colleagues. This shows that the challenge of growing inequalities still exists within the medical workforce.

**Q.2 What lessons have been learned?**

Despite the overwhelming cost of the pandemic to personal health and society and its impact on healthcare professionals’ safety and mental health, the response of the medical profession and the system more generally, has been outstanding. Changes have often been made rapidly and flexibly. This shows that it’s possible to make beneficial innovations to the way medical work is organised, to the benefit of healthcare staff. Whilst many of these changes have been operational (including the redeployment of doctors, how progression in training is maintained, and the rapid growth of virtual consultations), we have also been pleased to see the increased focus on wellbeing and team working being prioritised across the health service.

Compassionate and inclusive leadership will be vital in embedding the positive learning and changes from 2020 to benefit doctors and patients alike. As doctors from a BME background were less likely to have experienced positive changes than white doctors, it’s crucial that the improved ways of working are extended to everyone equally. This is not only in the interest of fairness but because BME doctors make up a growing part of the workforce.

We know that clinical leadership which is inclusive and compassionate drives positive cultural change. This was made clear in ‘Caring for doctors; caring for patients’ and in Dr Suzanne Shale’s report ‘[How doctors in senior leadership roles establish and maintain a positive patient-centred culture](#)’. The latter identifies doctors’ pathways into leadership, and the type of support and training needed at crucial points. It also provides new insights into the challenges of embedding a positive working culture, creating opportunities to improve work practices and tackling bullying and undermining behaviours.

**Q3. How can we move forward?**

As well as focussing on our own workforce priorities as described in the opening section, we also want to be able to support the Scottish Government and others as they consider their broader workforce priorities. For example, this year we provided a training session to workforce officials, focusing on how [our data](#) can assist them with their policy priorities. We will continue to explore opportunities to support our partners in in the development and retention of the workforce.
We are currently finalising our leadership plan. This will include:

- reviewing how the GMC regulatory framework supports leadership;
- reinforcing our messaging on existing GMC leadership and management guidance;
- exploring ways to promote messaging on the critical value of compassionate and inclusive leadership in medicine.

We are also taking forward some targeted work in Scotland. This includes:

- supporting the Scottish Government’s work on equality (particularly the national race equality network) including by providing them with relevant data;
- providing insight and advice to the Scottish Government’s Wellbeing, Leadership and Culture division;
- utilising our Outreach team to help collate and share good practice across the system. They also offer targeted advice and guidance to clinical leaders to help them address common challenges such as managing difficult conversations, supporting doctors’ transition points, and helping overcome obstacles often faced by BME and female doctors.

We have also established a medical wellbeing stakeholder group with the BMA, the Scottish Academy and individual medical royal medical colleges in Scotland. This group will collaborate and strengthen our existing areas of work where there is common interest, priority and influence, and offer a professional advisory function to the Scottish Government and others, to support their efforts related to the wellbeing of the health and social care workforce.

Addressing workforce and leadership challenges is not the responsibility of one organisation, but we can play our part as we describe. Fundamentally we want to work with the system to help leaders to ensure doctors are supported; minimising the negative outcomes including those stemming from burnout, poor leadership, bad cultures. Whilst we have undoubtedly seen some improvements as a result of the pandemic, future work to sustain these positive changes will be important and must ensure they are inclusive of all.

Thank you again for considering this response. We will continue to work with partners in government and beyond to do what we can to support improvements across the system. If we can be of any more help to the Committee’s work, then please let me know.
Yours sincerely

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Telephone: 0131 525 8700
Annex A – About us

The GMC is an independent organisation that helps to protect patients and improve medical education and practice across the UK.

- We decide which doctors are qualified to work here and we oversee UK medical education and training.

- We set the standards that doctors need to follow, and make sure that they continue to meet these standards throughout their careers.

- We take action to prevent a doctor from putting the safety of patients, or the public’s confidence in doctors, at risk.

Every patient should receive a high standard of care. Our primary purpose is to protect patients and the public. The way we do this is by supporting doctors in their efforts to deliver high-quality care, and reducing the pressures associated with the ever-changing demands of the health service in Scotland.
Annex B – Data

Question 1

Leadership challenges

1 Our national training survey (NTS) was carried out during the pandemic and showed that in Scotland 80% of trainees and 75% of trainers felt that their workplace encouraged a culture of teamwork between all healthcare professionals. Similar proportions answered that they believed their place of work, or their board, provided a supportive environment for everyone regardless of background, beliefs or identity. We also saw evidence that clinical leaders and senior doctors were often more visible and accessible.

Workforce practice challenges

2 Between 21 January and 10 March 2020, we conducted the ‘Completing the Picture’ survey, alongside NHS Education for Scotland, Health Education England, The Department of Health (Northern Ireland) and Health Education and Improvement Wales. 13,158 doctors who had previously practised in the UK completed the survey. They answered a series of questions, including why they had decided to stop practising, or if they had left the UK to practise elsewhere. Notably, over a third (35.7%) of doctors stated ‘Dissatisfaction with previous role/place of work/NHS culture’ contributed to their decision to leave UK practice.

3 We outline in our report The state of medical education and practice in the UK 2020 that in Scotland:

- 73% of doctors experienced significant changes to their work and over half (52%) were redeployed.
- 27% of doctors said the pandemic had a negative impact on their mental health and wellbeing.
- 65% reported positive changes in teamwork between doctors – 79% of these doctors thought it could be sustained.
- 79% of doctors feel satisfied overall in their day-to-day work.
- Across the UK, doctors from a black and minority ethnic (BME) background were less likely to share the same positive experiences reported by many of their white colleagues. While 68% of white doctors said there had been a positive impact on teamwork between doctors, this figure dropped to...
55% for BME doctors. It should be noted that this figure is UK-wide and not Scotland specific.

4 Our national training survey reported that many trainees felt supported by good teamwork and inclusive leadership, despite the challenges with training and workload. In Scotland, NTS found:

- 89% of trainees rated their clinical supervision as good or very good
- 78% of trainees felt they were a valued member of their team.
- Notwithstanding, 83% of trainees and 89% of trainers felt the pandemic limited chances for trainees to gain required training competencies.

**Scotland in numbers**

We hold a wealth of data on doctors practicing across the UK and can report on detailed trends in the medical workforce.

There are currently 24,066 doctors on our register with a Scotland Address. This represents 8.1% of the total number of doctors (298,063) on our register in the UK.*

**Table 1 - Doctors on the GMC register by UK country ***

<table>
<thead>
<tr>
<th>Doctor Location UK Country</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>243,981</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>7,806</td>
</tr>
<tr>
<td>Scotland</td>
<td>24,066</td>
</tr>
<tr>
<td>Wales</td>
<td>12,198</td>
</tr>
<tr>
<td>Non-UK</td>
<td>10,012</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>298,063</td>
</tr>
</tbody>
</table>

51.7% of doctors on our register are female and 48.3% male. UK wide, 52.5% of doctors are male and 47.5% female.*

**Table 2 – Number of doctors on the GMC register by primary medical qualification (PMQ) location ***

<table>
<thead>
<tr>
<th>Doctor Location by UK Country</th>
<th>European Economic Area (EEA)</th>
<th>International Medical Graduate (IMG)</th>
<th>UK</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>20,432</td>
<td>66,952</td>
<td>156,597</td>
<td>243,981</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>704</td>
<td>513</td>
<td>6,589</td>
<td>7,806</td>
</tr>
<tr>
<td>Scotland</td>
<td>1,402</td>
<td>2,733</td>
<td>19,931</td>
<td>24,066</td>
</tr>
<tr>
<td>Wales</td>
<td>744</td>
<td>3,234</td>
<td>8,220</td>
<td>12,198</td>
</tr>
</tbody>
</table>
82.1% of doctors hold a UK medical qualification, 5.8% have a qualification from a country in the EEA and 11.3% are IMGs.* Our data about doctors with a European primary medical qualification in 2020 provides further information about doctors from the EEA working in the UK.

There are 5941 doctors in training in Scotland. *

* Correct as at 03/11/2020