Title: 'It's like juggling fire daily': Well-being, Workload and Burnout in the British NHS - A Survey of 721 Physicians

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Abstract

Background: Physicians are at higher risk for burnout than workers in other fields. Burnout negatively impacts physician health, care delivery and healthcare cost. Existing studies quantify the workforce affected by burnout whilst qualitative studies use specific specialty groups limiting generalisability of solutions. This is important given increased stress during the COVID-19 pandemic.

Objective: The study aimed to understand the causes of work-related burnout, identify what supportive resources physicians utilise, and to propose solutions.

Methods: A questionnaire was circulated between March and May 2019 via the 'Doctors' Association UK' website and social media.

Results: 721 responses were received. 94% of respondents worked in the NHS, with over half being either general practitioners (GPs) or consultants. One in two (53%) respondents felt unable to raise workplace concerns regarding wellbeing, stress or workload. Almost all respondents (97%) felt the NHS has a culture of viewing excessive stress and workload as the norm. Three themes emerged from qualitative analysis: negative workplace culture; high workload and lack of resources; and generational change.

Conclusions: Respondents described system-level factors which negatively impacted their wellbeing whilst organisations focused on physician-level factors. The research literature supports multi-level change beyond the individual tackling work unit and organisational factors. These include providing infrastructure to allow delegation of administrative work and physical space for relaxation and flexible work with time for leave. At a national level, there is greater urgency for an increase in healthcare funding and resourcing especially during increased clinician workloads during a pandemic where burnout rates will increase.

Introduction

Burnout occurs as a result of chronic occupational stress encompassing feelings of emotional exhaustion, depersonalisation and reduced professional efficacy [1]. Occupational burnout is the most widely studied dimension of physician distress with studies indicating that physicians are at higher risk for burnout than workers in other fields [2]. Worldwide, a systematic review found physician burnout varied considerably by country and specialty up to 81% [3]. In the UK, 45% of trainers and 25% of trainees found their work felt emotionally exhausting whilst 23% of trainees reported feeling a high/very high degree of burnout due to work [4]. Burnout has negative consequences for the physician, the quality of care provided and cost of healthcare [5]. Systematic reviews evaluating the impact of physician burnout showed that burnout was associated with 2.6 times increased risk of patient safety incidents [6]. Burnout is associated with depression, suicidal ideation, problematic alcohol use, and motor vehicle accidents [7]. Poor work-life balance and career development as well as high work demands and concerns about patient safety were all significantly associated with burnout [8].

Before the coronavirus pandemic, a cross-sectional study (n=1651) found burnout affected one in three British doctors [9]. Since the onset of the pandemic, surveys [10,11] (n=4538, n=7453) consistently show that 40% of doctors suffered worsening of existing burnout and mental health conditions. This is consistent with international studies [12] (n=4727) indicating increased burnout. There is an urgent need to understand why clinicians suffer from burnout as well as what sources of support they seek when they experience burnout.

Existing large studies tend to quantify the proportion of the workforce affected by burnout and qualitative studies use specific specialty groups of doctors limiting generalisability of solutions to burnout.

Aims and Objectives

This study aims to conduct a large survey with open and closed questions to identify physicians facing burnout, understand the reasons for burnout and how they deal with burnout through qualitative analysis of free text answers.

The primary objective is to understand the causes of work-related burnout. The secondary objective is to understand what supportive resources physicians utilise, and to propose solutions following qualitative analysis in the context of research literature.

Methods:

Recruitment and Data Collection

A questionnaire created on an established online platform (Survey Monkey) was circulated between 6th March and 3rd May 2019 via the 'Doctors Association UK' website [13] as well as social media networks including Facebook and Instagram by AS. The 'Doctors Association UK' is not-for-profit advocacy group for the medical profession, patients and the NHS. All responses were anonymous, and no personal identifiable data were collected. Participants were provided with information on the study and potential dissemination in order to gain informed consent to use data.

Questionnaire

The final questionnaire asked 11 mandatory closed questions about their discipline, sector, grade, stress/mental wellbeing, sources of help sought in the past, sources of help to use in future, ability to raise concerns, culture about workload/stress, future sources of help (Appendix 1). Whilst the whole questionnaire has not been formally validated, the questions about workload and stress are derived from the 'emotional exhaustion' section of Maslach's Burnout Inventory [14]and the 'workload' section of the Areas of Worklife Survey [15]. There were 2 non-mandatory open questions with free text for open thoughts about ability to raise concerns about workload and culture about workload/stress. Data was collected via the online form and stored on secured encrypted devices.

Data Analysis

The quantitative dataset was analysed using summary statistics such as percentages. Thematic analysis was selected to analyse the qualitative free text responses. This was considered an appropriate approach [16] as it encourages the emergence of themes both 'inductively' and 'deductively'. It is effective in qualitative analysis [17] of open-ended survey responses. DG and CD independently coded responses into themes and created maps of overarching themes and links. With combined knowledge of the

literature, DG and CD discussed and agreed upon final themes. The responses were coded, quotations selected, and an interpretation of the data discussed to finalise the analysis.

Results:

Quantitative Analysis

A total of 721 responses were received which is 0.6% of the representative population of working doctors in the UK at the time of data collection [18] (Table 1). In terms of specialties, two in five participants (n=293) were GPs, with the rest spread across various hospital medicine specialities, e.g. 10% were from emergency medicine (n=38) and from cardiology (n=37). Most of the respondents (94%, n=676) worked in the NHS whilst 44% (n=314) were trainee doctors.

When asked if they had ever been stressed to the point that their mental wellbeing was affected due to their career 41% (n=291) of respondents felt it was regularly affected, and 43% (n=311) felt that it was sometimes affected. Most respondents were aware of resources such as The Samaritans (66%, n=437) and the British Medical Association (BMA) Confidential Helpline (63%, n=414) but only 9% (n=58) saw the General Medical Council (GMC), the national regulator as a source of help.

Of all participants, not just those who experienced burnout, most (57%, n=409) stated that they would seek help from family or friends alongside 31% (n=224) going to their GP and one in four (28%, n=201) dealing with it alone. Much smaller proportions would seek help from occupational health (14%, n=98) and the BMA (7%, n=54). In the future, the majority (76%, n=530 and 57%, n=399) would seek help from family and friends and their own GP respectively if they encountered difficulty.

One in two (53%) respondents felt unable to raise concerns in the workplace regarding wellbeing and stress or workload: many of those who indicated they were able to raise concerns stated that they felt no solutions would be implemented. The overwhelming majority (97%, n=695) of respondents felt the NHS has a culture of viewing excessive stress and workload as the norm.

Qualitative Analysis

Many sub themes arose from qualitative analysis which were grouped into 3 main themes: ‘negative professional culture’, ‘high workload and lack of resources’, and ‘generational change’ (see Figure 1). Whilst there is overlap between the first two themes, ‘negative professional culture’ presents a psycho-social aspect, and the ‘high workload and lack of resources’ theme allows presentation of the physical infrastructure or lack thereof. It was not possible to identify if the themes applied to physician disciplines or particular physician seniority.

(a) Negative professional culture

(a) (i) Lack of personal resilience

Respondents stated that they felt the current culture of the NHS was not conducive to positive mental wellbeing with great emphasis on building personal resilience rather than dealing with lack of system or workplace resilience such as inadequate staffing or resourcing:

“Doctors are constantly being told to work longer, harder, do more, be more resilient when it is the system that is actually broken”

(Participant 604, General Practitioner (GP))

Some found that it was not possible to discuss stress when it comes to competition to succeed with specialty applications and expected to separate their personal and professional lives:

“Unfortunately, in surgical training there is pressure to "get on with it". Sadly, the ethos is that if you are struggling then you just must try harder - try harder to get more theatre numbers/publications/audits…If one mentioned feeling stressed it would be perceived as a lack of resilience.’

(Participant 38, Urology Surgical trainee)

(a) (ii) Stigma, judgement and bravado

Respondents felt that senior colleagues would judge them for raising concerns regarding workplace safety which would in turn affect career progression:

“Within our small department I do not feel it would be treated confidentially and I feel it would hinder my future and count against me if I applied for consultant jobs”.

(Participant 9, Pathology trainee)

“How can we raise concerns when our own supervisors…happen to be the ones supervising you, writing your reports and your references?”

(Participant 569, GP trainee)

Respondents felt there was an expectation to deal with emotionally traumatic events at work and unable to talk this at work:

“There is pressure not to mention your own struggle with workload, emotional trauma and exhaustion.”

(Participant 219, GP)

“Expected to deal with traumatic events and second-hand trauma from patients' difficult lives without it affecting us.”

(Participant 367, Palliative Care Staff grade doctor)

Respondents raised the issue of ‘bravado’ about how much work was being done and rewarding those who prioritised efficiency at work over mental or physical health:

“There is a martyr complex amongst staff. They [colleagues] revere people who have never taken a day off sick.”

(Participant 36, Consultant Paediatrician)

“People bragging about how theirs was the most difficult on-call, how they got the least amount of sleep, how they did the most shifts back-to-back.”

(Participant 218, Consultant Clinical Pharmacologist)

(a) (iii) Fear of failure, perfectionism, guilt, and goodwill

Issues of fear of failure or innate perfectionism were prevalent amongst doctors:

“No back up for clinicians who are struggling combined with perfectionist tendencies and high expectations of meeting responsibilities in doctors leads to large stress burdens.”

(Participant 55, GP)

“There was a sense of guilt felt for putting extra work onto other colleagues if they had to take time off or seek help…huge levels of guilt when off sick due to colleagues having to pick up the slack, lists being cancelled and patients being disadvantaged therefore we don’t take time off.”

(Participant 470, Consultant Psychiatrist)

The issue was also raised of the NHS relying on the goodwill of doctors to function rather than increasing capacity and resources:

“The NHS only runs today on the goodwill of its staff. Every member of staff works copious hours above those paid through a duty of care and compassion for patients, but nobody extends that duty of care and compassion to the staff.”

(Participant 38, GP)

(b) High workload and lack of resources

(b) (i) Inadequate resourcing

Many survey participants highlighted inadequate resourcing including staff, funding, and time for providing healthcare leading to high workloads with inadequate support.

“Excessive and unsafe workloads are largely due to rota gaps which have become a chronic problem. When there's either a shortage of locum staff or shortage of funds to get in locums, there's undue

pressure placed on current staff to cover the gaps."

(Participant 78, General Internal Medicine trainee doctor)

"We can all see that everyone is under considerable stress and no-one can see any way out. We need 2-3 times as many doctors...we are often having to deal with the patient in front of us, at the same time as a trainee and a physician associate messaging for advice, a receptionist knocking on the door re a prescription query or an angry patient in reception, someone calling on the phone, red flagged tasks and letters building up during clinic (which you know won't be dealt with till after 10pm). It is like juggling fire daily."

(Participant 491, GP)

(b) (ii) Presenteeism

Some clinicians describe a pressure to attend work 'presenteeism' despite not feeling physically or mentally well enough to support poorly resourced clinical environments:

"When personal illness results in work absences in the NHS there is generally very little support and departments and organisations are so thinly stretched with clinical staff there is considerable pressure applied to staff to return to work quickly and potentially prematurely."

(Participant 50, GP)

"The NHS has a culture of presenteeism as well as being designed & set up with zero flexibility in staffing numbers, such that it isn't working safely when '100% manned', so even worse when staff are away for any reason."

(Participant 421, non-clinical aviation medicine doctor)

(b) (iii) Unsupportive management

Some doctors mentioned that management were or would be unsupportive in responding to poor resourcing:

“I think all clinical staff are struggling with workload…there is an unwillingness on the part of management to acknowledge there is a problem on the ground, so to me there is no point in raising concerns as I do not believe it would be listened to.”

(Participant 437, Locum junior doctor in acute internal medicine)

“I feel no confidence that the senior management in my Trust would be interested in helping. I have managed with the support of my wife to cut my hours, and I’m now in a happy place. I have considered taking my own life at various points in my career. I will not now go the extra mile for an uncaring system.”

(Participant 156, Consultant in Intensive Care Medicine)

(c) Generational change

(c) (i) Senior expectations

A common theme was that senior doctors held unrealistic expectations of medicine forged by their difficult training and seemed to believe that all juniors must undergo difficult experience to become competent doctors. This may have been compounded by psychosocial aspects indicated in theme (a) such as stigma and bravado.

“Older consultants had worse hours than current doctors, so this is seen as a reason for current juniors to 'get on with it' rather than an indication that there has always been a problem.”

(Participant 437, Locum junior doctor in acute internal medicine)

“Older generation doctors have less sympathy as they feel they suffered and got through it so we should too”.

(Participant 299, GP)

(c) (ii) Changing professional environment

Respondents noted shorter rotations as well as increasing administrative work without allocated time not previously required by senior doctors. Many found increasing demand to achieve outside of clinical practice to improve prospects for competitive training posts.

“Short rotations through training mean that you never get to know your bosses really well and they often only invest in you superficially.”

(Participant 217, GP)

“Things which are compulsory, such as keeping up to date with mandatory training modules, doing compulsory audits as part of training etc do not have any time allocated for them to be done, so they have to be done in 'free time'. In other careers if the company expects you to do an audit you would be allocated work time to do it.”

(Participant 27, Cardiology registrar)

Discussion

Our study fills a gap in the literature by conducting a large nationwide survey on physician burnout and highlighting systemic themes for healthcare system improvement on the background of a healthcare service which has received the lowest amount of funding, in real terms, as a percentage of Gross Domestic Product (GDP) for a decade [19]. There was a 33% over-representation of GPs but under-representation of many non-primary care specialities such as medicine (31%), surgery (67%), paediatrics (36%) and psychiatry (36%) [18,20,21]. Whilst there are numerous studies on physician burnout, the majority of these tend to be in the USA. There are similar British studies [9,22–24], but these do not include qualitative analysis of free-text questions or do not identify solutions to burnout beyond a specific specialty, such as general practice.

In our study, doctors describe organisational-level factors which negative impact their wellbeing which

require healthcare system-wide and infrastructural change. This qualitative data is complemented by a meta-analysis (19 studies, n=1750) which showed that organisational interventions are 16% more effective at decreasing burnout compared to physician-directed interventions [25]. However pitting physician and organisational interventions is counter-productive and multi-level change is required rather than individual responsibility including at physician, work unit, organisation and national level [26].

Systematic reviews of interventions [27] to reduce burnout in physicians and nurses show that mindfulness and cognitive-behavioural therapy interventions are effective in reducing stress, anxiety and depression and concluded that healthcare systems must promote health and well-being of practitioners through implementation of these evidence-based interventions. This is in direct conflict with our data as whilst most of our sample had experienced burnout found such interventions inadequate solutions to organisational and national problems. Despite this, there may be a role for such interventions to support physician mental health along with organisational solutions. Interventions must focus on the unique patterns exhibited by each speciality and use a multi-dimensional approach due to demonstrable differences in burnout levels and patterns across specialities [27]. It was not possible to corroborate this from our data as burnout levels were not formally measured. Individual factors that may be helpful include education about workflow prioritisation, saying 'no' and delegation [26]. As well as this there should be education about how factors which are selected for in physicians: perfectionism, altruism and exaggerated sense of responsibility and drive for success rather than purpose, can become pathological contributing to burnout [27].

Emotional intelligence, as well as certain personality types and effective mentorship were shown to be protective of burnout [28]. Lack of senior support and empathy for junior colleagues was highlighted in our data set (c (i) and (ii)) which may highlight the need for mentor-mentee personality matching. Other work unit and organisational level solutions include providing infrastructure to allow delegation of administrative work, physical space for relaxation, clear mental health support, flexible work with time for leave and opportunity to conduct research and provide education [26,29]. One example of an organisational intervention is provided by Schwartz et al who used fortnightly Balint groups as a low-cost physician wellness program reducing isolation, normalising experience and generating solutions to local

organisational problems [29]. This may alleviate traumatic experiences such as moral suffering, which was highlighted in this data set [30]. Whilst high expectations of doctors and associated stress or pressure may be localised to teams or whole departments, there may be an element of public expectation of doctors to deal with stress and provide good clinical care regardless of circumstances [31].

Organisational factors such as culture should be measured as part of a composite measure of healthcare quality known as the quadruple aim, e.g., staff satisfaction/wellbeing [32]. Furthermore, our organisations should be led by leaders who foster the values we wish to see such as inclusivity, empathy and integrity [33]. Realistically these changes cannot happen without adequate resourcing at a national level: the NHS budget has increased but this has been outstripped by demand [34]. This will require investment, and investment in healthcare workers is one of the World Health Organisation's (WHO) most pressing global health issues in the coming decade [35]. The importance of providing healthcare cannot be lost especially in the midst of a pandemic where physicians are likely to be overworked and at risk of burnout.

Responses to our survey suggest that doctors may prefer to seek help from outside established organisations such as the BMA or GMC such as family or their GP. It is particularly striking from our data that only a minority would turn to occupational health services, and that they view this as having an impact on their career. Furthermore, a number of respondents did not seem confident in the BMA's support provision. This corroborates the case for independent organisations such as the current 'Practitioner Health Programme' which now runs nationally to provide English doctors and dentists with confidential support with mental health or addiction problems.

The novelty of our study is the themes raised from qualitative analysis: considering the opinions raised by workers of the issues faced will allow for policymakers and leaders to focus on specific areas for improvement in practice. Further areas for research include regional and specialty-specific focus groups to identify particular problems and solutions which may be neglected through national change. Our study focussed on burnout and stress in doctors alone and it is likely that other healthcare professionals would be affected by burnout, as well as being affected by other mental health conditions such as depression. It is also difficult in such a large-scale study to capture the extent of individual responses. The lack of

mandatory participation in the open questions could have skewed the responses towards specific recommendations. Furthermore, though we have aimed to comment on the various organisational and individual factors affecting burnout within our discussion, we are aware it may not have been possible to every factor available as these will be context dependent.

The timing of data collection preceded the coronavirus virus 2019 (COVID-19) pandemic, but a meta-analysis [(36)] with a search up to June 2020 found that direct exposure to patients infected with COVID-19 during the pandemic was associated with significant mental health burden. These included depression, anxiety, stress and burnout. An international cross-sectional study (41 countries, n=2527) found that symptoms of depression were associated with re-assignment to intensive care or with perceived unsatisfactory training, inadequate personal protective equipment and poor workplace or mental health support [(37)]. Another similar international study (60 countries, n=2707) found that burnout was associated with exposure to patients with COVID-19, work impacting household activities and feeling pushed beyond training [(38)]. A recent Cochrane review evaluating the interventions to support the mental health of healthcare professionals during or after a disease outbreak found insufficient high-quality interventions [(39)]. Factors facilitating successful intervention implementation include effective online and offline organisational communication, interventions that can locally adapted and supportive learning environments. Barriers included lack of equipment or time for an intervention and personal or organisational lack of awareness of support needs. More studies are needed to support healthcare worker mental health during pandemics.

Conclusion

Our study concludes that in the NHS today morale is low, peer support is minimal and the system as a whole does not yet embrace the concept of non-judgemental, non-repercussive attitudes to wellbeing. Existing resources are confidential, independent and offer a “peer-to-peer” service, but it is clear there is a lack of awareness of these features amongst doctors. It is also entirely feasible that these facts have not been communicated effectively to doctors to provide a secure level of reassurance and drive uptake. An opportunity exists for an independent, non-affiliated entity to drive change to improve uptake of support organisations through working with others to address real and perceived barriers and signpost doctors to resources. There is a need to tackle negative professional culture, inadequate resourcing and

high workloads with multi-level intervention beyond individual physicians: at work unit, organisation and national level. This will require significant investment in our healthcare system to support doctors as well as healthcare staff as they manage this pandemic and future pandemics which are yet to come.

Words: 3623

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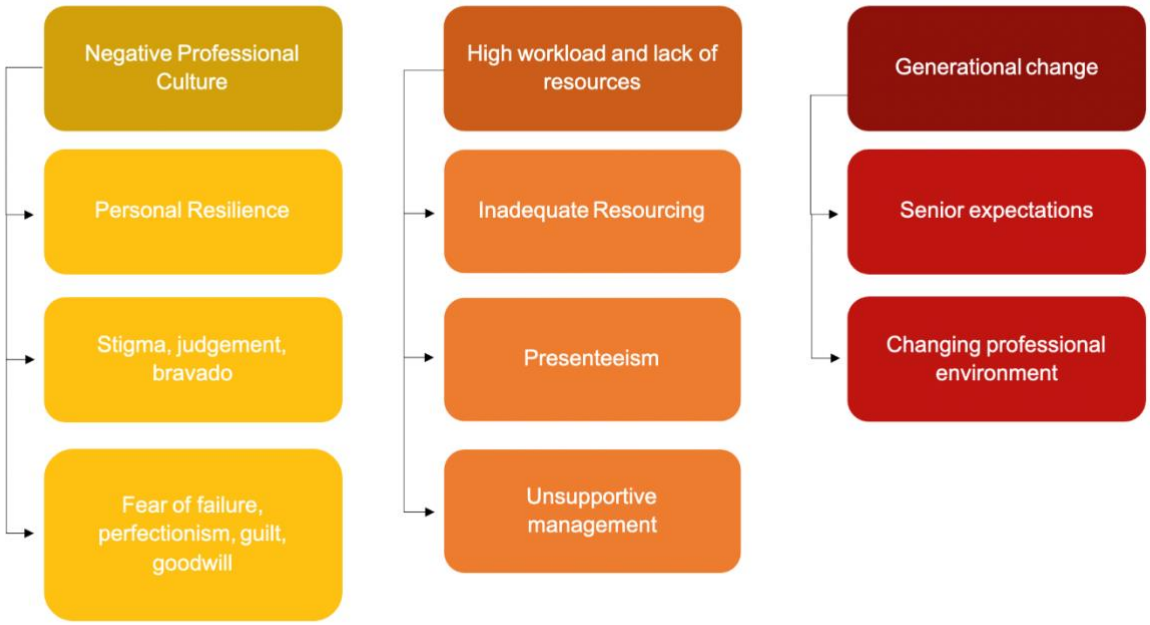
Tables

Table 1: Participant Summary Characteristics Table (n=721).

Characteristic		Frequency (n=)	Percentage (%)
Role/Grade	Foundation Year 1 Doctor	21	2.9
	Foundation Year 2 Doctor	18	2.5
	Specialty trainee in a hospital specialty	88	12.2
	Specialty registrar in a hospital specialty	57	7.9
	Specialty registrar in general practice	36	5.0
	SAS	24	3.3
	General Practitioner	252	35.0
	Consultant	155	21.5
	Academic	4	0.6
	Other	48	6.7
	Did not answer	18	2.5
Sector	NHS	676	94.0
	Private	10	1.4
	Other	33	4.6
	Did not answer	2	0.3
Area of Specialisation	Anaesthesia	34	4.7
	Clinical Oncology	6	0.8
	Clinical Radiology	6	0.8
	Community sexual and reproductive health	1	0.1
	Emergency medicine	38	5.3
	General practice (GP)	293	40.6
	Intensive care medicine	12	1.7
	Medical Specialities	132	18.6
	Obstetrics and gynaecology	13	1.8
	Ophthalmology	6	0.8
	Paediatrics	35	4.9
	Pathology	14	1.9
	Psychiatry	36	5.0
	Surgery	49	6.8
	Other	32	4.4
	Did not answer	14	1.9

Figures

Figure 1: Thematic analysis revealed themes of negative professional culture, high workload and inadequate resources and generational change.



Appendix 1: Survey Questions

Question	Answer Selection
What is your area of discipline?	Anaesthesia Clinical Oncology Clinical Radiology Community sexual and reproductive health Emergency medicine General practice (GP) Intensive care medicine Medicine - Acute internal medicine Medicine - Allergy Medicine - Audiovestibular medicine Medicine - Cardiology Medicine - Clinical Genetics Medicine - Clinical neurophysiology Medicine - Clinical pharmacology and therapeutics Medicine - Dermatology Medicine - Endocrinology and diabetes Medicine - Gastroenterology Medicine - General internal medicine Medicine - Genitourinary medicine Medicine - Geriatric medicine Medicine - Immunology Medicine - Infectious diseases Medicine - Medical oncology Medicine - Medical ophthalmology Medicine - Neurology Medicine - Nuclear Medicine Medicine - Palliative medicine Medicine - Rehabilitation medicine Medicine - Renal medicine Medicine - Respiratory medicine Medicine - Rheumatology Medicine - Sport and exercise medicine Medicine - Stroke medicine Medicine - Tropical medicine Obstetrics and gynaecology Occupational medicine Ophthalmology Paediatrics Pathology - Chemical pathology Pathology - Haematology Pathology - Histopathology Pathology - Medical microbiology and virology Psychiatry - Child and adolescent psychiatry Psychiatry - Forensic psychiatry Psychiatry - General psychiatry Psychiatry - Liaison psychiatry Psychiatry - Medical psychotherapy Psychiatry - Old age psychiatry

Question	Answer Selection
	Psychiatry - Psychiatry of intellectual disability Public Health Surgery - Cardiothoracic surgery Surgery - General surgery Surgery - Neurosurgery Surgery - Oral and maxillofacial surgery Surgery - Otorhinolaryngology (ear, nose and throat surgery) Surgery - Paediatric surgery Surgery - Plastic surgery Surgery - Trauma and orthopaedic surgery Surgery - Urology Surgery - Vascular surgery Other (please specify)
What sector do you primarily work in?)	NHS Private Other (please specify)
If you work in the NHS - what is your role/grade?	FY1 – foundation year one junior doctor FY2 – foundation year two junior doctor ST – specialty trainee in a hospital specialty SpR – specialty registrar in a hospital specialty GPST – specialty registrar in general practice SAS GP Consultant Academic Other (please specify)
In your career have you ever been stressed to the point that you felt your mental wellbeing was affected?	Yes - Regularly Yes - Sometimes Yes - rarely No - Never Other (please specify)
Which of the below charities/helplines are you currently aware of as a resource to help Doctors suffering from stress/anxiety? (please select all that apply)	BMA Confidential helpline GMC The Doctors' Support Network Charity The Practitioner Health Programme/GP Health Service The Cameron Fund The Samaritans Others not on this list (please specify)
If your mental wellbeing WAS ever affected, from where did you seek help & support? (please select all that apply)	PLEASE TICK IF YOUR WELLBEING HAS NEVER BEEN SIGNIFICANTLY AFFECTED Line Management Occupational Health own GP Family/friends BMA GMC

Question	Answer Selection
	The Doctors' Support Network Charity The Practitioner Health Programme/GP Health Service The Cameron Fund Nowhere - I dealt with it myself Other (please specify)
If your wellbeing WERE to be affected, from whom would you seek help & support (tick all that apply)?	Line Management Occupational Health own GP Family/friends BMA GMC The Doctors' Support Network Charity The Practitioner Health Programme/GP Health Service The Cameron Fund Nowhere - I will deal with it myself Other (please specify)
Do you feel able to raise concerns within your organisation regarding your wellbeing and stress/workload?	Yes No Please expand/describe
Do you feel the NHS has a culture of viewing excessive stress/workload as the norm?	Yes No Please expand - why do you think this is the case?
If a new charity / campaign group/ advocacy group was setup with the aim of helping Doctors at all levels under stress/excessive workload, what would you want it to provide that would encourage you to engage with it? (please select all that apply)	Provide confidential and independent one 2 one support and reassurance Direct me to external resources/other areas of help Provide a listening ear from a peer to peer support network Campaign for a positive culture change within the profession and NHS with respect to stress/workload levels (Agenda TBC) Please also list what else you think a new charity or support group can do for you/your colleagues that are under stress and have nowhere else to turn to.