General Medical Council

Reflecting on our first engagement panel for regulatory reform

Introduction

Reforming the legislation that governs us has been a long-standing priority. The Medical Act (1983) is over 40 years old, complex, overly prescriptive and slow to adapt to change. It prevents us from being as effective as we could be in our work to protect the public, and support those we regulate in delivering good, safe patient care. Reforms will allow us to be a more relevant, effective and compassionate regulator.

The introduction of the Anaesthesia Associates and Physician Associates Order (AAPAO) in 2024 brought physician associates (PAs) and anaesthesia associates (AAs) into regulation, which was a key first step toward broader regulatory reform. This legislation serves as a blueprint for future changes to how we and other healthcare professional regulators operate.

As we prepared to consult on and later implement the AAPAO, we wanted to make sure that members of the public, doctors, PAs and AAs could help shape the way we work in the future. While we regularly engage these groups through consultations and research, for regulatory reform we aimed to go further by exploring whether we could co-produce policies, processes and communications in collaboration with our audiences.

To support this, in late 2023, we commissioned the research agency Community Research to bring together a panel of 30 members of the public, doctors, PAs and AAs. They facilitated the panel independently through a series of workshops and online discussions over a 12-month period. We asked them to explore a co-productive approach to help meaningfully embed panel members' voices in our work. This was an initial project designed to gather input from key audiences as we prepared for the first stage of reform, the implementation of the AAPAO. We'll continue to explore this type of engagement as we move into the next phase of reform.

The anticipated benefits of this project included:

- Providing members of the public, doctors, PAs and AAs the opportunity to inform the development of new policies, processes and communications in regulatory reform using co-productive principles.
- Contributing to our role as a compassionate regulator through the development of more understandable clear, and concise communications.
- Making our processes and communications as inclusive and accessible as possible by hearing from diverse groups.

This project represented a novel approach for us as we explored how using more co-productive methods could enhance the development of our processes and communications. We used a flexible design including focus groups and multi-methods to enable meaningful involvement from a diverse range of stakeholders. The project involved several workshops and online discussions to

explore whether participants from different groups could work together to co-produce changes to our work.

This report provides an overview of our engagement approach, a summary of the purpose and key findings from each engagement, and broader reflections on the impact and value of this type of work.

Our role

The General Medical Council (GMC) is the independent regulator of doctors, physician associates (PAs) and anaesthesia associates (AAs) in the UK. We work with them and other stakeholders to:

- set the standards of patient care and professional behaviours doctors, PAs and AAs need to meet.
- make sure doctors, PAs and AAs get the education they need to deliver good, safe patient care.
- check who is eligible to work as a doctor, PA or AA in the UK and work with them and their employers to confirm they're keeping up to date and meeting the professional standards we set.
- give guidance and advice to help doctors, PAs and AAs understand what's expected of them.
- investigate where there are concerns that patient safety, or the public's confidence in doctors, PAs or AAs may be at risk, and take action if needed.

Approach

As part of our aim to explore more co-productive ways of working, we considered a range of engagement methods that would allow members of the public, doctors, PAs, and AAs to meaningfully shape our work on regulatory reform. We identified that a panel format would support informed, reflective contributions over time, and help participants to build familiarity with the topics being discussed. The ongoing nature of the panel also enabled us to explore how different groups could engage with each other and with complex subject matter in a co-productive way.

To support this work, we commissioned Community Research through a competitive tender process. They independently recruited and facilitated the panel on our behalf, and we worked collaboratively with them throughout, providing subject matter expertise and input into the

design and delivery of the engagement sessions. This approach helped ensure that the panel sessions were well-informed and focused on relevant topics, while maintaining independence in facilitation and analysis.

The panel consisted of a mix of 30 members of the public, doctors, PAs and AAs, who participated in one to four engagement sessions between April 2024 and March 2025. This was a particularly novel approach for the GMC, as we haven't brought together registrants and members of the public in this way before.

These sessions were aimed to be as meaningful as possible, with some topics, outlined below, lending themselves to co-productive methods more so than others.

- **A new fitness to practise process (accepted outcomes[*]):** what we can do to build trust and confidence in the accepted outcomes process – *April/May 2024*
- **Challenging decisions in fitness to practise:** how people can challenge the decisions we make by requesting a revision – *July 2024*
- **Compassionate communications in fitness to practise:** how we can make the letters we send clearer and more compassionate – *November 2024*
- **Communicating our role in education quality assurance (QA):** what people understand our role to be in education QA and how we can communicate this more clearly through our website – *March 2025*

The following sections summarise the aims, methods, and findings of each engagement session.

Panel membership

The panel included 15 members of the public and 15 professionals including doctors, a medical student, PAs, and AAs. For this report, we refer to these groups as 'patients' and 'registrants', as they were grouped during the panel. It is important to note that 'registrants' includes all participating healthcare professionals, including PAs and AAs, who were not regulated by the GMC until 13 December 2024.

The patients' group represented a range of ages, backgrounds, and experiences, including individuals with disabilities or long-term health conditions, parents, and those with recent

[*] This process is now called the case examiner stage, but for the purposes of this document and to accurately reflect the discussions at the time, we'll be using the previous name of accepted outcomes.

hospital visits. Registrants came from a mix of roles and settings across the UK, including primary and acute care, GPs, consultants, doctors in training, PAs and AAs. Across both groups, we aimed for broad representation in terms of gender, minority ethnic backgrounds, and geographic spread across the four countries of the UK.

Methodology

Community Research used several different methods to engage with the panel. Across the four engagement periods, there were four virtual workshops on Zoom, three discussion boards where panel members reviewed materials and shared comments in their own time, and one face-to-face (F2F) workshop in Manchester. All engagements included patients, doctors, PAs and AAs. The methods used for each engagement are summarised below:

Our new fitness to practise process (accepted outcomes)

- Face to face workshops with 15 panel members in Manchester and an online workshop with 15 panel members from the rest of the UK.
- Ahead of this session, registrants were sent background information, while the patient group took part in a live briefing to introduce them to regulation and our work, helping to balance knowledge across the groups.
- The panel provided feedback on the accepted outcomes process, more specifically on the support and information needed during this process.

Challenging decisions in fitness to practise

- Online discussion forum followed by an online workshop with 16 panel members.
- The panel viewed an animated PowerPoint presentation and reviewed some hypothetical case studies in the online forum. This was followed by a live session that included a plenary and breakout group discussions.

Compassionate communications in fitness to practise

- Online discussion forum followed by an online workshop with 16 panel members.
- The panel members reviewed and provided feedback on two template letters which were based on a fictional case study.

Communicating our role in the quality assurance (QA) of medical education

- Online discussion forum with 21 panel members followed by an online workshop with 16 panel members.

- As this was the final session, all panel members were invited to the online forum. Both the online and live sessions included an evaluative component where participants reflected on their experiences of being part of the panel.
- In the online forum, panel members shared their understanding of QA and explored some education QA webpages. Their understanding and feedback on this were then discussed further in the live workshop.

Summary of findings

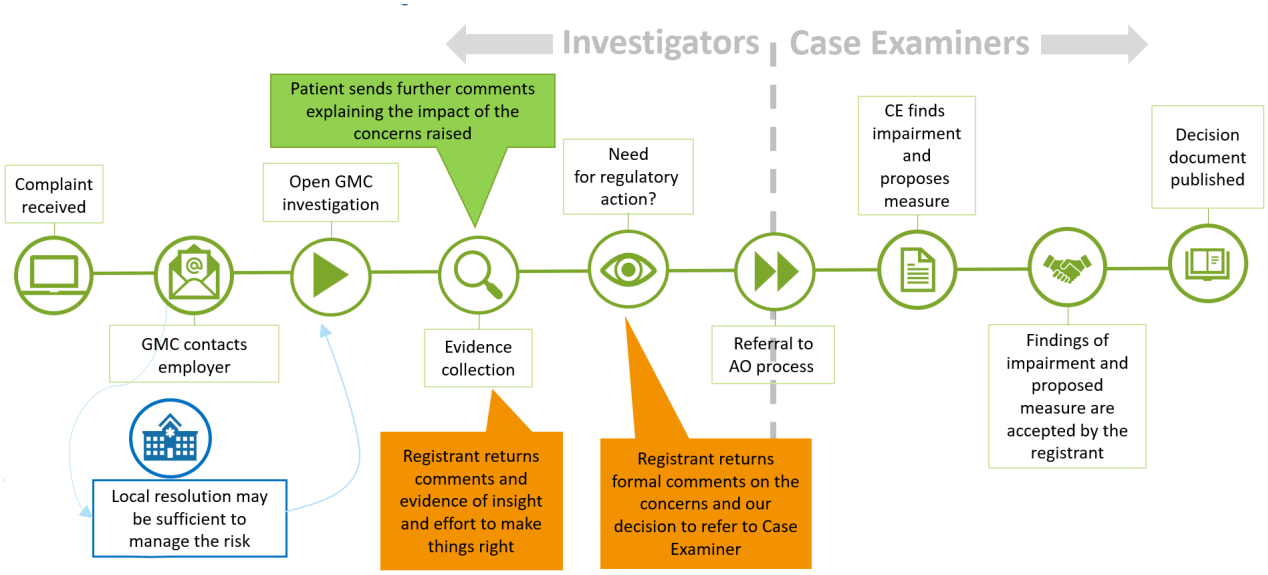
The following sections summarise the key findings from each engagement.

Accepted outcomes

Background

Accepted outcomes is a new approach which will be introduced as part of reforms to our fitness to practise processes. We currently have limited opportunity to resolve cases without going to a tribunal, even where a doctor would be prepared to accept the regulatory action proposed. This prolongs resolution, increasing stress for registrants, complainants and witnesses alike. In future, senior decision makers will be able to propose what action we should take to protect the public at the end of an investigation. If a registrant accepts both a finding that their fitness to practise is impaired and the action proposed to address this, the matter can be resolved without a tribunal. This will allow for quicker, less stressful conclusion, while continuing to protect the public.

An overview of how this new process could work was shared with panel members during the engagement sessions:



- understand what we can do to help those involved in our fitness to practise processes to engage us, which will in turn support our decision making at the accepted outcomes stage.
- get views on what how we can establish trust and confidence in the decisions made at the accepted outcomes stage - before, during or after the process.

Starting points for patients and registrants

The first engagement explored panel members' awareness of the GMC's role and priorities. The patients had no prior awareness of the regulatory reform programme and there was also very low awareness of PAs and AAs and their roles. In contrast, registrants had mixed levels of awareness of the regulatory reform programme, but most were aware of the forthcoming regulation of PAs and AAs.

Accepted outcomes process

Both registrants and patients felt that the direction of travel towards adopting accepted outcomes was the right one. The key advantages they identified included:

- A more streamlined, quicker, and efficient process - though registrants noted the importance of not sacrificing accuracy for the sake of speed
- Reduced stress for all parties – some registrants said avoiding the prospect of a tribunal would help them provide better care for patients, while patients noted particular benefits for registrants with health issues who would not have to go through a tribunal.
- Focusing on local resolution where possible when a fitness to practise concern is initially raised, allowing more resources to be devoted to more serious cases.

Participants also welcomed having sight of the process diagram for accepted outcomes that was shared during the presentation. They felt that it gave clarity, with registrants explaining that understanding the different stages of the processes could further help reduce stress.

However, registrants, in particular, voiced concerns about the proposal for a single decision maker, known as a case examiner, to make accepted outcomes decisions, rather than two case examiners as is currently the case in some parts of the fitness to practise process. They also questioned how an emphasis on local resolution would play out in practice.

Additional discussion points related to our future fitness to practise processes included:

- Whether doctors who supervise PAs and AAs could have their fitness to practise called into question if those they supervised are referred to the GMC.
- The extent to which supervisors would be informed or involved in the fitness to practise process concerning those they supervise.
- Thresholds for closing a case without a formal investigation.

- What measures would be in place to prevent registrants from practising while an investigation is ongoing.

Communications and support

Patients and registrants both called for the format of any communications to be tailored to the preferences of the individual concerned and, potentially, the severity of the case. They also recognised the need to balance transparency with confidentiality for all involved. In recognition that the process could still be stressful for patients and registrants, they emphasised that any available support - emotional, practical or financial should be clearly signposted from the beginning.

Both groups said they'd want the process for accepted outcomes and the approximate timelines involved to be clearly communicated from the outset, so that they'd know what to expect and when. Patients, in particular, said they'd want to be informed when a case had been referred to accepted outcomes. However, compared with registrants, patients indicated that they'd require less information and support about the process by which an impairment or a proposed outcome is set out and accepted by the registrant.

Additionally, patients believed that they should be allowed some control over the frequency and level of detail shared about a case to avoid feeling overwhelmed by information. Many suggested that generic updates would be sufficient to reassure them that the process was underway, and the case had not been forgotten. Both groups spontaneously came up with the idea of a self-serve portal to allow complainants and registrants to find updates on the process when they wanted them rather than waiting for communication, allowing them some sense of control within the process.

Challenging decisions in fitness to practise

Background

The corporate review process is one of the ways in which a decision made about a registrant's fitness to practise can be challenged. The GMC can only review a decision under this process if:

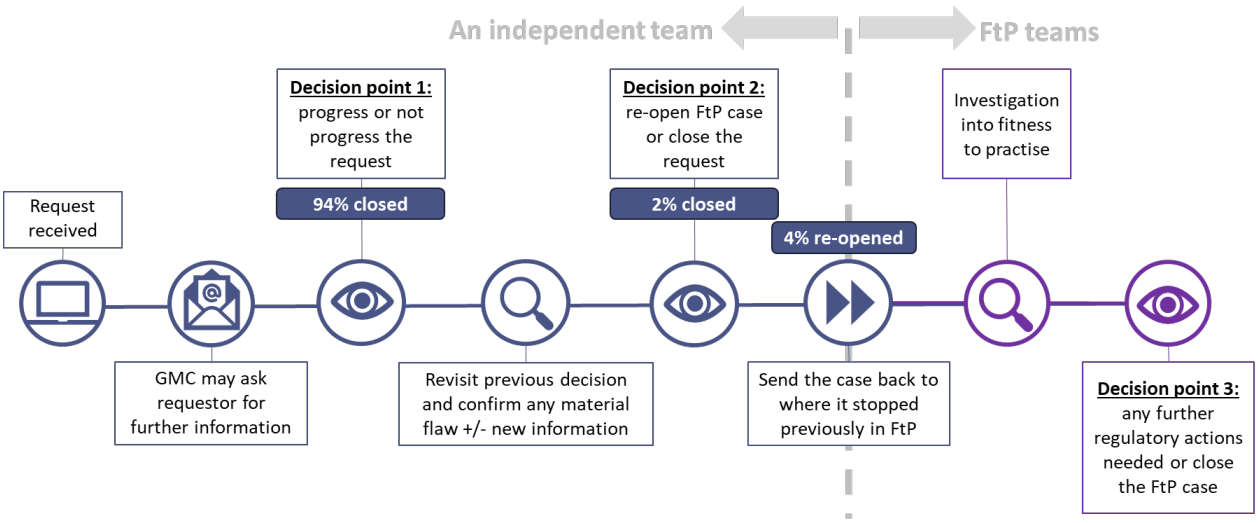
- there is an error with the decision (a 'material flaw')
- there is new information that would have changed the decision
- the decision was made within the last two years (unless in exceptional circumstances)

The aim of the session was to:

- explore the views different stakeholders may have on the corporate review process

- design user friendly processes and communications to best support stakeholders with complex and sometimes competing needs

A brief overview of the process that participants fed back on is provided below:



Findings

The current process was viewed positively, with the staged approach seen as logical and reasonable. The group recognised that the disadvantages of the process were those associated with any review process rather than the specific model.

The fact that the corporate review process is separate from the fitness to practise team that made the original decision gave participants confidence in the independence and robustness of decision making. Participants were comfortable with the idea of a single decision maker in this context. In terms of the timeframes that somebody can request a review of a decision we've made, participants were generally happy with a two-year cut off period for requests. They were also broadly content with the 28-day time limit given to the registrant to provide their response to the review. There were more mixed views from registrants on whether they should be informed when someone requests a review of a decision about their practice. Some felt strongly that it was important for transparency, believing that not knowing about background processes could undermine trust. Others preferred not to be informed, noting that most review requests do not progress, and being notified could cause unnecessary stress.

In terms of support for those involved in the review process, it was felt appropriate that we signpost individuals to other organisations rather than provide support directly. Participants were positive about the current model continuing to be used once accepted outcomes are introduced.

There was no real appetite for change in light of the greater flexibility offered by regulatory reform. It should be noted though that alternative models hadn't been developed at the time of this engagement, so feedback cannot be seen as definitive as participants were not comparing like with like. However, participants could see some benefits in potentially streamlining the process as long as it remained clearly defined, decisions continued to be made robustly, and registrants are always given the opportunity to comment.

Compassionate communications in fitness to practise

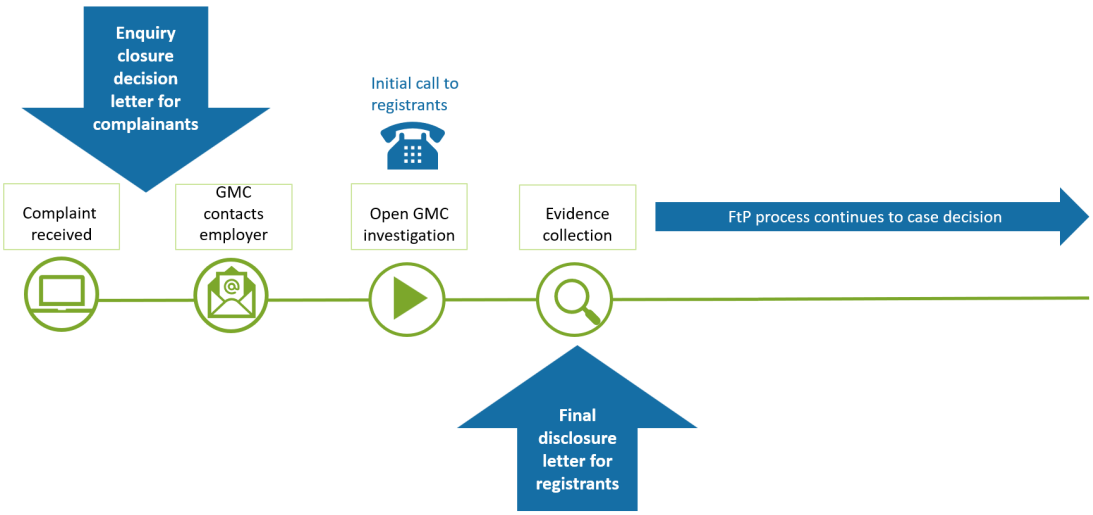
Background

This engagement aimed to support our ongoing commitment to compassionate communications and the continuous improvement of letters in fitness to practise. The purpose was to understand how the letters are perceived by patients and registrants and to gain broader lessons on drafting customer-facing communications.

Participants were asked for their views on the **enquiry closure decision letter** and **final disclosure letter**:

- The **enquiry closure decision letter** is sent to a complainant when a decision is made to close a complaint without a full investigation.
- The **final disclosure letter** sets out the formal 'allegations' against a registrant and gives them the opportunity to respond to the allegations.

The simplified process diagram below shows where these two letters fit within the fitness to practise process. It was used during the engagement to provide context for participants.



Enquiry closure decision letter

Patients believed that the letter was jargon-free for the most part and appreciated the clear subheadings. However, some patients found specific sections confusing and difficult to read, noting a mismatch in tone. Patients generally perceived the letter as empathetic rather than compassionate. Our fitness to practise written communication principle - that writing should be compassionate and empathetic - was not consistently aligned with patients' expectations or interpretations. However, many felt that compassion was not necessary in the context of the example letter and that it was more important for the GMC to demonstrate neutrality. Overall, they suggested improvements to the structure of the letter and highlighted the need for more detail about the process.

Registrants welcomed the length, tone and level of detail of the letter. In contrast to patients, they did not comment on order, flow or ease of comprehension. They suggested adding more process detail and improving the signposting information and terminology within the letter.

Final disclosure letter

Registrants' views of this were very positive, feeling that the structure, tone and content met or exceeded expectations. There was discussion around the tone of the letter, particularly its balance between professionalism and compassion. Registrants felt the letter struck this balance well, describing its neutral tone as appropriate. There was a sense that the letter needed to be factual and serious in order to convey a robust and professional process. The main suggested changes related to the inclusion of likely timescales and an earlier acknowledgement of the stressful nature of the process and support resources available.

Patients had a more mixed response, with some finding it clear but others feeling that it was overwhelming in terms of detail. However, it should be noted that the letter is not aimed at this audience.

Communicating our role in the quality assurance of medical education

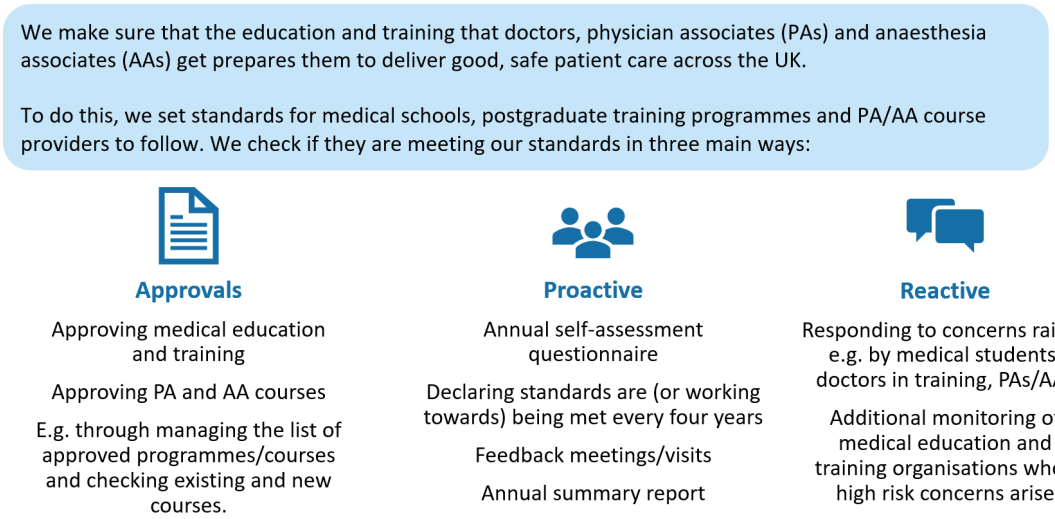
Background

This aim of this session was to understand how well patients and registrants understand our role in quality assuring (QA) education for doctors, PAs and AAs. It also explored their views on the benefits of our role and sought views on how well education QA processes are communicated on our website.

Participants were invited to review a high-level summary of our QA activities, which is published on our website:

"As part of our statutory duty, we set standards for providers of education and training, and we regularly check those are being met. Our quality assurance (QA) framework describes how we do this through our approval, proactive, and reactive QA processes."

They were also able to access additional information about our QA role via our website. This information was summarised (see graphic below) to support their understanding and engagement:



Overall confidence in the education and training of doctors, PAs and AAs

Patients generally reported themselves as having high confidence levels in the quality of education and training that doctors, PAs and AAs receive. Registrants expressed lower confidence than patients in this area, with some citing pressures on the healthcare system and how these impact training opportunities. Both groups questioned whether PA and AA training is sufficient for their roles, though these concerns often stemmed from acknowledged lack of awareness rather than specific knowledge of quality issues.

Understanding of QA

Both patients and registrants generally understood the term 'quality assurance', though registrants had a deeper understanding of our role, often due to direct involvement in education, training, and/or completing surveys. Some doctors, however, were unclear about our role in PA and AA education.

While both groups grasped the concepts of ‘proactive’ and ‘reactive’ QA, they found these terms made our high-level summary of QA harder to understand.

Reactions to webpages

Both patients and registrants found the webpages informative and there were few, if any, issues with the overall language and tone. They also welcomed the fact that similar, comparable information is provided on QA processes for PAs and AAs and doctors. Both audiences were generally more confident in the education of registrants after reviewing the webpages.

However, patients felt the content wasn’t aimed at them and struggled to see its relevance in everyday situations. They also found some summaries, particularly of proactive and reactive QA, too simplified to provide confidence that the processes are robust.

In contrast, registrants felt the pages were accessible and appeared to have been targeted at both health professionals and patients. However, they noted a lack of depth in some places, with requests for more detailed QA examples. Both groups found the site structure unhelpful, describing navigation as difficult and the content as ‘buried’ or like ‘getting lost in rabbit holes.’

Communication of education QA

In terms of the panel’s thoughts on how the GMC should communicate education QA activities, feedback from registrants broadly tended to be on the regulation of multiple professions and the need for clearer distinction between the roles of different professions. This included entry routes, course content, and the content of the national exam. Patients highlighted the importance of tailoring QA information to the audience and making key details more accessible.

Impact of the engagement panel so far

The use of a panel approach

Feedback from panel members, Community Research, and GMC colleagues indicates that the panel approach was broadly successful in achieving its primary aim of embedding participant voices meaningfully into our work. Using this type of approach has helped show that bringing together different types of respondents in this way is practical for our purposes.

With this approach being particularly novel for the GMC, we’ve found it useful having patients and professionals’ input into the development of new policies, processes and communications. Ongoing dialogue with a consistent group of participants has offered fresh, external perspectives and helped us navigate the complexity of our work more thoughtfully.

Impact on our work

The panel feedback has had the most impact on how we communicate what we do at the GMC but has also made a difference to discussions around our policy and processes. For example:

- The accepted outcomes session contributed to a decision to change our proposed approach of using a single case examiner for certain fitness to practise decisions, instead opting to retain two case examiners.
- We've updated the form used to request a revision of a decision and revised our frequently asked questions to make it clearer how the corporate review process works and how it is independent of our other work in fitness to practise.
- Reflections on the letters we send in fitness to practise have informed the drafting of new versions. We'll also use feedback to build on the set of principles that staff are trained to follow when drafting communications to complainants or registrants.
- We're considering changes to our webpages explaining quality assurance in education, focusing on the level of information provided and how it's presented to different audiences.

Lessons learnt

As this was a new approach for the GMC, we've taken time to reflect on what worked well and where improvements could be made. The experience of running the panel has provided valuable insights in how we engage with participants, and how we plan, deliver, and support this kind of work internally. These reflections will help shape how we approach future engagement, ensuring it remains meaningful, inclusive, and impactful. Some of the key lessons we've learned so far are outlined below

Choosing topics and methods

- Some topics may be better suited to a panel approach than others, particularly those that:
    - require ongoing engagement, such as those involving long term policy development or iterative decision making.
    - could benefit from external validation or diverse perspectives, where external input can add credibility to organisational decision making.
- Participants found it easier to engage with topics that were more tangible or directly relevant to them. The feasibility of using more of a co-productive approach varied depending on the topic of discussion.
- Engagement is most impactful when there are clear ideas or proposals to explore, but before final decisions have been made. This allows participants to meaningfully influence the direction of policy or communications.

- Face to face sessions were generally preferred for their interactivity, though online formats offered greater flexibility and inclusivity.

Practical delivery considerations

- When intending to co-produce, it's important to design activities that reflect the distinct needs and perspectives of different groups, and to reflect on whether or not those groups should be brought together. While we had some concerns about how well mixing audiences might work in practise, participants showed compassion and respect, reinforcing the value of thoughtful design and facilitation. Certain topics made sense to cover together, while others, such as registrants commenting on letters received by patients and vice versa were better explored separately.
- Striving for a balanced mix of voices is important, though it can be challenging to achieve with a relatively small group of people.
- Allowing enough time to develop the aims and materials for the sessions is key to running smooth and effective engagements.
- Using more collaborative approaches can look quite different from traditional research. Traditional research norms, such as avoiding client presence, may not apply and need to be reconsidered.

Next steps

Some of the panel feedback is still being explored, and its influence is beginning to shape how we approach certain areas of our work, particularly as we continue to progress with regulatory reform. The panel's input is helping us reflect more deeply on how our policies, communications, and processes can better respond to the needs of our audiences.

We are extremely grateful to the 30 individuals who shared their reflections and experiences as part of the panel. The empathy and fresh perspectives they brought to complex discussions will help our work to become a more compassionate, effective and relevant regulator. We're thankful too for the facilitators from Community Research, who provided independence, expertise and constructive challenge to help us get the most value out of this experience.

To support the next phase of reform and continue hearing directly from our audiences, we intend to maintain this type of engagement. This will help us build on what we've learned so far, explore emerging topics of interest, and ensure that patient and professional perspectives continue to guide our approach. We hope this ongoing dialogue with our audiences will help us better protect patients and support the professionals we regulate.