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Health Education and Improvement Wales

Sent by email only to: HEIW.EducationStrategy@wales.nhs.uk

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Dear Colleagues,

GMC response to HEIW education strategy

1. Thank you for inviting the GMC to contribute to the call for evidence that will inform development of the education strategy for Wales. In this response, we have responded to the five key focus areas that you have helpfully identified.

Our role

2. As you know, the GMC's role is to protect patients and develop medical education and practice across the UK. As part of this, we oversee UK medical education and training, and we set the standards that doctors need to follow throughout their careers. We also take action where necessary to prevent a doctor from putting the safety of patients or the public's confidence in the profession at risk.
3. As the strategy develops, we can offer HEIW our support in the following ways:
 - We hold valuable data on medical education which can provide insight into planning for future needs.
 - We undertake research into the learning and training experience of doctors from different backgrounds.
 - We are able to track the trends in doctors joining the UK register from UK medical schools and from abroad, using data derived from the registration process.

General observations about the education landscape

4. We have observed that the most significant change in the doctor population over the last decade in both Wales and England has been the increase in the number of locally employed doctors, who do not have access to approved training pathways, and whose numbers are now similar to the number of doctors in formal training. In England and Wales, the proportion of licensed doctors not in training that are locally employed doctors is 58%. In Wales, 31% of licensed doctors not in training are in SAS roles, compared to 18% in England.
5. These groups are not part of the approved, quality assured system, so there is no recognition for or regulatory oversight on any learning that they do. This means that the current model

does not meet the needs of a significant part of the doctor population. Equally, many trainees are choosing to take time out of training because they do not find that the training meets their needs, for a variety of reasons.

6. We are considering how this, and other issues with the current model, can be addressed as part of our Future of Education and Career Development (FutureEd) programme.
7. Within formal training, we believe that there are opportunities to make significant improvement. As part of the FutureEd programme, we will be reviewing our educational framework to ensure that it is fit for purpose for the needs of today's population and better enables others across the system to adapt more quickly and share a common approach where possible.
8. In our response below, we have indicated where and how HEIW's areas of focus align with the FutureEd programme.

Focus area 1: Educational Quality

Preparedness of learners

9. In the GMC, we hear mixed views about the preparedness of learners to take up future healthcare roles. We have heard both that the outcomes-based curricula that are now in place are better at preparing people, but also that there is significant additional learning required in future roles. We think that as part of HEIW's education strategy, it is worth considering how to support people through transitions, with mentoring, buddying and shadowing.
10. Within our overall assessment, it is worth noting that differences in feelings of preparedness emerge early, with ethnic minority F1 doctors feeling less prepared than white peers for their first clinical post. Our data shows that 68.0% of UK White respondents felt prepared for their first clinical post, while 52.3% of UK Black respondents felt prepared.
11. It is likely that those entering the workplace without the support of a training programme will feel even less prepared. GMC data on postgraduate exam pass rates shows that those doctors who have never been in a training programme have a 44% pass rate compared to 69.5% pass rate for doctors in specialty training at the time of their exam attempt.
12. Evidence suggests far fewer UK BME and IMG candidates apply for reasonable adjustments, or declare a disability which may impact their access to support.
13. Breaking down barriers to access the right support is essential to ensuring doctors are prepared at all stages of their journey. Creating a culture that promotes mentoring and positive role models would help.

Quality assurance

14. We believe that the GMC's quality assurance approach, where deaneries quality manage training, is effective in supporting a high-quality learning environment for most doctors in formal training. This is supported by our National Training Survey responses. As noted above,

this current system excludes the quality assurance of learning environments for doctors not in approved training.

15. In our research with UK learners from ethnic minority backgrounds, they told us that an inclusive, supportive learning environment was the most important factor to help them successfully navigate postgraduate training. In this context it is worth noting the findings from the most recent National Training Survey. This shows that more than a quarter of learners from ethnic minority backgrounds said they've experienced micro-aggressions, negative comments, or oppressive body language from colleagues.
16. In our Fairer Training Cultures programme of work, we aim to eliminate discrimination, disadvantage, and unfairness for agreed index measures of medical education and training pathways by 2031. Our work in this area is split into the following six key focus areas, which we believe will also be important for the HEIW Education Strategy:
 - Recruitment and selection. We have identified the opportunity to align recruitment practices with GMC standards to promote equitable access to training and research opportunities, ensuring a fair, transparent system;
 - Personalised learning and early intervention. Early, tailored support for learners, especially for ethnic minority and IMG doctors who face social, cultural and structural barriers, can improve outcomes and progression;
 - Quality assurance of inclusive learning environments. Strengthening our quality assurance systems for learning environments will ensure the voices of marginalised learners in these environments are heard, and that environments the GMC approves for training are equally supportive regardless of background;
 - Recognition and approval of Trainers Framework and 'Support for Trainers';
 - Evidence for change. Since 2015, our data and research have highlighted the attainment gap for ethnic minority learners and the effectiveness of targeted interventions. Moving forward, our priority is to demonstrate which interventions work to close this gap; and
 - Addressing the attainment gap and promoting EDI. Addressing bias in exams and providing inclusive support for trainees is essential. Effective steps include targeted exam training, diversifying examiners, alignment with clinical practice, and accessible, quality feedback.

Focus area 2: Curriculum and Pedagogy

Curriculum focus

17. We think there needs to be a greater emphasis on meeting changing patient needs. This may mean that in postgraduate training curricula there would be a greater focus on addressing health inequalities, social determinants of health, and population health. These will be a key focus of our FutureEd programme, which will include reviewing our educational standards and outcomes to ensure that they are fit for the needs of the Welsh population, as well as the UK population.

18. Part of our work on curricula development will focus on differential outcomes that exist today and how the outcomes and our broader framework can help identify the causes of these differences. It will also need to consider how curricula address the role medics can play in breaking down barriers, for example:

- The role that the attitudes/biases of medics can play in health outcomes, for example poorer maternity care and biases around pain relief;
- The role that having a diverse community of doctors can play in ensuring that the needs of different members of the community can be recognised and met;
- Making sure that curricula accurately reflect the diversity of patients in Wales and the UK, and that content, teaching and assessment do not reflect only certain groups; and
- Making sure that curricula ensure that doctors have the skills to meet the needs of patients who have communication barriers and neurodiverse conditions.

Flexibility of training

19. We believe that more can be done to promote flexibility and shared learning for doctors who wish to gain experience, both for those in training and those in locally employed roles. Some progress has been made, but there is more we can do collectively.

20. *Excellence by design* was established to ensure that curricular content could support greater flexibility through shared learning and transferability. This included:

- Establishing our Curriculum Oversight Group (COG) to provide strategic guidance on the underlying purpose of each curriculum. The group includes representation from the four statutory education bodies, including HEIW, HEE, NIMDTA, NES, and invitees from the four departments of health;
- Convening developmental discussions between COG and each individual medical royal college or faculty responsible for one or more curricula. These gave the opportunity to explore key issues and priorities for the design and development of the new curricula, including alignment with patient, service and population needs, and flexibility and consideration of allied disciplines;
- Requiring the submission of a purpose statement for each curriculum as part of our approval process. The proforma for this stage of the process included the question 'Please describe how the proposal will support a more flexible approach to training, such as embedding shared learning outcomes and content with other relevant specialties,' All purpose statement submissions were shared with the COG for their feedback and advice.

21. In a few areas, developmental discussions have led to more shared content across related curricula. For example Medical Oncology and Clinical Oncology now have a shared 'Oncology Common Stem' year with 13 shared learning outcomes (6 generic, 7 oncology-specific). This was the result of extensive joint working and discussions which we convened with the COG, Royal College of Radiologists, Joint Royal Colleges of Physicians Training Board, and Association of Cancer Physicians to agree a way forward.

22. You will recall that the Academy of Medical Royal Colleges, in collaboration with the GMC, also produced guidance on transfer between specialties and, more recently, a high-level template setting out the principles for shared clinical practice. The latter is applicable to all medical professionals at any stage of their career and is intended to help support and signpost them should they be required to call on speciality-specific knowledge that they may not have covered in their training.
23. However, as noted above, there is also a growing part of the doctor population that is locally employed which does not have access to formal training, limiting the opportunities for flexibility on a structural level. We are actively considering how more support can be provided for these doctors that will ensure they have a positive learning experience and importantly that they can have that experience recognised.
24. Some groups are less able or willing to take advantage of the flexibility currently offered, which may be because of visa requirements for IMGs, culture or concern that doing so may be perceived as evidence of 'struggling'. GMC data (2012-2020) shows UK BME Foundation Year 2 doctors are significantly less likely to take a break than UK white Foundation 2's (-16.9%).
25. Addressing this may require more use of Learning Needs Identification tools or identifying risk factors (such as having studied overseas on a non-English speaking programme). This could provide signposts like a period of familiarisation at the start of training before the training clock begins, time in job plans to attend mentoring or buddying, study leave or support prior to a high stakes exam retake, or being given a longer period before being required to take high-stakes exams.
26. Against this background, and as part of our Fairer Training Cultures and FutureEd programmes, we will consider how greater flexibility can support doctors who wish to follow different learning pathways, how experience can be recognised and how learning can be shared across different specialties. To this end, we look forward to exploring opportunities with HEIW and other stakeholder partners.

Focus area 3: Inclusion and Equity

27. The continuing existence of significant differential attainment based on protected characteristics suggests that there is still more to be done to ensure an equitable and inclusive environment for doctors from diverse backgrounds.
28. Our 2023 report *Tackling disadvantage in medical education* highlights the differential experience & outcomes for doctors from diverse backgrounds. Our research into the attainment gap shows that issues exist at a macro (policy / procedure) level, as well as at an institutional, environmental and individual, and personal level.
29. Key steps which may help in addressing this include:
 - Identifying and removing unfair barriers built into training processes from recruitment, access to resources, the lack of a system for the early identification of learning needs and

‘one-size-fits-all’ training programmes that don’t recognise that everyone is not starting from the same point;

- Better mechanisms for earlier identification of needs and mechanisms to address these before a high-stakes fail which damages learners’ confidence and may affect trainers’ perceptions of their capability and their investment of time in them;
- Ensuring that there is diversity in key educational roles: Supervisors/Training Programme Directors (TPDs), Annual Review of Competence Progression (ARCP) panel members, examiners;
- Creating a culture in which accessing support such as mentoring or coaching is not stigmatised as only for failing trainees, but encouraged to help everyone perform at their best. Having senior doctors talk about the support they have benefited from and talk about experiencing struggles such as failing an exam would go a long way to changing the culture. Perhaps developing a system of peer support, which gives more senior learners time to act as peer support or mentors for more junior colleagues and which could evidence learning outcomes around teaching, communication, and professional support. This may also be helped by making Professional Support Units (PSUs) self-referral or a combination of trainer and trainee referral feel less punitive;
- Better signposting of resources available and how to access these, by way of better quality induction and enhanced IMG inductions;
- Curricula with learning outcomes around differential attainment and the barriers faced by diverse doctor and patient groups; and
- Better quality EDI training & support – including more interactive formats such as role-playing, discussions around personal experiences, and peer-groups for trainers supporting learners from diverse backgrounds such as EQiT – Embedding Compassionate, Courageous, Cross-cultural Conversations into Training.
- Raising awareness and encouraging uptake of the GMC’s Welcome to UK Practice programme, which supports doctors from overseas to adapt to working in the UK by offering practical guidance and the chance to connect with other internationally-qualified doctors.

Focus area 4: Technology in Education

30. Digital healthcare technologies, including genomics, digital medicine, machine learning such as AI and robotics are the emerging means of addressing the big healthcare challenges of the 21st century. As part of the FutureEd programme, the GMC will consider how these technologies can be incorporated as part of the review of our education and training framework.
31. We will consider how our education and training standards can enable organisations involved in the delivery of medical education and training to equip the professions we regulate with the necessary skills and knowledge to effectively use and critically evaluate AI and other innovative technologies in order to ensure patient safety.

32. This work will consider competencies that lay the foundational knowledge of machine learning and large language models such as AI, diagnostic tests, digital tools, medical devices and other technologies
33. The potential risks and benefits associated with the use of emerging and other innovative technologies such as AI will also be considered, while ensuring responsible, ethical and equitable access to such technological resources as part of the learning environment.
34. We will consider the competencies required of the professions we regulate as part of the review of our standards to equip them with the skills to apply these technologies responsibly and ethically in their practise.

Focus area 5: Supporting Educators

35. In the GMC, we have significant evidence that educators are facing growing pressures and are at increasing risk of burnout. Our *State of medical education and practice in the UK* report shares our latest data on this from our annual Barometer survey, where the main trends are consistent across the 4 UK nations.
36. Of the trainers we surveyed, 64% were specialists. Specialists who were trainers had consistently poorer experiences than those who were not. They were more likely to be struggling with their workload (26% of specialist trainers, compared with 21% of specialist non-trainers) and more likely to have difficulty providing sufficient patient care at least once a week (38%, compared with 30%).
37. SAS doctors who were trainers were more likely to have worked beyond rostered hours once a week (59%) than SAS doctors who weren't trainers (48%).
38. It also worth reflecting back that in research for our 2016 report Fair Training Pathways for All: Understanding Experiences of Progression, trainers acknowledged they sometimes avoid giving difficult feedback for fear of causing offence or being perceived as biased.
39. Addressing these issues requires the whole system to value educators and their time, as well as more widespread acceptance that delivering training is delivering the service. As part of the FutureEd programme, we are considering what steps the GMC can take to better support this through our oversight role, recognising that we are only one part of a much wider system.
40. Educators need to be supported to identify and meet the learning needs of an increasingly diverse learner population, many of whom have not come through UK medical schools, have a less well-developed peer network and may need additional guidance & advice from their supervisors throughout their educational journey.
41. It may be that those supporting new-to-UK learners need, for example, additional time as well as more support. In 2022 we asked trainers if they'd had the opportunity to learn about differential attainment – over 30% of specialty trainers said they had not.
42. As part of the FutureEd programme we are exploring the possible expansion of who can be considered and supported as an educator, based on a person's function rather than the role

they hold. We believe this will better reflect the reality of who contributes to learning environments and will offer flexibility to meet future workforce needs.

43. We are also considering ways in which we might set expectations and standards for employers to help place education on an equal footing with service delivery and strengthen support for educators. We believe standards positioned at the employer level, using our data and quality assurance to hold them to account, will best assure a resourced, reinforced learning environment that can foster both formal and informal learning.

I hope this response provides context that you will find helpful for development of the strategy.

Yours sincerely

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