UK Advisory Forum (UKAF) Scotland – Summary note

Date: 29 April 2026

Attendees:

- Carrie MacEwen (Chair)
- Nico Bridge, Assistant Director for Education Operations, GMC
- Nicola Cotter, Head of GMC Scotland
- Alan Denison, Deputy Medical Director, GMC
- Lindsay Donaldson, Public Services Delivery Scotland
- Graham Ellis, Deputy Chief Medical Officer
- Helen Freeman, Directors of Medical Education Group
- Iain Kennedy, BMA Scotland
- Robert Khan, Assistant Director of Public Affairs and National Offices, GMC
- Ellie Hothersall, Leads of Undergraduate Medical Education in Scotland
- Mark MacGregor, Scottish Association of Medical Directors
- Push Mangat, Medical Director & Director of Education and Standards, GMC
- Charlie Massey, Chief Executive and Registrar, GMC
- Alasdair McFadyen, Scottish Academy Resident Doctors Group
- Lynne Meekison, Public Services Delivery Scotland
- Douglas Millican, GMC Council
- Anthony Omo, Director of Fitness to Practise, GMC
- Robbie Pearson, Healthcare Improvement Scotland
- John Robertson, BMA Scotland
- Gillian Russell, Scottish Government
- Ian Somerville, Policy and External Affairs Manager, GMC
- Karen Titchener, Patient Safety Commissioner for Scotland
- Daphne Varveris, Scottish Academy of Medical Royal Colleges
- Emma Watson, Public Services Delivery Scotland

- Simon Watson, Healthcare Improvement Scotland
- Amy Wilson, Scottish Government

Welcome and Chair's introduction – Carrie MacEwen

1. The Chair welcomed attendees and noted the meeting would trial a new format.
2. She set out the purpose of the forum: to work collaboratively to ensure doctors have the right opportunities to develop, and to identify and address barriers to progression and good working environments.
3. She welcomed attendees joining for the first time, including the GMC's new Medical Director and Deputy Medical Director, Push Mangat and Alan Denison. She also welcomed Karen Titchener, the first Patient Safety Commissioner for Scotland, and Daphne representing the Scottish Academy.
4. She thanked Iain Kennedy for attending his final meeting and for his constructive input over the last four years as Chair of BMA Scotland.

Actions from previous UKAF meeting

5. Nicola provided an update on actions from the previous meeting, including work to support 'creating the conditions for change' in the context of NHS renewal. This had informed the GMC's input to the Scottish Government's Future Medical Workforce work, particularly around data and insight on working environments, and it has also shaped our Outreach work with health boards in Scotland.
6. She noted work is ongoing with Healthcare Improvement Scotland (HIS) to collaborate with senior leaders, including through the 'Leading for safer care' programme.
7. A session bringing together past and current Scottish Clinical Leadership Fellows (SCLFs) was also held that morning to discuss leadership and how this could be supported.

Chief Executive's update

8. The Chief Executive welcomed the UK Government's consultation on regulatory reform. He noted that reforms could provide greater flexibility to avoid unnecessarily adversarial processes, support accepted outcomes, and enable a more proportionate approach to opening cases.
9. He highlighted the proposed approach they had taken to the retention of the GMC's right of appeal, noting this relates to recommendations of the Mann Review, which had not yet published.

10. He reflected on the GMC's continued focus on equality, diversity and inclusion, noting progress in reducing disproportionality in referrals, and ongoing challenges regarding differential attainment.
11. He noted the GMC is reviewing its personal beliefs guidance as part of improving accessibility of guidance and support for registrants to provide safe care.
12. He updated on the Future Education and Career Development programme, including positive engagement with Directors of Medical Education (DMEs) the previous evening, and ongoing system challenges in balancing training needs with service delivery pressures.

External presentation

13. Lynne Meekison, Associate Postgraduate Dean and Operational Lead for the SAS Programme, PSDS, provided the external presentation.

- Lynne noted that work to support learning and education in non-training posts can draw on learning from Scotland's approach to Specialty, Associate Specialist and Specialist (SAS) development. SAS and locally employed (LED) cohorts have some common features (including being outside formal training pathways), but that many SAS doctors are already on the specialist register and choose SAS roles.
- She outlined the SAS workforce context in Scotland and encouraged completion of the SAS/LE survey (the previous survey in 2019 found 73% of SAS in Scotland wanted to remain in the same role; a minority wanted to enter postgraduate training, and around 19–20% wanted to become consultants).
- She emphasised that leaving a training pathway does not mean the end of learning, and described the value of structured development for individuals and for service delivery.
- She described current support, including SAS education advisers in all boards providing training and career advice, and Professional Support and Development (PSD) support for portfolio routes, leadership development and training courses.
- She noted the importance of autonomy, wellbeing, induction and mentoring for both SAS and LE doctors, and of ensuring they feel part of the communities where they work, to support retention and patient safety.
- She reflected that GMC workforce experience data often shows SAS doctors are among the most satisfied, but that challenges remain and similar positive experiences should be supported for LE doctors.
- She updated on work through the GMC and Academy of Medical Royal Colleges Short Life Working Group (SLWG) to develop a framework for recognising competence and evidence for LE doctors, including design principles reflecting heterogeneity of the group and the need for flexible support. She noted discussion of assessment and recognition approaches (including an ARCP-like framework), recognising that resource implications would need to be considered.

- Following the presentation it was observed that Healthcare Improvement Scotland regulates the independent sector and is seeing more LE doctors working there; it was noted this group may be vulnerable when issues arise and this may require future attention as the sector grows.

GMC Presentation

14. Push provided an update on the Future Education and Career Development programme (FutureEd), including work on an overarching framework, standards for assessment and supporting learning in non-training posts.

- He began by summarising stakeholder feedback, including a desire for greater flexibility in training pathways, stronger support for educators, a more active role for employers in education, and education representation at board level (recognised as part of service delivery). But alongside these we also hear of challenges and constraints. These include financial pressures, workforce pressures and limited capacity beyond direct patient care.
- He described three areas of focus within FutureEd: areas the GMC is required to do, areas it can enable, and areas it can influence (including alignment with national plans). As part of the GMC's work we have convened a four-country stakeholder group to develop a knowledge, skills and experience framework for locally employed doctors, with the aim of brining some consistency of process for employers and clarity for LEDs.
- He highlighted patient expectations, noting that patients frequently emphasise professional behaviours such as communication, shared decision making patient empowerment, and that this aligns with elements of the Generic professional capabilities (GPC) framework.
- He noted the role of the medical royal colleges in considering how relevant behaviours and expectations are embedded within curricula, and how the GPC framework could be used more widely beyond formal training, including for SAS and LEDs.
- He referenced available data and emerging evidence, including continued growth in LEDs across the UK.
- He highlighted some of the challenges being experienced by SAS and LE doctors, including risk of burnout, sufficient access to development opportunities, and career progression. He also demonstrated how our data evidenced pressures on trainer capacity and job satisfaction. Feedback from group discussions

Group discussion

15. Attendees split into three groups to consider discussion questions. An annex to this note provides the discussion questions and notes of each discussion. Following the discussions, meeting reconvened to hear the highlights of each.

- Feeding back from her group, Nico Bridge highlighted themes including: embedding patient perspectives in design and evaluation of service delivery; creating safe spaces for doctors and patients to consider feedback and learning; recognising lived experience amongst patients and addressing health inequalities; and balancing generalism and specialism alongside strong communication skills.
- Alan Denison summarised his discussion, reflecting that while some support mechanisms already exist (for example protected time, funded study time, and time for supervising clinicians), provision is patchy. He noted examples of 'pseudo-ARCP' approaches in some areas, but challenges sustaining these without dedicated resource. He also highlighted the lack of portable tools for LE doctors to record and evidence competence and learning, and the need to avoid a one-size-fits-all approach given heterogeneity in LED roles.
- From her discussion, Nicola Cotter highlighted tensions between flexibility and workforce planning, and a system that can be seen to reward rigidity. She emphasised the importance of educational supervision for SAS and LE doctors, noting potential patient safety risk where support mechanisms are absent. She also highlighted challenges in aligning flexible learning with service pressures, and the lack of clear career maps showing alternative pathways (including approaches to full-time working expectations).

Plenary discussion

16. A plenary discussion was held with all participants, who were asked to reflect on the feedback and consider what steps our organisations can take to work together to influence how education and career progression for all is valued and delivered in Scotland. A number of themes were discussed:

- The importance of supporting educators with time and resource, and ensuring education is recognised at board level. It was noted challenges in some settings (including general practice) where education can be deprioritised due to financial pressures.
- That patients and families can influence education and changes in practice. A gap between learning from serious incidents/complaints and sustained change in practice was noted. The need to embed patient voice and learning proactively, including supporting doctors to speak up and recognise cues from patients early, was emphasised.
- There have been efforts to align undergraduate curricula with professional values and behaviours, but a perceived misalignment between those expectations and what learners observe in clinical environments, creating a risk of disengagement or failure for young doctors going into those environments.
- The risk of medicine becoming transactional and the need to re-emphasise seeing the patient as a person, beyond communication skills training.
- Participants discussed the impact of system pressures on forming personal connections with patients and maintaining team-based working. It was reflected that not all

experiences are negative, but that shift patterns and fragmentation can reduce a sense of belonging and team identity.

- That doctors can mirror the culture and investment they experience within the system, affecting how care is delivered.
- The value of reverse mentoring, noting that clear frameworks and ground rules can support powerful learning, and that small investments of time can help people understand each other's perspectives and navigate power gradients.
- It was suggested that no single programme would address these issues in isolation, and therefore the importance of connecting strands of work (including culture) and continuing to work collaboratively through challenges such as increasing demand for less-than-full-time working.

Closing reflections – Charlie Massey

17. The Chief Executive thanked presenters and attendees, noting the richness of discussion and the breadth of themes raised.
18. He highlighted the centrality of patient voice, emphasising not only listening but also embedding and co-designing with patients and the public in shaping education and training.
19. He reflected that many of the issues discussed relate to the environments doctors work within, including culture and leadership, and that effective solutions require coordinated action across organisations.
20. He noted recurring themes around time and resource for learning and for educators, particularly in a resource-constrained environment, and the importance of valuing and protecting educational capacity.
21. He emphasised that the SAS and LED survey will be important to inform future policy and avoid missing opportunities to meet the needs of these cohorts.
22. He reflected on the need to better demonstrate and normalise alternative career pathways, beyond traditional trajectories, to support fulfilling careers.
23. He highlighted the vulnerability experienced by doctors early in their careers and the importance of translating the discussion into meaningful, practical support (including time, supervision and educational capacity) to help them thrive.
24. The Chair thanked attendees and noted that the next meeting is scheduled for November.

Annex – Breakout Group Notes

Group 1:

Facilitator: Nicola Cotter

Participants: Ellie Hothersall, Iain Kennedy, Carrie MacEwen, Robbie Pearson, Daphne Varveris, Emma Watson, Amy Wilson.

Questions:

- *Creating the conditions for more flexible learning and career pathways: Knowing what's already in place, what else needs to happen to make this a reality?*
- *Increasing educator capacity: What are the ways in which clinicians can be incentivised to take up educator roles as part of career development?*

Discussion:

- Concerns were raised that current training structures often present binary outcomes, rewarding rigidity rather than flexibility. There was broad agreement that ARCP progression should allow for greater adaptability, focusing on competence rather than rigid metrics such as time, number of procedures, or hours worked, while recognising the subjectivity involved. Regulation and standards may hinder flexibility, though some doctors prefer the structure offered by traditional training routes.
- The group observed that the current workforce values stability, prompting consideration of how systems might deliver this. Tensions between workforce planning requirements and enabling flexibility were identified, and the feasibility of unlimited flexibility was questioned.
- It was suggested that education and service have become too distinct, with doctors increasingly separated from the wider multidisciplinary team (MDT) workforce.
- Participants noted that students and resident doctors often lack clarity on the variety of available career pathways, leaving them to navigate options independently. The group proposed that comprehensive career maps outlining entry points and potential lateral moves would be beneficial.
- The group recognised that embracing less-than-full-time (LTFT) working is essential, though challenging; it is preferable to retain staff through flexibility than risk burnout and attrition. In light of shifting workforce expectations, participants suggested reconsidering the definition of LTFT, including why 40 hours per week is classified as such.
- There was consensus on the need to allocate dedicated time, resources, and status for education across the system~~s~~.

Group 2:

Facilitator: Alan Denison

Participants: Graham Ellis, Helen Freeman, Push Mangat, Alasdair McFadeyen, Mark McGregor, Lynne Meekison, John Robertson.

Questions:

- Recognising doctors experiential learning: What steps should employers be taking to support locally employed doctors (LEDs) who are not part of a formal training programme but who undertake experiential learning?
- Working together: How can employers and education bodies most effectively work together in future and how do you think the GMC can help facilitate this?

Discussion:

- There was broad recognition that the LED grade is distinct from SAS, and that the workforce consists of multiple groups with differing needs and identities.
- Participants identified several practical steps employers can take to support LEDs, some already implemented in certain areas. These include: dedicated time for LEDs within job plans (typically one hour per week), allocation of time for supervising clinicians, provision of funded study leave (potentially exceeding that available to NTN holders), and the creation of a "pseudo ARCP" process to document skills and inform personal and professional development plans. However, it was noted that such initiatives have sometimes faltered due to insufficient support or funding.
- A key gap is the absence of standardised evidential tools to record competences and a lack of agreement across Scotland for their recognition by all boards. A unified system could also highlight training opportunities, track attendance, and serve as accepted evidence in training post applications. There was strong support for a tool aligned with GMC GPCs. While the needs of SAS doctors differ and would require a distinct approach, the ongoing SAS survey is expected to provide further insights.
- An example was shared of an LED who used the RCEM portfolio to record competences; this was subsequently accepted by the Deanery when the individual entered emergency medicine training, resulting in accelerated progress. However, it was highlighted that other colleges have varying practices, leading to inconsistency in recognition.
- Despite significant interest in LEDs from various organisations, LEDs themselves often report feeling invisible, lost, and left to navigate complex systems unaided.
- Suggestions to improve support for LEDs included: establishing a Scotland-wide agreement on the principles of a "good" LED employment contract (with obligations for career development), drawing lessons from England's national LED support infrastructure, and considering a dedicated Scotland-wide LED charter akin to the existing SAS charter. It was also proposed that guidance for Boards on supporting LEDs should ultimately be strengthened, potentially becoming mandatory. While the GMC

may have a role, there was consensus that PSDS should provide leadership for LEDs, with appropriate nuance, particularly regarding career support.

- The group reflected on how medical education is represented to NHS clinical Boards, typically via staff governance committees. This route may dilute the influence and perceived value of education compared to clinical audit and risk functions. Participants considered whether Board chairs and chief executives should be encouraged to explore alternative models for education governance.
- There was some debate around the potential benefits of returning to a traditional "firm" structure; those with experience of such teams reported mixed, occasionally negative, experiences. However, the group agreed that fostering stronger connections with teams—acknowledging that doctors form only one part of many multidisciplinary groups—would be advantageous.

Group 3:

Facilitator: Nico Bridge

Participants: Lindsay Donaldson, Charlie Massey, Douglas Millican, Anthony Omo, Gillian Russell, Karen Titchener, Simon Watson, Dan Wynn.

*Margaret Reid-Arbuckle (The Health and Social Care Alliance) sent her apologies to UKAF but offered thoughts to contribute to this discussion.

Questions:

- Strengthening the professional skills of doctors: Are there areas that need greater emphasis, for example communication, patient safety, patient doctor interactions, empathy, or interprofessional working?
- Patient involvement: How can patients be involved in shaping and designing change?

Discussion:

- The group discussed the definition of "patient", noting that, in essence, we are all patients at some stage and that individual expectations can vary significantly. Nevertheless, certain commonalities emerged: patients generally want accessible doctors, continuity of care, empathy, and to be listened to/involved in their care from the beginning. There is usually trust in doctors' clinical abilities, but concerns and complaints tend to focus on professional skills. This raises questions about whether patient expectations are consistent across different members of the multidisciplinary team (MDT), or if there are distinct expectations for various roles.
- It was emphasised that patient involvement must be embedded from the outset in both the design and development of healthcare and education, rather than treated as an

afterthought. Undergraduate curricula should place greater emphasis on patient lived experiences. Regulators should coordinate more closely on involving patients in policy development, and better mechanisms are needed for learning lessons when things go wrong.

- Monitoring and managing the outcomes of patient involvement is vital. Professional skills should be seen as lifelong attributes, not restricted to early medical qualifications or specialty training. Students and doctors should be exposed to health inequalities, for instance by shadowing in deprived areas, to develop awareness of lived experiences.
- Communication was identified as critical; doctors can sometimes become defensive in response to feedback or complaints, yet patients are often simply seeking an apology and acknowledgement. Early resolution of complaints could prevent escalation.
- The discussion also considered the balance between generalism and specialism, highlighting the need for continuity of care and a more integrated service from the patient perspective.
- Examples of good practice included reverse mentoring and the use of external mediators when patient care has gone wrong, helping to change perspectives and resolve issues.