Thames Valley GP School Faculty Day

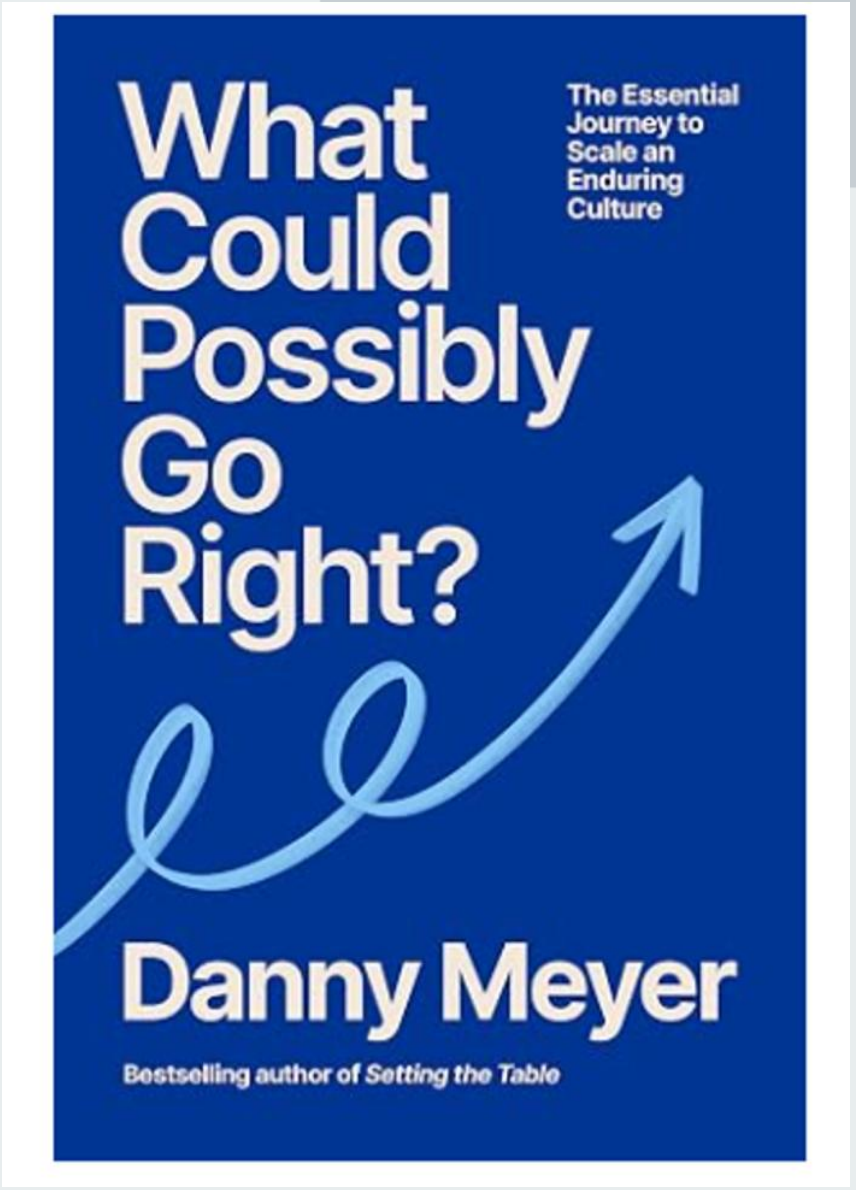
13th October 2026

Today is an opportunity for us.....

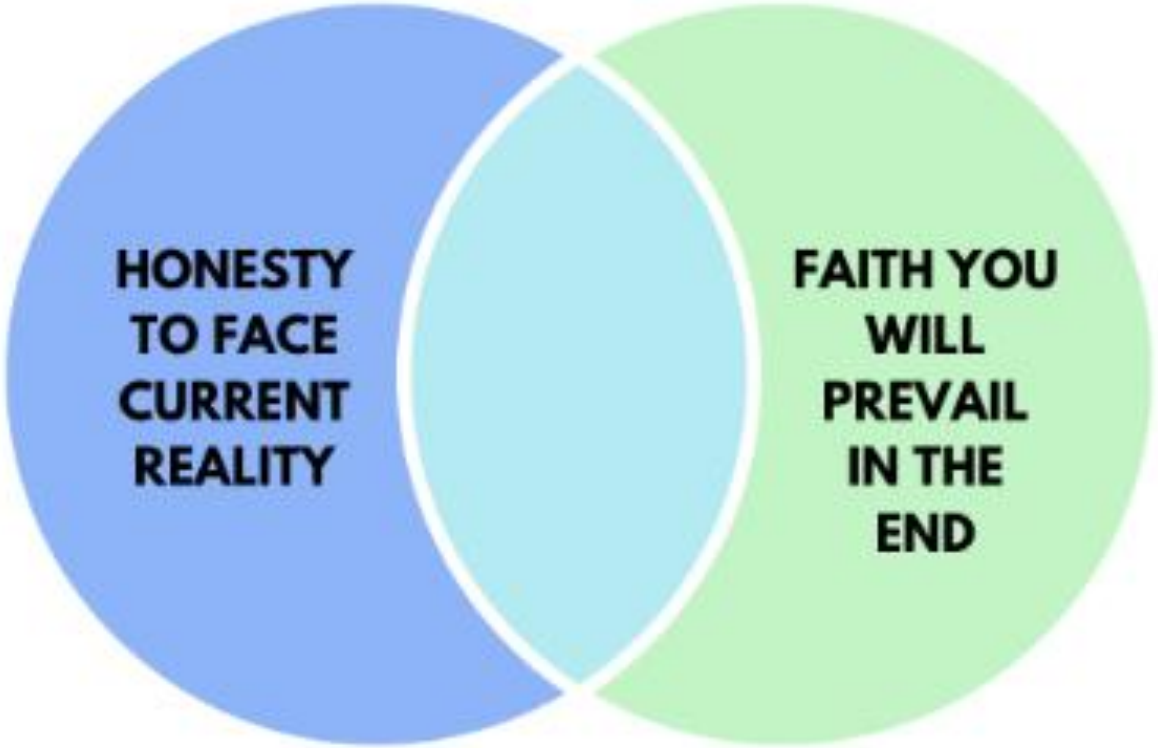
to come together as a Thames Valley educator community

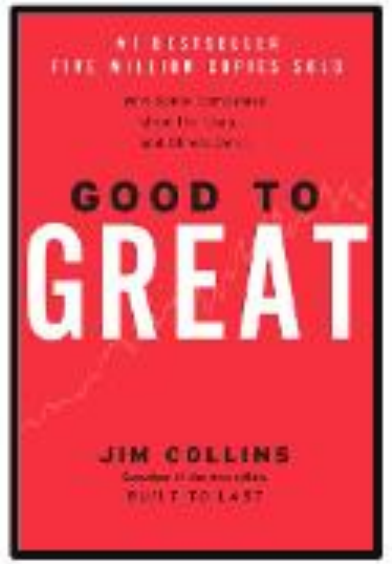
- To appreciate our work and its value
- To share information and updates
- To learn
- To network
- To share best practice and resources
- To build our strength as a community of educators

Working alongside each other, supporting the development of our future workforce


What Could Possibly Go Right?
The Essential Journey to Scale an Enduring Culture
Danny Meyer
Bestselling author of Setting the Table

“Stockdale Paradox”





Please make any suggestions for future topics for our Faculty day

Next Faculty day – Virtual

16th March 2027

Thames Valley Deanery Faculty conference

October 2026

Presented by:

Dr Manjiri Bodhe

Head of GP School Thames Valley and Wessex

Welcome

To all educators

Welcome to all our trainers, TPD’s, ADs and admin team.

A particular welcome to any new trainers since our last faculty conference.

We have some fabulous workshops and talks for you today, including ARCP, Structured learning programmes, AI and workshops on a diverse set of topics.

News

NHS structures

- We have a Regional Southeast Postgraduate Dean **Jo Szram** who was the KSS PGD.
- We also have a new South East Primary Care Dean **Professor Chris Warwick.**

- We are part of a wider Southeast team and are looking at ways to align processes and functions, though our deanery functions still stay separate.
- Our **Locality Dean** is **Rebecca Black.**

News

DHSC/NHSE news.

- The amalgamation of DHSC functions with NHSE functions continues apace, the senior executive team across both is coming together.
- Lots of changes already since we spoke last Autumn. VR/admin
- Unclear where PGMDE will be placed, whether hosted by another NHS service or within DHSC, discussions seem to be continuing.
- We have an October consultation where PGMDE structures and job descriptions will be finalised.
- The final merger can only take place once legislation to abolish NHSE has been passed. This will be likely in 2027.

Admin

Admin changes major

- Matrix working across whole of South east for Primary care, changes have begun, Admin working across boundaries and whole of southeast, for e.g. for LTFT, for ARCP , though some local input of admin currently remains.

Southeast Primary Care

Chris Warwick
Primary Care Dean

Wessex GP School/TVW Primary Care School

Manjiri Bodhe
Head of GP School
Sue Clarke
Head of Primary Care School

Nick Moore
Deputy Head of School

Thames Valley GP School/TVW Primary Care School

Andy Goode
Deputy Head of School

KSS GP School and Primary care school

Liz Norris Head of GP School
Alli Hawes
Head of Primary Care School

Deputy Head of school

Expansion

2026

174

2027

188

2028-2031

240

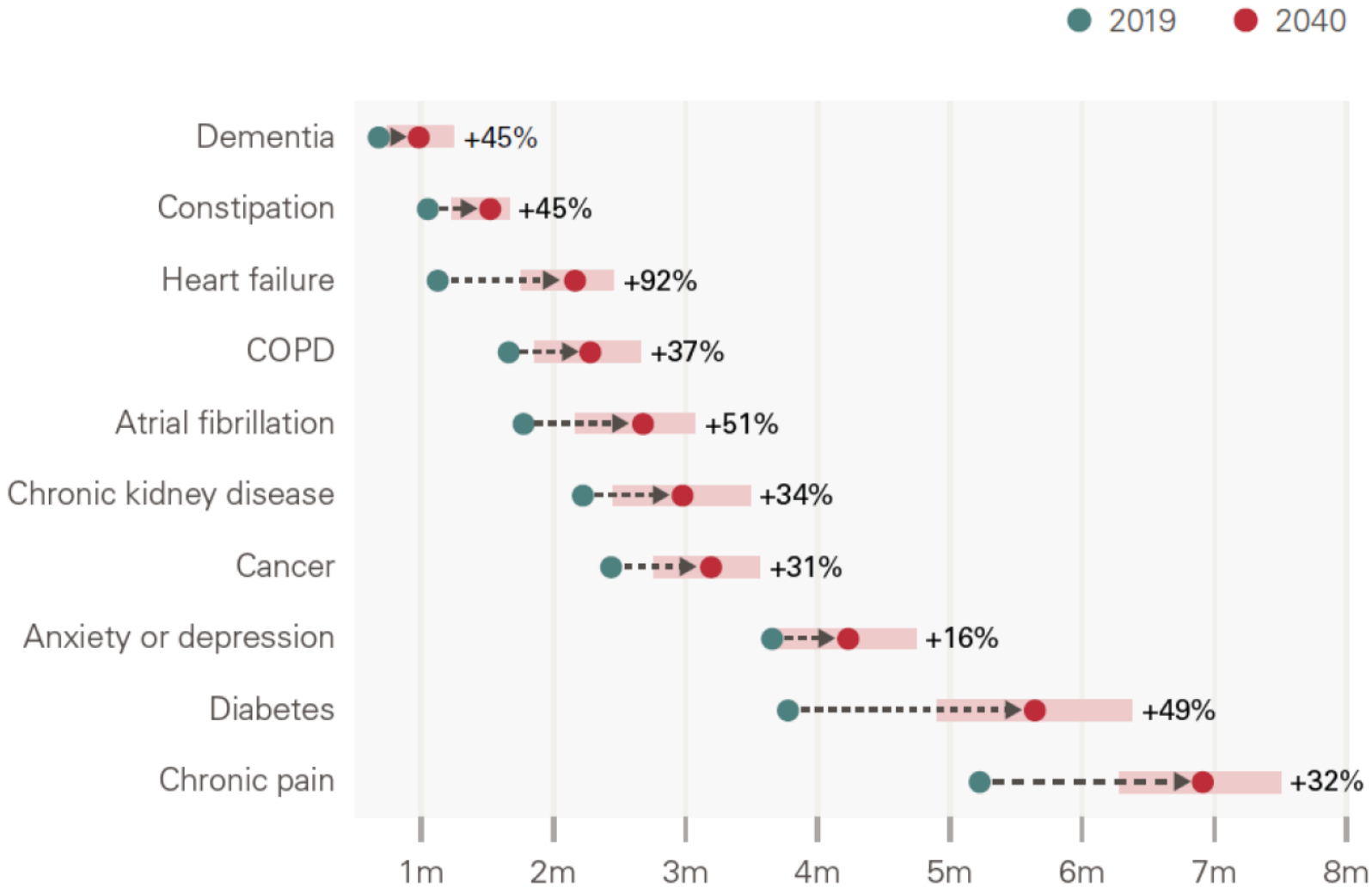
Total of 78 extra spaces in 6 years, on average an extra 13 spaces per year, not a lot but enough to cause stress!

The draft drawn up by the current government promises a “fundamentally different approach”, arguing that a **50 per cent increase in doctors in the NHS** over the past decade “**has not led to better access, experience or outcomes for citizens**” and instead has seen productivity fall. The new measures would downgrade annual staffing increases to 1.1-2 per cent, suggesting that up to 380,000 fewer people will be working in the NHS in the mid-2030s than previously forecast. To help get by with fewer staff, the draft envisages far wider use of AI

As the government seeks to move care closer to home, however, the plan says that up to **49,000 more GPs** might be needed by 2035, 23 per cent **more than in the 2023 plan**, at the expense of those working in hospitals. The proposals envisage an increase of about 50,000 nurses over the next decade, down from 170,000-190,000 in 2023.

Projected growth in demand for healthcare services

Projected total number of diagnosed cases for the 10 conditions with the highest impact on health care use and mortality among those aged 30 years and older, including demographic changes, England, 2019 and projected for 2040

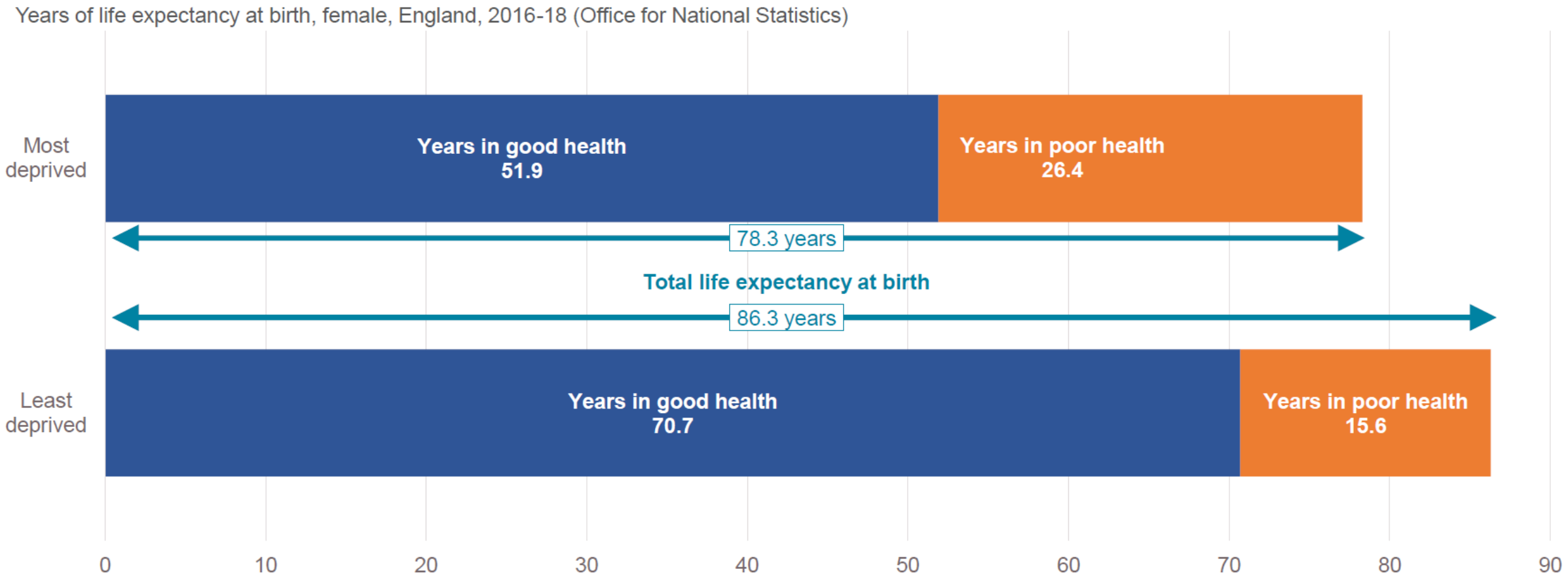


Source: Health in 2040: Projected patterns of illness in England, The Health Foundation

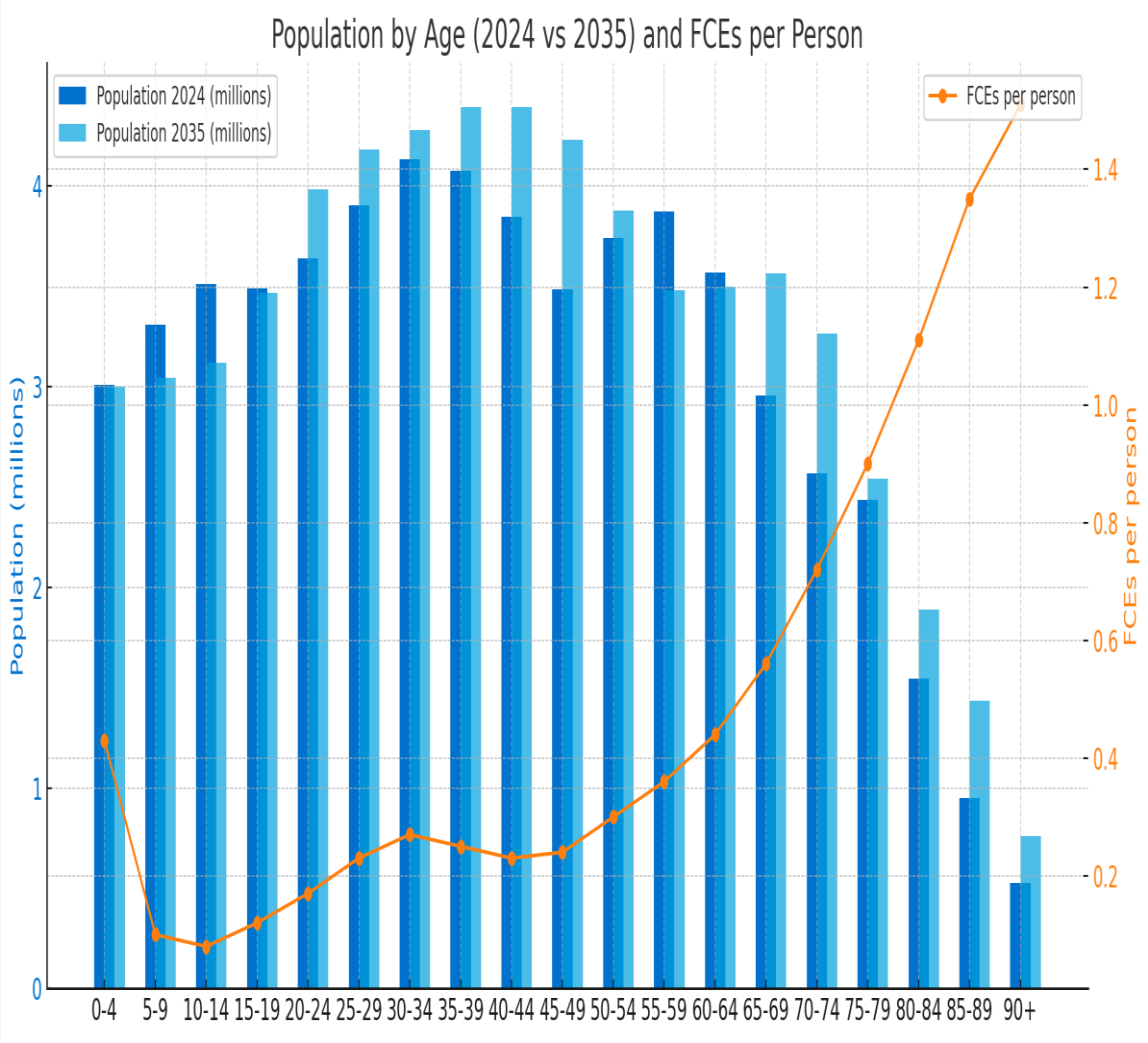
The Case for Compressing Years Lived in Poor Health

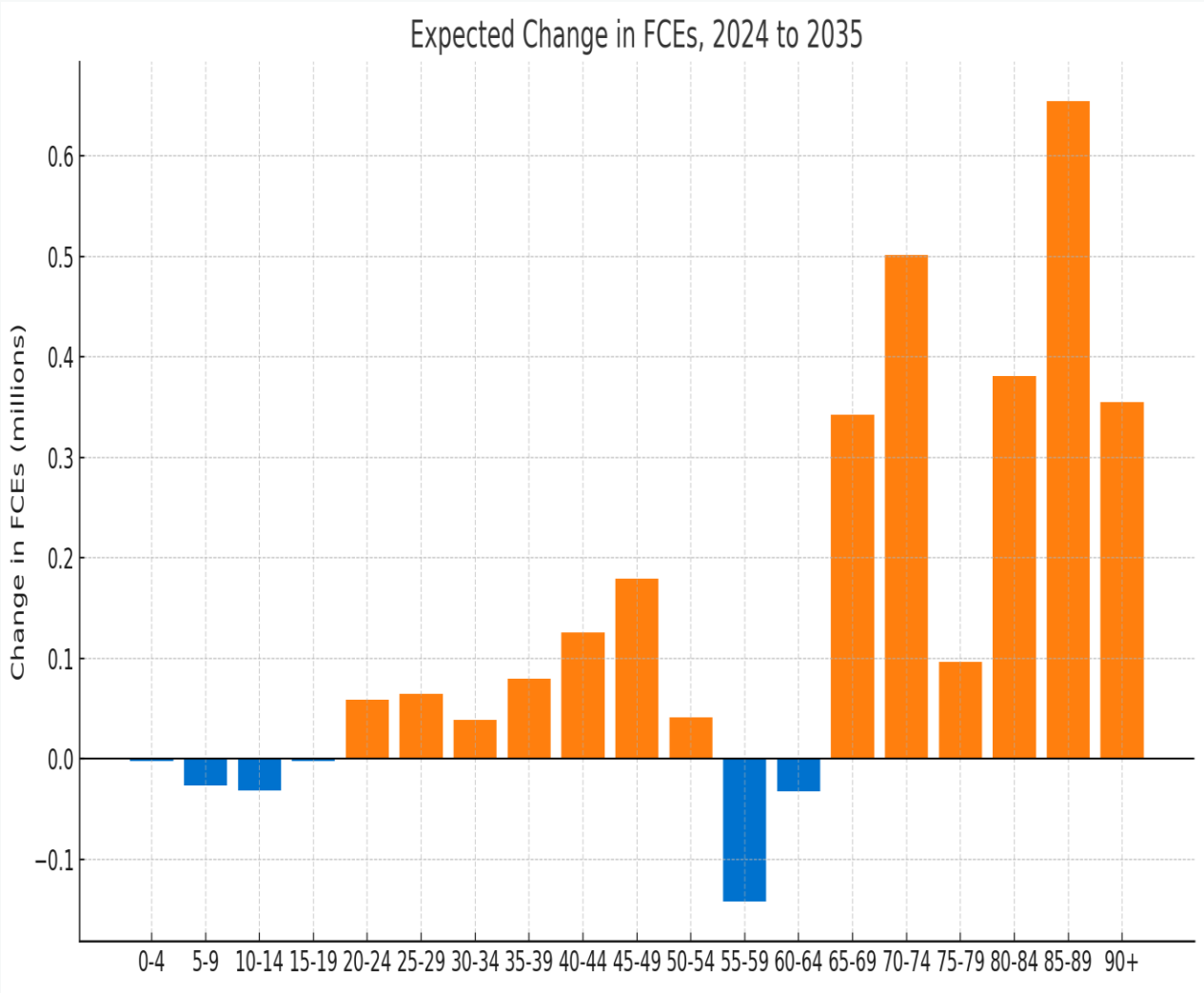
The proportion of major conditions attributable to behavioural risk factors is:

- 46% for CVD
- 43% for Diabetes and CKD
- 43% for Chronic respiratory diseases



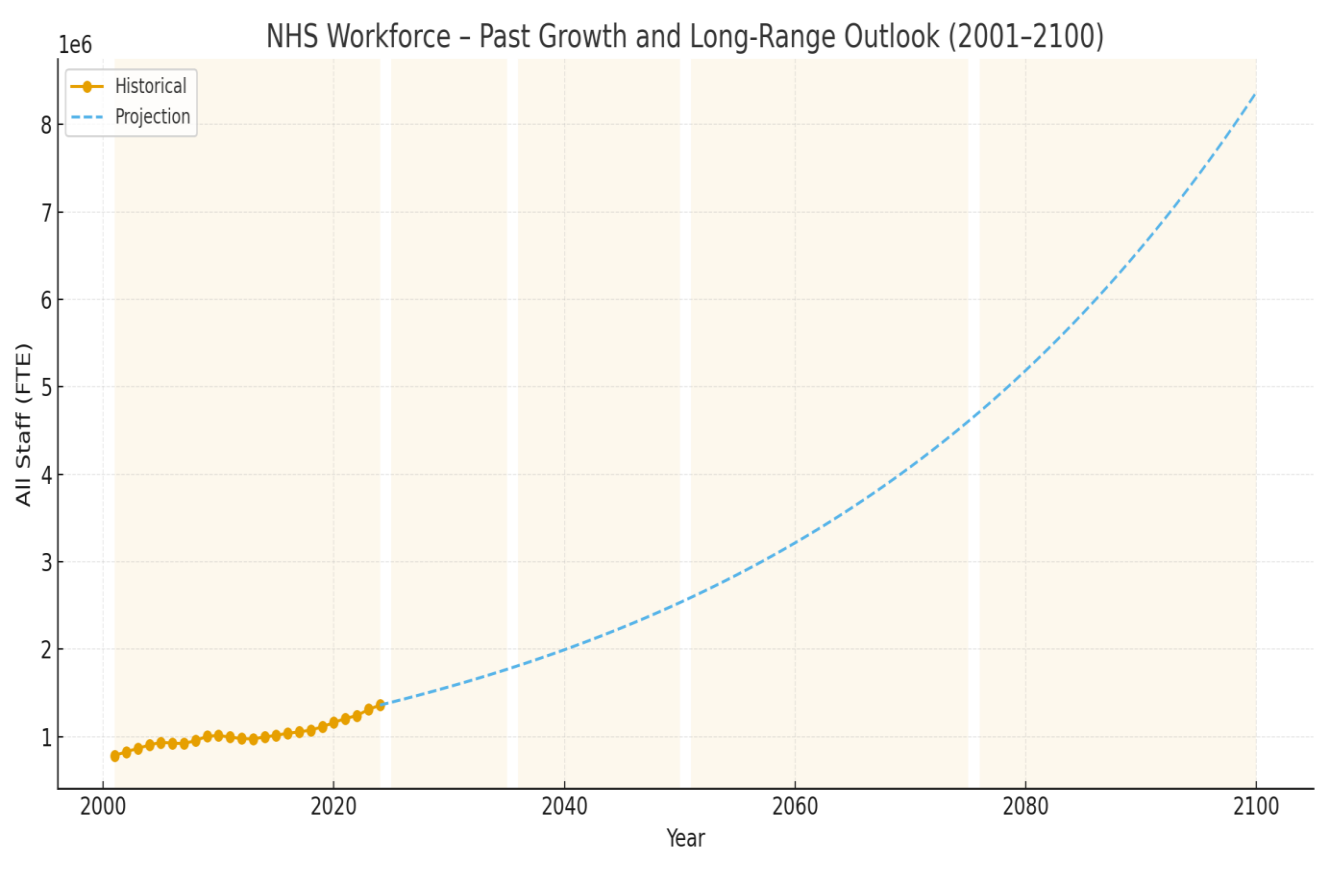
We will have more older people, needing more care





Moreover, simply ‘growing our way’ out can’t be the answer

If we just continue growing our workforce at **2.4% per year,** the numbers we require become impossible to sustain. This means pivoting towards demand management is non-negotiable… as is become more strategic in how we manage our supply



Period	What has happened/needs to happen
2001 to 2024	**Rapid workforce expansion under NHS Plan, followed by austerity-era stagnation after 2010 and then shar rebound driven by Covid-19, international recruitment and LTWP**
2025 to 2035	Continued growth following 10 Year Health Plan – moderated pace as automation, new care models and prevention moderate demand. Focus moves from “more staff” to “different skills” – especially digital, data and integrated community teams
2035 to 2050	The workforce may reach a plateau as population ageing and slower labour force growth limit supply. Shift to productivity, flexible retirement and intergenerational workforce balance. Potentially may need to commit to workforce being no more than x% of the population
2050 to 2075	New innovations – e.g. precision medicine – reduce the need for traditional FTE growth. However, new professions emerge so total workforce numbers may remain broadly stable
2075 to 2100	Ideally… NHS workforce size aligns with population health and fiscal cycles rather than expanding continuously.

What are the choices and trade-offs involved?

This table **below** compares five main workforce planning levers for ***impact, feasibility, political risk, and cost***.

- **International Recruitment:** High impact, feasible, but politically sensitive and contrary to 10YHP; reducing reliance needs demand management + retention + training growth.
- **Domestic Expansion:** Big impact, but costly and slow (training pipeline).
- **Retention:** Low cost, easy to implement, but more limited scale and volatile (labour market dependent).
- **Demand Management:** Essential for sustainability; upfront investment and time needed (prevention, digital, community shift).
- **Other Levers:** Wider labour market recruitment and reducing churn help, but impact is modest.

Bottom line: *No single lever ever solves this—success needs a balanced mix and early decisions.*

Option	Impact	Feasibility	Political Risk	Cost
International Recruitment 🌍	🟢 Higher	🟢 Higher	🔴 Higher	🟡 Medium
Domestic Expansion 🎓	🟢 Higher	🔴 Lower	🟡 Medium	🔴 Higher
Retention 🔄	🟡 Limited	🟢 Higher	🟢 Lower	🟢 Lower
Demand Management 🔍	🟢 Higher	🔴 Lower	🟡 Medium	🔴 Higher
Other Levers ⚙️	🟡 Limited	🟡 Medium	🟡 Medium	🟡 Medium

Expansion plans

- So why do we need extra GPs? 6000 by 2031 acc to 10year plan?will this change
- Less GPs 1 WTE, so are we just running to stand still? Or do we work in a different way, agile, Technologically savvy, prevention?
- **Drivers of variation**
- Rurality and deprivation both drive variation, with practices that are less deprived and in rural settings having **higher numbers of GPs per patient**.
- Practices that have remained under doctored over the past 10 years draw a higher proportion of their patients from deprived areas and are **highly unlikely to host trainees**.
- **Impacts of variation**
- GP partners continue to be a **key driver of capacity**, offering **more GP appointments per FTE** than any other GP type and also **building future capacity** since practices with higher numbers of partners also train more GPs.
- ARRS does not target deprivation: **some ICBs with low GP/patient ratios have also recruited few GPs through the scheme**. ARRS also does not improve the distribution of GPs according to deprivation.
- At the PCN level, the most under doctored PCNs **are reliant instead on a larger number of DPC DIRECT PT CARE staff**.

Some new projects

Structured learning programme

On programme 2 from aug26-feb 27.

Also new SCA ITP SLP also started , 7 weeks programme, further info later today,.

Looking at innovative training, job shares in general practice, group tutorials, PCN or LE based placements, using innovative learning environments to deliver training such as federations, innovative non clinical ITPs such as med ed, public health,

Using AI/Sim to help train, consistency across programmes, innovative placements, job shares.

Self assessment for re-approvals

- First process already run and summaries in process
- Will allow up to date information on all educators in all LE.
- In order to inform this, we would suggest that, as a minimum, GP educators will be able to provide their appraiser with evidence of their continuing professional development and competence, including:
- • ***Regular attendance at Trainer Groups / educator conferences and meetings to remain up-to-date (we will publish on our website all deanery courses)***
- • ***Evidence to confirm continuing professional development in your educational role***
- • ***Reflection on learner feedback***
- Experienced trainers' courses no longer mandatory as part of re-approval.

Updates

- Main update, after d/w BMA Trainee reps, and to not have unwarranted variation across southeast, TVW study leave policy updated to include that that 5 days can be taken for personal study across the year .
- LTFT we now do agree most LTFT applications, as long as done within code of practice and deadlines. If not within deadline, treated as exceptional case and looked at individually. Those cases are dependent on the host employer and what can be accommodate particularly in secondary care.
- We are looking at more job shares both in primary and secondary care, with the new SLP and many ITP posts helping us with this.

Q and A.

“It is the long history of humankind that those who learned to collaborate and improvise most effectively have prevailed.”

– Charles Darwin

ARCP issues and WPBA updates October 2026

Shellani Knight
AD for ARCP

Kim Emerson
RCGP WPBA Clinical Lead
and External advisor

NHS England South East

ARCP Update October 2026

Topics to Cover

NHS England South East

1. Introduction
2. Requirements for Conducting a Panel
3. What happens at an ARCP panel
4. Panel outcome review meetings (face to faces)
5. Review of Outcomes.
6. Missing evidence- common issues
7. Extension figures
8. Reminders- general issues
9. Appeals process.

Requirements for Conducting a Panel

- ESR
- Form R
- Trainee at work

Educational Supervisor Review (ESR) Guidance

NHS England South East

Pre-Sign-Off Verification

Preparation & Deadlines

- Complete a full ESR 2 weeks before panel (but not more than 8 weeks).
- Check it is the correct review level.
- Confirm they have all evidence they need before final sign-off.
- Check before signing off that date is correct and ends day of review

Post-Sign-Off & Access

System Rollover & Continuity

- Open a new review straight away once signed off, even if it is their final review.
- This ensures missing evidence can be seamlessly added for Outcome 5s.
- **CRITICAL:** Portfolio access is lost between the last review and the next one starting if a new review is not set up.

Form R- must include

1. Any complaint- however small
2. Any SEA
3. Any TOOT- time out of training
4. Any mitigation

Mitigation

1. Trainees need to declare this on the Form R.
2. ES/CS/TPD can add it in the Educator notes
3. Panel need to know about this at the time of the ARCP to be able to take it into account.

ARCP Evidence and Triage Process

NHS England South East

1. PD Triage
1 Week Before Panel

- PDs check and triage all submitted evidence.
- Educator Note added detailing exactly what is missing.

2. Panel Check
At the Panel

- Outcome 5: Given 2 weeks to add missing evidence for next panel.
- Outcome 2: Issued if lots missing or unachievable in time.

3. ES Action Steps
Post-Panel (Outcome 5)

- ES must create a new review window for evidence upload.
- Log entry marked as 'ARCP evidence' or add educator note.

4. Final Review
Follow-Up Panel

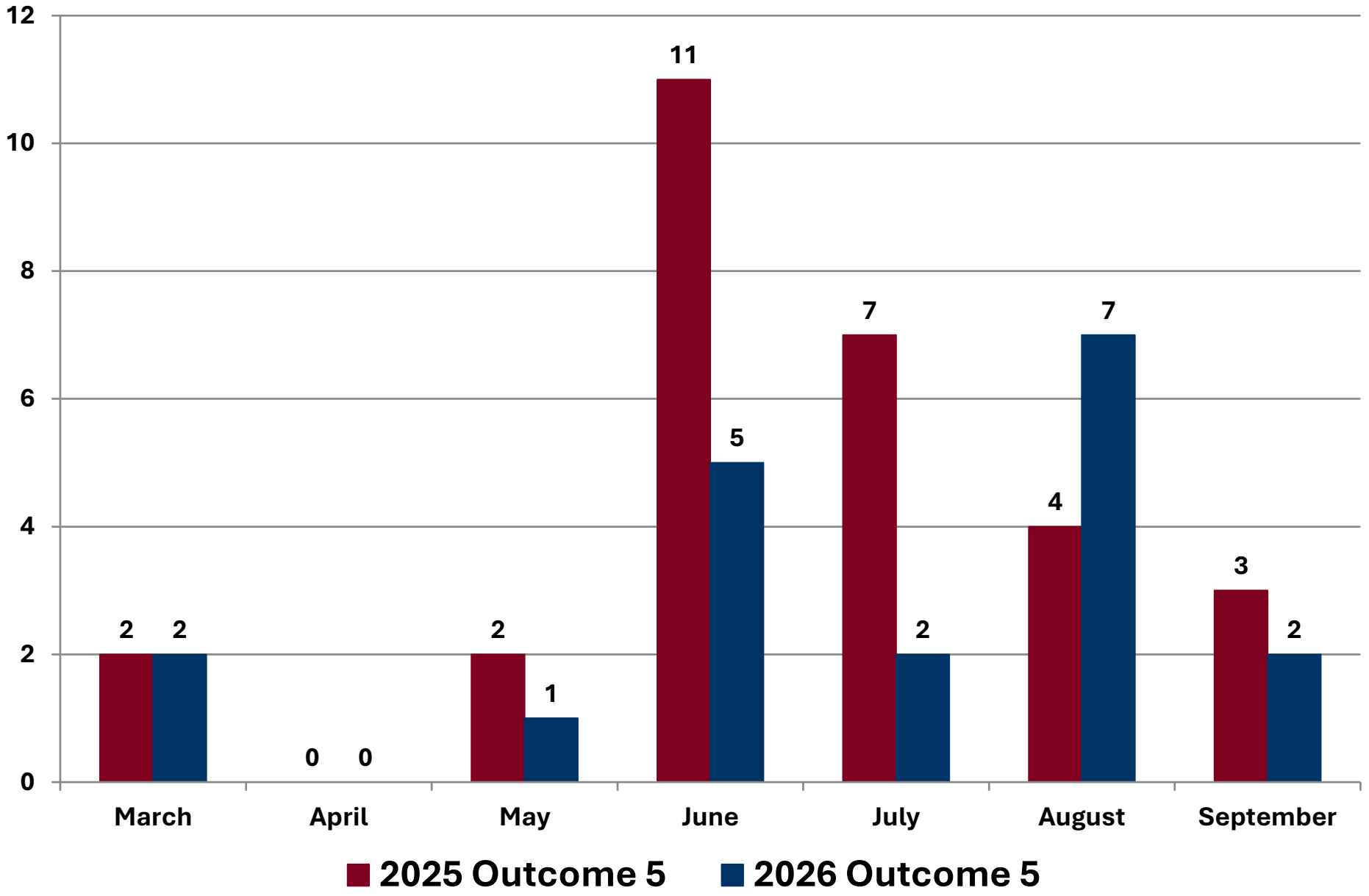
- If evidence is still not present, an Outcome 2 or 3 may be given

Post-Panel Process

Timeline, objectives, and routing action plan for trainee progression

1. **Session Timeline:** Post-panel follow-ups are hosted entirely online and are typically scheduled during the week immediately following the panel.
2. **Be prepared:** If you are already aware that your assigned trainee is flagged as not progressing satisfactorily.
3. **F2F purpose:** The purpose of this session is to explain the panel's final decision to the trainee- not to challenge it. Any formal appeals must use the official process.
4. Straightforward F2F will be managed locally by the PD educator team.

Outcome 5 Results: 2025 vs 2026



ARCP Common Missing Evidence

Common Gaps Resulting in Outcome 5 or 2/3

PREVIOUS ARCP

Outstanding actions from prior training reviews must be completely resolved.

CCRS

Must relate directly to a specific clinical case to be valid.

BLS / AED

Face-to-face certification is strictly mandatory every single year (Paeds & Adult).

SAFEGUARDING

Requires either a clearly linked CCR entry or full 12-monthly updates.

AGREED PDPS

Panel actively evaluates explicit development ideas and realistic action plans.

PRESCRIBING

All individual assessment components must be completely finalised.

QIP SUBMISSIONS

Quality Improvement Project requires the inclusion of all core component pieces.

QIA UPDATES

Quality Improvement Activity evidence is required to be updated each year.

Clinical Case Reviews

- Must be about clinical cases the trainee has actively consulted with.
- Clinical Case Reviews must be about real patients that you have personally seen and should be about a clinical learning experience.
- We exclude those not about clinical cases which means the minimum 36 required each year may not be met

Safeguarding requirements for Adults and Children

📝 **Case Reviews- 1 per ST year**

- Involvement in cases
- Awareness of responsibilities
- Application of safeguarding knowledge

🎓 **Level 3 Safeguarding Certificate-** Valid **3 years**

🗓️ **Annual Update- Every 12 months**

- Not required if **Level 3 completed that year**

PDP issues

- PDPs are not reviewed- must achieve at least one each year
- PDPs are not added for next review/ post CCT
- PDP are ideas only in the log
- ESs are not accepting PDPs when doing ESR
- PDP items are often mandatory requirements

Reminders for Educational Supervisors

- **Consult Program Directors (PDs):** Speak with PDs before emailing ARCP admin.
- **ARCP Check:** Review the last ARCP outcome early in the process.
- **Fourteen Fish- requirements page**

Educator Notes are very helpful for us!

Use Educator notes to

- track sick leave and monthly totals.
- to advise that the ARCP should not happen (the training clock pause
- Document dyslexia screening/confirmations,
- Document Occupational Health (OH) advice, and Practitioner Performance Advice Service (PSWS) guidance, provided the Resident consents.

Less Than Full Time (LTFT) Residents

NHS England South East

- **Annual, not Transitional:** ARCPs are strictly annual calendar events
- **LTFT Focus:** Check all evidence for Less Than Full-Time (LTFT) trainees at the end of the calendar training year, regardless of their grade progression.
- **WPBA Consistency:** WPBA required numbers remain exactly the same, regardless of LTFT or FT

Other issues

- **No Minimum Training Time:** Training is now fully **competency-based**—there is no fixed minimum time requirement to progress.
- **AI Policy:** If generative AI was used to assist in drafting a CCR, it must be openly commented on, but the core case **must** still be a real clinical interaction.
- **Other Log Types:** Use alternate log types (like supporting documentation) to show capabilities demonstrated outside of direct patient contact.

CEPs, COTs, and Out-of-Hours (OOH)

NHS England South East

CEPs: must be performed continually. Even if a trainee was signed off as "competent" in earlier training years, they must maintain and prove ongoing capability.

COTs Variation: COTs must display a healthy balance of formats, covering a range of **both audio and F2F consultations**.

OOH Expectations: are no longer mandatory but there is still an absolute **expectation of some OOH exposure within the WPBA**.

The MRCGP Tripartite Principle

NHS England South East

MRCGP consists of three independent pillars

AKT, **SCA**, and **WPBA**.

Treat Each Pillar Separately:

- **WPBA success does not guarantee an SCA pass:** Trainees can achieve *Competent for Licensing (CFL)* status in WPBA while still struggling with the SCA.
- Over-reliance on strong portfolio reviews can lead to missed warning signs in exam readiness.

Extension Distribution by Failure

30 ST3 trainees currently on an Extension

16

Single Assessment Fail

Trainees struggling with a single component (8 SCA, 6 AKT, 2 WPBA)

12

Double Assessment Fail

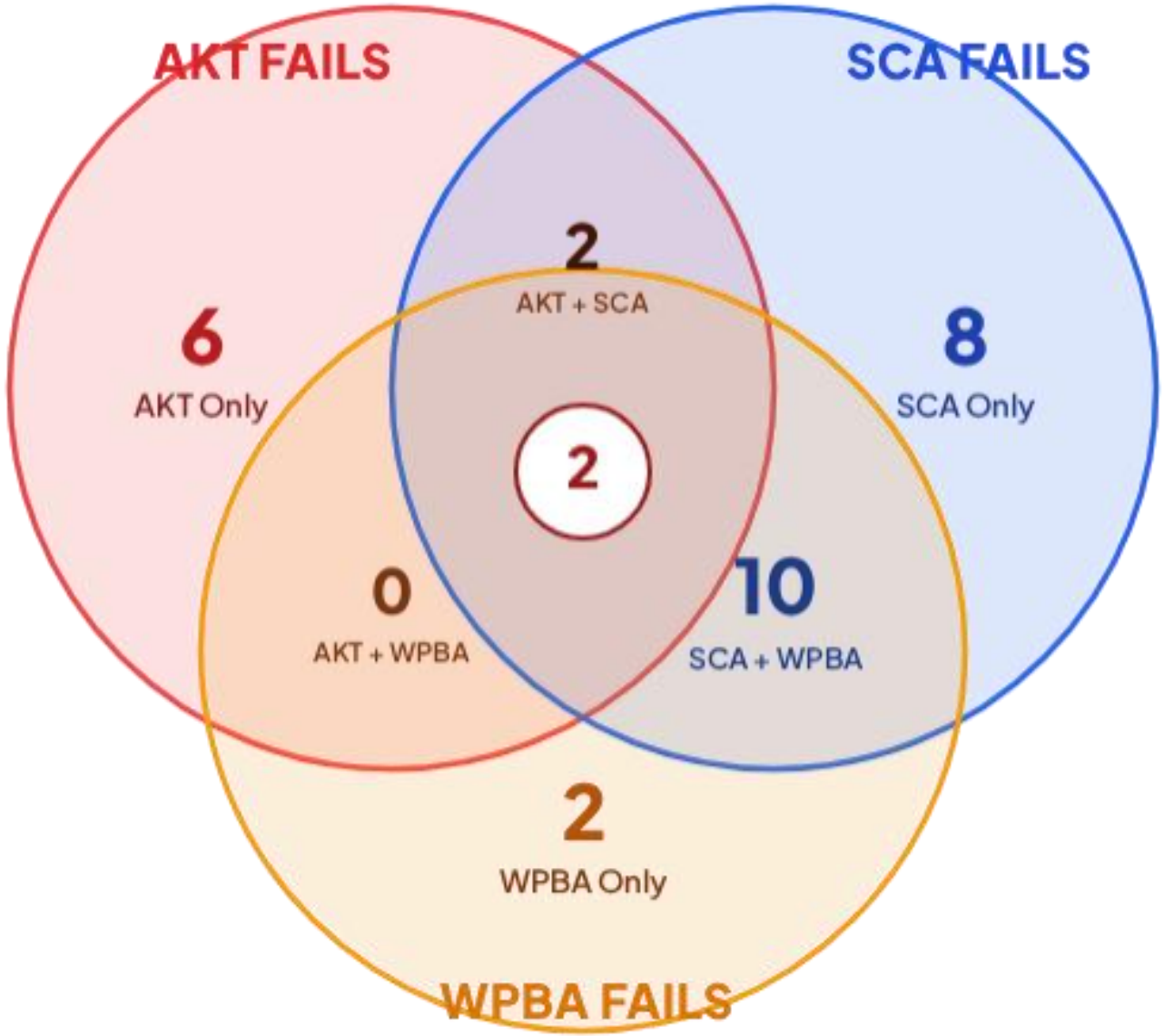
Trainees failing two areas (10 SCA + WPBA, 2 AKT + SCA)

2

Triple Assessment Fail

Trainees needing holistic support across all 3 components

NHS England South East



Reviews and Appeals

NHS England South East

ARCP Outcome Issued - 2/3/4

Result:
- Outcome **amended**
- Outcome **upheld**

Review

- Request **within 10 working days**
- **Original ARCP panel reviews decision**
- Trainee may submit **additional evidence**

Appeal

- Outcome **3** or **4**
- Request **within 10 working days of review outcome**
- **New independent panel**

This document helps track WPBA and other evidence requirements for each Training year. You can add it to your Trainee Portfolio (Supporting Documentation) for ARCP preparation. You can track progress by adding numbers and dates etc next to each assessment, and click each assessment/evidence type to be taken to the relevant section of the RCGP website (make sure you save this document and your work first as opening a web page may close this document!)

Date: Your name: Training Year: Choose...

WPBA Assessments	ST1		ST2		ST3	
	Requirement	Date/ Number	Requirement	Date/ Number	Requirement	Date/ Number
Mini-CEX/COTs all types[a]	4[a]		4[a]		7[a]	
CBDs / CATs	4 CbD		4 CbD		5 CAT	
MSF[b]	1 (min. 5 clinical 5 non clinical)[b]		1 (min. 5 clinical 5 non clinical)[b]		2 (1 MSF 5&5 resps[b], 1 Leadership MSF)[b]	
CSR	1 per post[c]		1 per post[c]		1 per post[c]	
PSQ	0		0		1	
CEPS[d]	Ongoing: some appropriate to post (including some 'system'/'other' CEPS)[d]		Ongoing: some appropriate to post (including some 'system'/'other CEPS)[d]		For CCT: all intimate + a range of others (including 7 'system'/ 'other' CEPS)[d]	
Learning logs	36 CCRs[e]		36 CCRs[e]		36 CCRs[e]	
Placement planning meeting	1 per post		1 per post		1 per post	
QIP	1 (if in GP) assessed by Registrar & ES		1 (if in GP) – if not done in ST1		0 (unless not been completed in ST1/2)	
Quality improvement activity	Involvement in Quality Improvement must be demonstrated each training year[f]					
Significant event	Only if reaches GMC threshold of potential or actual serious harm to patients-any Fitness to practise issues should be considered and commented upon. Must be declared on Form R.					
Learning event analysis	1		1		1	
Prescribing	0		0		1	
Leadership activity	0		0		1	
ESR	1[g]		1[g]		1[g]	
Other Evidence	**ST1 Requirement**	**Date/ Number**	**ST2 Requirement**	**Date/ Number**	**ST3 Requirement**	**Date/ Number**
Safeguarding adults level 3[h]	Certificate and reflective log entry[h]		Certificate, knowledge update every 12 months, and reflective log entry[h]		Certificate, knowledge update every 12 months, and reflective log entry[h]	
Safeguarding children level 3[h]	Certificate and reflective log entry[h]		Certificate, knowledge update every 12 months, and reflective log entry[h]		Certificate, knowledge update every 12 months, and reflective log entry[h]	
CPR/AED[i]	Annual evidence of competence in CPR & AED(Adults & Children)[i]		Annual evidence of competence in CPR & AED(Adults&Children)[i]		Annual evidence of competence in CPR & AED(Adults & Children)[i]	
Form R or SOAR (Scotland)	1 per ARCP[j]		1 per ARCP[j]		1 per ARCP[j]	
PDP	A minimum of 2 PDPs created per training year, with progress demonstrated in at least one		A minimum of 2 PDPs created per training year, with progress demonstrated in at least one		A minimum of 2 PDPs created per training year, with progress demonstrated in at least one	
Any requirements of last ARCP	Check (even if Outcome 1)		Check (even if Outcome 1)		Check (even if Outcome 1)	

NHS England South East

Dr Kim Emerson
RCGP Clinical Lead
WPBA

• Top tips for trainers

- Engage early and become familiar with the GP Capabilities and Progression Point Descriptors
- So they:
- Show engagement and progression in each year across the Clinical experience groups CEGs
- Demonstrate competent in all 13 by end ST3
- Meet the minimum requirements each year and by end of ST3
- Help them use Generative AI wisely

• Revised curriculum and WPBA updated capability descriptors

GP Capabilities and Progression Point Descriptors

(Taken from the GP Curriculum updated in August 2025)

Progression point descriptors – Fitness to practise

Capability summary: Professionalism and protecting self and others from harm, including awareness of when an individual's performance, conduct or health, or that of others, might put patients, themselves or their colleagues at risk.
Curriculum and assessment links: GPC: professional values
MRCGP: WPBA: CATs, COTs, MiniCEX, QIP, Leadership MSF, PSQ, CSR, SSR

Learning outcome	Indicators of potential underperformance	Needs further development (expected by end of ST2)	Competent for licensing (required by CCT)	Excellent
Demonstrating the attitudes and behaviours expected of a good doctor	Does not comply with accepted codes of professional practice. Fails to respect the requirements of organisations, such as meeting deadlines, producing documentation and observing contractual obligations. Does not recognise limits of own ability and experience.	Understands and follows the GMC's 'duties of a doctor' guidance.[1] Complies with accepted codes of professional practice, showing awareness of their own values and attitudes. Applies relevant ethical, financial, legal and regulatory frameworks within the care provided. Evaluates their clinical care and is able to justify actions to patients, colleagues and professional bodies.	Demonstrates the accepted codes of practice to promote patient safety and effective team working. Reacts promptly, respectfully and impartially when there are concerns about self or colleagues. Works within the limits of their own ability and expertise as a GP. Adopts a self-directed approach to learning, engaging with assessment. Encourages scrutiny of professional behaviour, is open to feedback and demonstrates a willingness to change.	Encourages an organisational culture in which the health and wellbeing of all members is valued and supported, especially in the workplace.
Managing the factors that influence your performance	Is the subject of multiple complaints. Repeatedly fails to cope effectively with the demands of the job, such as dealing with stress or managing time.	Demonstrates insight into any personal physical or mental illness or habits that might interfere with the competent delivery of patient care. Identifies and notifies an appropriate person when their own or a colleague's performance, conduct or health might be putting others at risk. Responds to complaints or performance issues appropriately.	Takes advice from appropriate people and, if necessary, engages in a referral procedure or remediation. Uses mechanisms to reflect on and learn from complaints or performance issues to improve patient care. Takes effective steps to address any personal health issue or behaviour that is impacting on their performance as a doctor.	Anticipates system or practice areas requiring improvement, and proactively rectifies them to improve patient care. Anticipates situations that might impact on their work–life balance and seeks to minimise any adverse effects on themselves or their patients. Fosters a supportive environment where colleagues are able to share difficulties and reflect on their performance.

- Linked to curriculum learning outcomes
- Updated to reflect current GP
- Expanded IPUs
- Encompassing environmental sustainability within a revised community health previously orientation
- Single page per capability printable version

• Revised curriculum and WPBA updated capability descriptors

CbD question generator and CATS guidance updated with revised capability descriptors

- https://www.rcgp.org.uk/getmedia/7a73a213-59d3-464f-9ce1-a1c59dffd7e0/Progression-Point-Descriptors.pdf

• Minimum Mandatory requirements evidence sheet

RCGP WPBA mandatory requirements summary sheet

- Downloadable editable PDF
- Updated- Aug 26
- Available from portfolio and website
- Info expanded further on all requirements
- links directly to website,
- More obvious in Fourteenfish- front page coming
- Clear minimums needed for ARCP and CCT

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CSR	1 per post[c]		1 per post[c]		1 per post[c]	
PSQ	0		0		1	
CEPS[d]	Ongoing: some appropriate to post (including some 'system'/'other' CEPS)[d]		Ongoing: some appropriate to post (including some 'system'/'other CEPS)[d]		For CCT: all intimate + a range of others (including 7 'system'/ 'other' CEPS)[d]	
Learning logs	36 CCRs[e]		36 CCRs[e]		36 CCRs[e]	
Placement planning meeting	1 per post		1 per post		1 per post	
QIP	1 (if in GP) assessed by Registrar & ES		1 (if in GP) – if not done in ST1		0 (unless not been completed in ST1/2)	
Quality improvement activity	Involvement in Quality Improvement must be demonstrated each training year[f]					
Significant event	Only if reaches GMC threshold of potential or actual serious harm to patients-any Fitness to practise issues should be considered and commented upon. Must be declared on Form R.					
Learning event analysis	1		1		1	
Prescribing	0		0		1	
Leadership activity	0		0		1	
ESR	1[g]		1[g]		1[g]	
Other Evidence	**ST1 Requirement**	**Date/ Number**	**ST2 Requirement**	**Date/ Number**	**ST3 Requirement**	**Date/ Number**
Safeguarding adults level 3[h]	Certificate and reflective log entry[h]		Certificate, knowledge update every 12 months, and reflective log entry[h]		Certificate, knowledge update every 12 months, and reflective log entry[h]	
Safeguarding children level 3[h]	Certificate and reflective log entry[h]		Certificate, knowledge update every 12 months, and reflective log entry[h]		Certificate, knowledge update every 12 months, and reflective log entry[h]	
CPR/AED[i]	Annual evidence of competence in CPR & AED(Adults & Children)[i]		Annual evidence of competence in CPR & AED(Adults&Children)[i]		Annual evidence of competence in CPR & AED(Adults & Children)[i]	
Form R or SOAR (Scotland)	1 per ARCP[j]		1 per ARCP[j]		1 per ARCP[j]	
PDP	A minimum of 2 PDPs created per training year, with progress demonstrated in at least one		A minimum of 2 PDPs created per training year, with progress demonstrated in at least one		A minimum of 2 PDPs created per training year, with progress demonstrated in at least one	
Any requirements of last ARCP	Check (even if Outcome 1)		Check (even if Outcome 1)		Check (even if Outcome 1)	

[a] COTs of all types to be completed over the training time including audio, face to face/in person (i.e. patient is in the same room as the registrar) and virtual/remote. At least 1 Audio COT and 1 face to face/in person COT should be completed.

[b] In non-primary care posts where it is not possible to find 5 non-clinician respondents it is acceptable to ask more clinicians, but the minimum of 10 total respondents still applies. In ST3, the MSF should be completed in the first 6 months of the training year, with the Leadership MSF being completed in the second 6 months and after the Leadership Activity has been completed.

[c] CSR to be completed in each post in ST1 and ST2, and in ST3 if any of the following apply: 1) The clinical supervisor in practice is a different person from the educational supervisor. 2) The evidence in the Portfolio does not give a full enough picture of the registrar and information in the CSR would provide this missing information, and 3) if either the registrar or supervisor feel it is appropriate.

[d] Throughout your training, you must be completing some, relevant to post, CEPS in each training year. By the end of ST3, and to be awarded your CCT, evidence for all the intimate examinations must be included, and you must have a range of additional CEPS relevant to General Practice which demonstrate competence. 7 "system" GP focussed observed CEPS categories are included in the Clinical Examination and Procedural Skills section of the Portfolio. For complete clarity, a range cannot be demonstrated with just 2 CEPS, nor could it be demonstrated with CEPS of only one type (i.e. 3 "ENT" CEPS). It will always be up to the judgment of the Trainer/Educational Supervisor as to what evidence is required for CEPS. As such, there are no set numbers for how many 'non intimate'/'other'/'system' CEPS should be completed. However, being graded as "able to complete unsupervised" in all of the 7 "system" GP focussed observed CEPS would provide strong evidence of competency in the capability of CEPS, and strong evidence that he CEPS requirements for WPBA have been met.

[e] Clinical Case Reviews (CCRs) must be about real patients that you have personally seen. Registrars should have more than one log entry which addresses each capability in each 6-month review period. Therefore a range of logs should be completed, not only CCRs, in order to capture capabilities such as organisation, management and leadership, ethics, and fitness to practice. Other logs that don't demonstrated clinical learning, or are not about patients that you have personally seen, should be recorded in the other learning log formats available, such as Supporting Documentation.

[f] QIA is required in every training year. If you do a QIP in ST1 or ST2 this can count as the QIA for that year (the QIP must be in a GP post and assessed using the QIP form by the registrar and trainer). Please see RCGP website for further details of what counts as a QIA. An LEA, reflection on feedback, or leadership project do not count as the mandatory QIA.

[g] An interim ESR review can also be completed at the mid point of each year only if the registrar is progressing satisfactorily. If there are any concerns about the registrar's performance, or they have had a developmental outcome in their previous ARCP then the full ESR will be required.

[h] Safeguarding certificates may last 3 years but a knowledge update is needed in addition every 12 months (even if LTFT) if not completing the full level 3 in that year. Demonstration of the application of knowledge should be presented in the portfolio using a CCR in each training year (ST1/2/3). Certificates should be added to Supporting Documentation and the Compliance Passport and application of knowledge recorded in CCRs. If a registrar does not have a placement within a specific training year that includes children, then it is not mandatory (but still recommended) to record and document their learning on Child safeguarding.

[i] All initial and refresher training in CPR and AED for both adults and children must be face-to-face and include active participation. ALS though lasting for 3-4 years needs to be updated every 12 months with evidence of competence in CPR and AED. Certificates (such as a BLS certificate) should be added to Supporting Documentation and the Compliance Passport.

[j] Form R should be uploaded to your compliance passport and is required for ARCP at least annually. Ensure Time out of Training ('TOOT') days match between the form R and the portfolio and any complaints are declared and reflected on in a LEA. In Scotland SOAR must be completed along with a separate absence declaration.

Assessments should be spread throughout the training year with roughly half being done in each review period. Registrars on Less Than Full Time programmes are expected to do the same total number in the full training year but pro-rata in each review period dependent on their percentage of time training. CPR&AED and Safeguarding knowledge update requirements are not pro rata, and evidence must be provided every 12 months. The ESR requirements are also not pro-rata and an ESR is also required every 6 months. See roadmaps for further details.

•Changes August 2026

- CATS being expanded to include all primary care post so also in ST1/2 as options in place of just CbDs
  - WPBA CAT guidance
- Introduction of a Supplementary supervisor's report SSR for use in nonclinical posts
  - WPBA SSR guidance
- CSR grading in ST1/2 in primary care matching that in secondary care
  - WPBA CSR updated
- Updating and improving the COT criterion descriptors
  - WPBA COT updated
- Adding exemplars for each assessment to the website
  - WPBA exemplars
- Leadership changes
- RCGP Leadership

•CATs- now in any primary care post- ST1/2/3

CbD/ CAT -question-generator.pdf

TYPES

Routine/non-duty session

Document management

Duty/Triage doctor session

Electronic/digital/online consultations review

Laboratory and radiology results review

Leadership

Prescribing assessment follow-up

Random cases review

Referrals review

Supplementary supervisors report SSR, areas to complete

- Areas of strength and areas to develop in each of the following:
- Area of capability:
  - Knowing yourself and relating to others
  - Managing complex and long-term care
  - Working well in organisations and systems of care
  - Caring for the whole person, the wider community, and the environment.

While the post is regarded as non-clinical, the following may be able to be commented on and could include evidence from simulation.

- Area of capability: Applying clinical knowledge and skill:

SSR Overall assessment:

Overall performance

In this non-clinical post please rate the performance of this GP registrar and clarify the standard you are assessing them against.

This GP registrar has been assessed against the following standard based on (please tick):

Other doctors in the Speciality at the same stage of training ☐
A GP trainee at their current stage of training ☐

Rating (please tick):

Significantly below expectations ☐
Below expectations ☐
Meeting expectations ☐
Above expectations ☐

• CSR grading- Primary and secondary care same ST1/2

Moving from:

- Needing Further Development Below Expectations;
- Needing Further Development Meeting Expectations;
- Competent; or Excellent- only option in ST3

To:

- Significantly Below Expectations;
- Below Expectations;
- Meets Expectations;
- Above Expectations.

- Revised COT criterion

PC4: The doctor explores the patient's health understanding

Explores patient's health understanding/beliefs including identifying and addressing patient's ideas and concerns and expectations.

- This criterion is about what the patient comes to the consultation thinking and knowing.
- The patient's perspective of the problem (including health beliefs and 'ideas, concerns and expectations') is explored e.g. has the patient read something on the internet, consulted generative AI, or been told something by a friend, family member or colleague?
- An effective exploration of the patient's health understanding is observed, in the context of the problem discussed within the consultation with further questions asked in response to what the patient stated.
- What the patient thinks or is concerned about is explored using a range and series of probing questions where appropriate. Evidence of reflection in the consultation may be evident, which may enable the patient to talk more easily about their concerns, or repeating a patient's phrase and then leaving silence, to explore their thoughts more.

• Exemplars

- CSR – Example in ST1 or ST2 (PDF file, 165 KB)
- CSR – Example in ST1 or ST2 More Supervision (PDF file, 169 KB)
- CSR – Example in ST3 More Supervision (PDF file, 191 KB)
- CSR – Example in ST3 (PDF file, 192 KB)

Examples for log entries/evidence tools

Clinical case review.....

Supporting Documentation (CPD Evidence) .....

Learning Event Analysis/Significant Event .....

Reflection on Feedback .....

Leadership, management and professionalism.....

QIA Reflective Log .....

Prescribing trainee assessment reflection.....

CEPS reflection.....

Academic Activity .....

Leadership MSF

Examples of leadership activities

The Leadership Activity could include working with commissioning organisations, networks of primary care teams, community nursing teams, palliative care teams or other colleagues with whom GPs regularly work. It may also include relevant leadership roles undertaken outside the GP registrar's practice, for example acting as a GP Registrar representative for an RCGP faculty, or in a leadership role with another relevant healthcare, educational or professional organisation. Where the activity takes place outside the practice, appropriate feedback from colleagues within that organisation should be included to support reflection and development.

Some more detailed examples of Leadership Activities are below. This is not intended to be an exhaustive list, and GP registrars may develop other suitable activities in discussion with the Educational Supervisor. Quality Improvement Activities are a form of leadership activity, but are not included in these suggestions because they are assessed separately within WPBA.

- The free-text sections include specific areas of leadership for respondents to comment on.
- Respondents are asked to consider commenting on how the GP registrar performs in the following areas:
- Listens to what colleagues have to say
- Gives clear information to others in a way they understand
- Integrates and communicates with all staff respectfully
- Values the contributions of others
- Delegates effectively and appropriately
- Responds to questions in a professional way
- Works cooperatively with colleagues
- Takes on board the views and opinions of others
- Recognises the effect of their behaviours on others
- Demonstrates leadership whilst also involving team members.

- CCR questionnaire

• CCRs survey

Educator / GPR : https://app.onlinesurveys.jisc.ac.uk/s/rcgp-wpba/registrar-educator-ccr-consultation-2026

Reviewing Clinical Case Reviews (CCRs) and their value in supporting learning and development for GP registrars, as well as their contribution to Educational Supervisor Review and ARCP decision-making.

Generative AI

- College guidance:
- https://www.rcgp.org.uk/mrcgp-exams/artificial-intelligence-exams-training

Further generative AI guidance

https://www.rcgp.org.uk/mrcgp-exams/wpba/generative-artificial-intelligence

- Development of AI literacy is essential and the capabilities - and limitations - of generative AI must be understood by anyone seeking to use it in a professional context.
- Generative AI can be a valuable tool for those undertaking WPBA, but as a resource to support the development of skills and competences required for independent General Practice - not to replace them.
- Generative AI should not be used to generate reflections without real patient experience.

Dr Selva Selvarajah

THAMES VALLEY GP SCHOOL · FACULTY DAY · 13 OCTOBER 2026

GP training in the age of AI

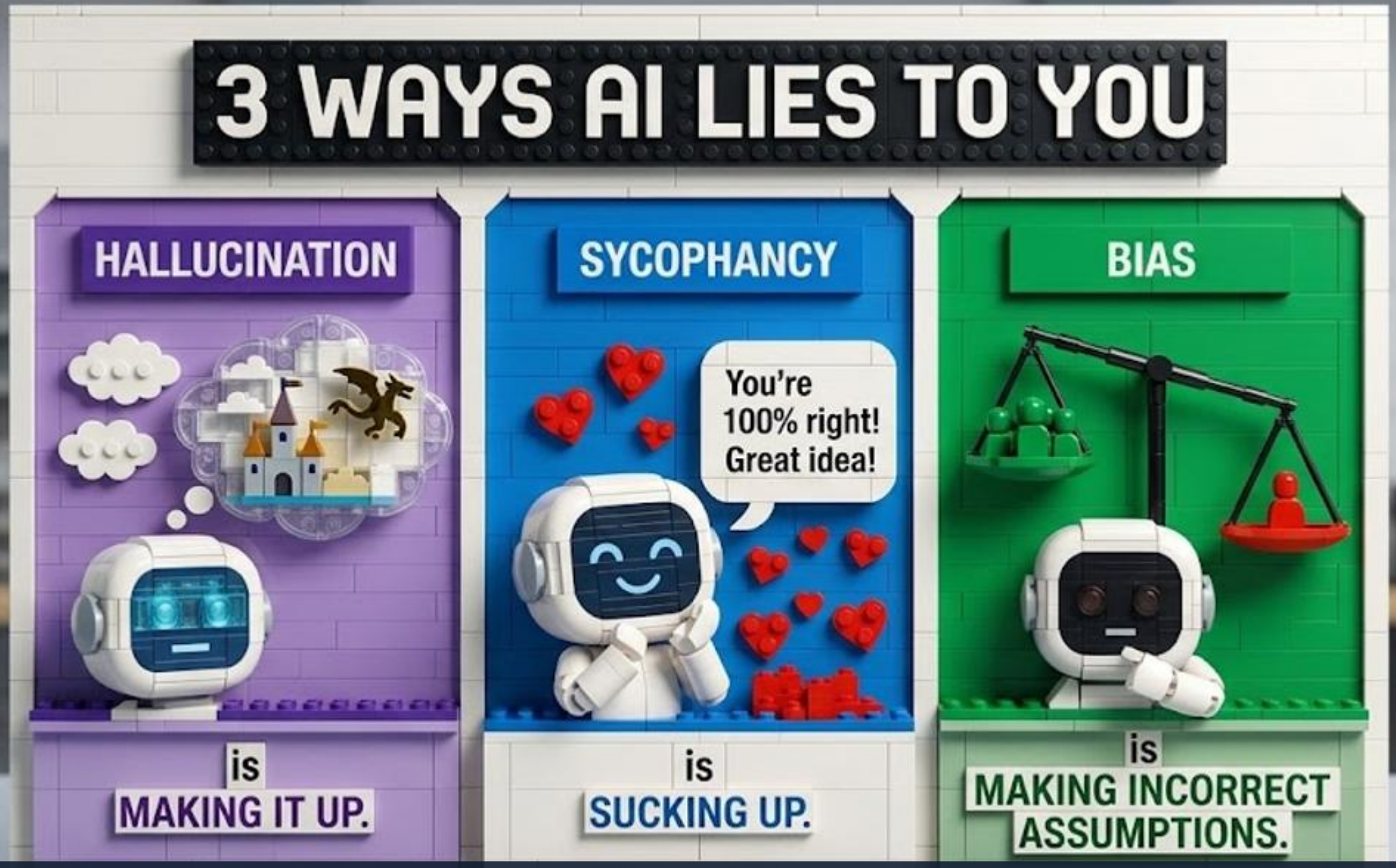
What we keep when everything changes

Dr Selvaseelan Selvarajah

GP Partner, Bromley by Bow Health, East London
RCGP Council Member · Co-Chair, RCGP AI Special Interest Group
Associate Director, GP School South London

WARNING:
AI COULD
WIPE OUT
HUMANITY
TODAY.

WE'VE BEEN HERE BEFORE



The failure rarely looks like failure.

BEFORE WE START

Three questions — hands up

1. Who has used AI this week?
2. Who has used AI for something clinical?
3. Who is worried about what AI means for training?

Remember your answer to the third one. We'll ask it again at the end.

PART ONE

The honest picture

What's real, how it fails, and who ends up holding the risk.

FOR EVERYONE

AI is already in the surgery

28%

of GPs now use AI in clinical practice

23.5%

more direct patient time with AI scribes

89%

say liability is their top concern

NHS 10 year plan is committed to accelerating it.

RCGP / Nuffield Trust, 'How are GPs using AI?', Dec 2025; NHS AI note-taking study, Jan 2026; NHS 10 Year Health Plan, 2025.

FOR EVERYONE

It depends on what the tool claims to do

What is the tool's stated purpose?

NOT a medical device

- Transcribe
- Summarise
- Draft correspondence
- Suggest codes for clinician review

STILL a medical device

- Support diagnosis
- Act without clinician review
- Give decisive diagnostic information — Class IIa, Rule 10

MHRA, 'Ambient voice technology-enabled products', 29 July 2026. RCP: a summary that shapes a code is decision support in all but name.

WHO CARRIES THE RISK

FOR EVERYONE

The gap settles on one person

The manufacturer

states a narrow purpose

The regulator

draws a defensible line

The clinician

checks a summary at the end of a long day that is shaping a decision — whether or not anyone calls it decision support

The real threat isn't replacement. It's becoming the accountable human in a system built to shed accountability onto you.

PART TWO

The training lens

Why this lands hardest on the people you train — and the UK data to prove it.

FOR EVERYONE

The model is brilliant. The hand-off fails

THE MODEL ALONE

90–99%

names a relevant condition when tested on its own

REAL PEOPLE USING IT

<34.5%

no better than ordinary search or their own judgement

The failure was in the interaction, not the knowledge.

Bean et al., 'Reliability of LLMs as medical assistants for the general public', Nature Medicine, Feb 2026 (1,298 UK adults).

DESKILLING

FOR EVERYONE

Now measured, not hypothetical

28.4%

before AI

→

22.4%

after AI, with it switched off

−20%

relative fall, 19 experienced operators

Unassisted adenoma detection fell after routine AI exposure — in experts who had a baseline to lose.

A registrar has no baseline. A skill handed to AI before competence is built may never be built — and we cannot even see it happen.

Budzyń et al., 'Endoscopist deskilling risk after exposure to AI in colonoscopy', Lancet Gastroenterology & Hepatology, 2025.

FOR EVERYONE

GMC National Training Survey 2025

~72% no training at all in using AI

~54% have not used AI in their current post

~44% their AI responsibilities are ‘not applicable’

~69% want AI-simulated patients — not offered

The gap isn't reluctance. It's that nobody is teaching it — and that lever is yours.

GMC National Training Survey 2025, programme-specific AI questions (n = 4,716–8,411). Figures approximate — confirm against published data.

THE RISK NOBODY DISCUSSES

FOR PDs & ADs

The benefit of AI is not evenly shared

Bias in the tool

Skewed developers and skewed training data, baked into the output.

Bias in who benefits

A trainee whose first language isn't English is slower to spot poor output — and may never safely take the shortcut.

It can cut the other way. In a trainee's own language, and as a translation aid, AI could narrow gaps rather than widen them. Which future we get is a supervision decision — not a property of the technology. As a TPD for IMG trainees, this is the one I'd bet on us getting wrong by default.

RCGP statement on the use of AI in postgraduate training, examinations and registration.

PART THREE

The practical toolkit

Four kinds of AI already in practice — and the three things your registrars are assessed on.

WHAT'S AVAILABLE NOW

FOR EVERYONE

Four kinds of AI in your practice

1

AI scribes

Ambient voice — writes the note as you talk. Look at the patient, not the screen.

2

Decision support

Differentials, interactions, risk. A second opinion that never tires.

3

AI triage

The digital front door. Most hyped, thinnest evidence.

4

Admin & docs

Coding, letters, email. The paperwork that follows you home.

Most of the real-world footprint today is scribes and admin — not diagnosis and triage.

THE SINGLE BIGGEST WIN

FOR EVERYONE

Ambient scribes: how they work

Step 4 is where your professional judgement lives.

23.5%

more direct patient time

8.2%

shorter appointments

19

IG-verified tools on the NHSE registry

NHS AI note-taking study, Jan 2026 (17,000 encounters); NHS England AVT self-certified registry.

FOR REGISTRARS

Tools for exam preparation

GREEN-ZONE USES

- AKT-style questions — mark your own reasoning
- Upload RCGP topic guides as the source
- Role-play the SCA: bad news, hard conversations

WATCH FOR

- Confidently wrong answers
- Scripts that flatten their own voice
- Hallucinated guideline detail

The common thread: the trainee verifies. Stop verifying and a study aid becomes a liability.

FOR REGISTRARS

Tools for WPBA and the portfolio

GREEN-ZONE USES

- Map real cases to curriculum capabilities
- Structure a reflection you've already thought through
- Spot gaps in breadth

WATCH FOR

- Fabricated or composite patients — red line
- Generic entries, no individual voice
- Reflection outsourced wholesale

The common thread: the trainee verifies. Stop verifying and a study aid becomes a liability.

FOR REGISTRARS

Tools to support clinical knowledge

GREEN-ZONE USES

- A second opinion to pressure-test your own
- Referenced answers — then trace every reference
- Interrogate a guideline you've uploaded

WATCH FOR

- Generic tools to diagnose — RCGP red line
- Identifiable patient data — never
- References that don't exist

The common thread: the trainee verifies. Stop verifying and a study aid becomes a liability.

A SIMPLE FRAMEWORK

FOR EVERYONE

Green, amber, red

GREEN

Use freely

- Learning & revision
- Guideline review & Q&A
- Non-patient text
- Reflection & portfolio
- Exam prep

AMBER

With governance

- Approved documentation tools
- Ambient scribing
- Triage under supervision
- Diagnostic suggestion
- Patient comms drafting

RED

Do not use

- Patient data in unapproved tools
- Unsupervised diagnosis
- Unverified output in records
- Delaying urgent action
- Bypassing governance

After RCGP generative-AI guidance and the iatroX AI policy framework.

THE ONE RULE

Never put identifiable patient data into a tool your organisation hasn't approved.

If you are unsure: anonymise, then ask. If in doubt, leave it out.

POLICY IN PLAIN ENGLISH

FOR EVERYONE

What the RCGP actually says

PERMITTED

Permitted in training.

No requirement to declare AI use in portfolio entries. Critical, ethical use is a skill all GPs will need.

CONDITIONAL

Reflection must be authentic.

The registrar's own, about real patients. Fabricated encounters raise probity questions.

RED LINE

Clinical AI use is a red line.

No generic tools to generate diagnoses or management. The College calls this potentially dangerous.

Accountability for every output stays with the clinician.

RCGP statement on AI in postgraduate training (Sept 2024) and RCGP guidance on generative AI in GP training and WPBA.

OVER TO YOU

Turn to the person next to you

Pick any theme — exam prep, WPBA & portfolio, or clinical knowledge — and take two minutes on:

a What AI teaching methods have you seen actually work?

b What tools would genuinely help our registrars?

c What are the risks — and who carries them?

PART FOUR

The educator's role

From gatekeeper to guide — as a trainer, and at programme level.

FOR TRAINERS

The same traffic light — for supervision

GREEN

No concern

- Discusses the case from memory
- Reflection has insight & uncertainty
- AI used to structure, not fabricate

AMBER

Explore further

- Generic, no individual voice
- Struggles to recall the patient
- Breadth implausible for the stage

RED

Escalate

- Fabricated encounters
- Unsupervised clinical AI use
- Cannot account for entries

Probe. The CBD, COT and ES review are conversations AI cannot sit for them.

PRACTICAL ACTIONS

FOR TRAINERS

Four things to take back

1 Have the conversation early

First ES meeting: what do you use, and how do you check it?

2 Map it to the curriculum

It sits within Fitness to Practise — assessable, not optional.

3 Protect the reflective space

What did you feel? What would you do differently? Not outsourceable.

4 Build your own literacy

You can't spot good from poor use of a tool you've never opened.

AT PROGRAMME LEVEL

FOR PDs & ADs

What this means for the scheme

Faculty development first	Build a baseline AI session into trainers' workshops before you ask it of registrars.
Decide the deployment order	Agree when a trainee meets a scribe — not ST1 by accident. Protect the write-before-you-approve window.
Watch differential attainment	Make the IMG and first-language lens explicit in equality monitoring.
Share practice	Local practice is ahead of national guidance — pool what works.

Programme-level framing — my own view as an Associate Director, not RCGP policy.

PART FIVE

What stays human.

What we keep when everything changes — and the line no tool crosses.

FOR EVERYONE

AI passes the exam. The exam was never the job

96%

AI on MRCGP-style questions

vs

73%

GP peer average

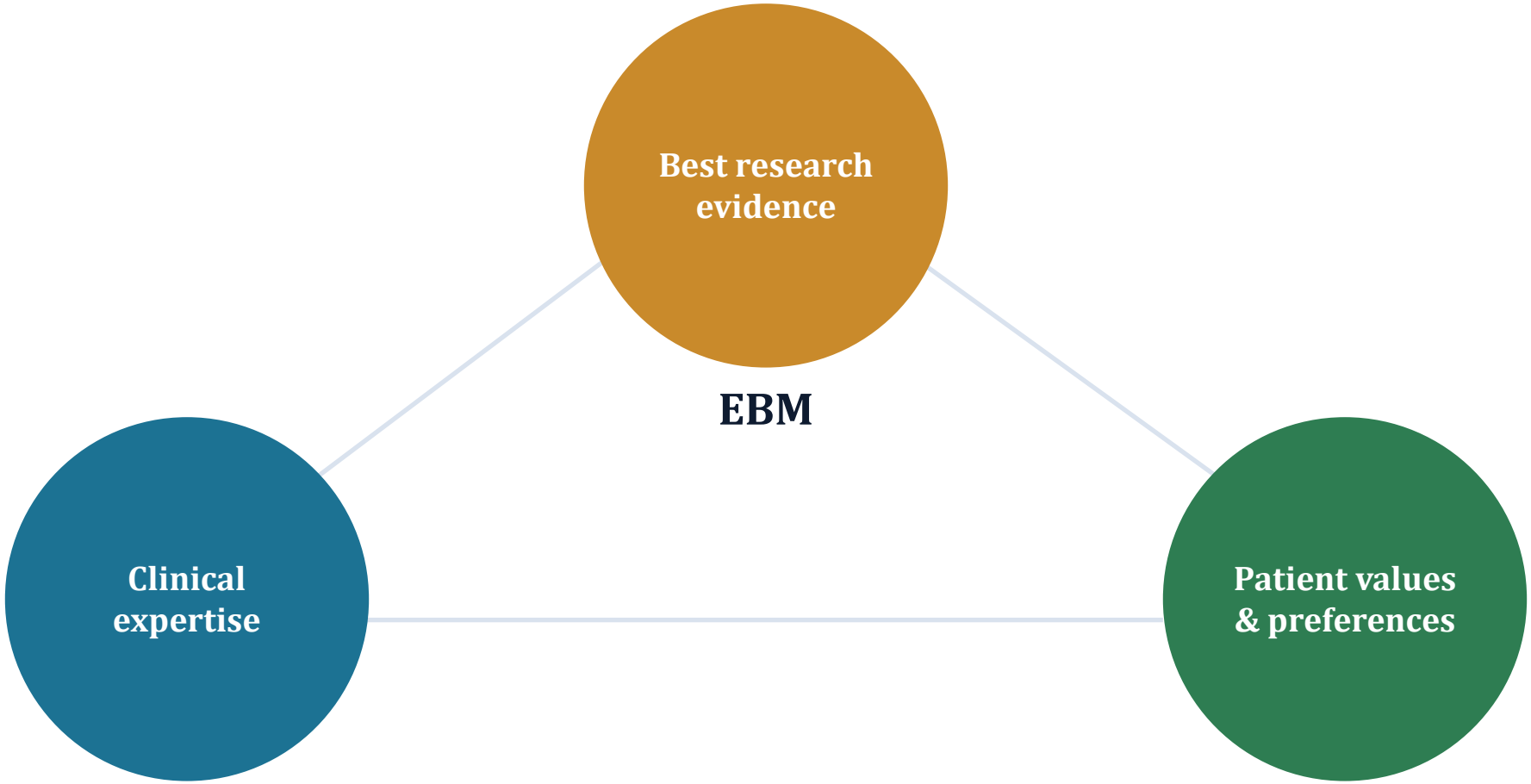
574

sandboxed cases: an AI agent outperformed physicians on accuracy

If your reassurance depends on AI being bad at clinical knowledge, it has a very short shelf life.

AI vs GP peer scores via Digital Health; MIRA autonomous medical AI agent study, Nature, 2026 (sandboxed).

Evidence-based care was never just the evidence



AI is closing fast on one leg. Keep the triangle in your head — it's how we judge every tool that follows.

After Sackett's definition of evidence-based medicine.

THE BETTER ANSWER

FOR EVERYONE

Continuity of Care

25%

lower odds of dying

28%

fewer acute admissions

30%

less out-of-hours use

>15 years of continuity with the same GP vs one year — a dose–response effect across 4.5 million people.

Sandvik et al., BJGP 2022 (Norway, 4.5m). Review: Pereira Gray et al., BMJ Open 2018 — 82% of high-quality studies link continuity to lower mortality.

A QUIET, RADICAL IDEA

We assume the patient is well, until proven otherwise.

We manage risk. We hold uncertainty.

The founding assumption of general practice — the exact opposite of a machine built to find the abnormal in everything it sees.

THE OLDEST PART OF THE JOB

Before the science, the doctor was a healer, a witness, a meaning-maker.

“The most frequently used drug in general practice is the doctor.”

Michael Balint, 1957 — you can only be a drug to someone whose story you hold. No algorithm reaches this.

FOR EVERYONE

Augment the connection, not the transaction

Does it give time & attention back to the two humans in the room?

YES — use it

The scribe that lets you look at the patient. Augmentation.

NO — wrong tool

The bot that fragments accountability — however clever the demo.

One test for every product a vendor puts in front of you.

THE LINE

FOR EVERYONE

What you must never hand over

LET THE MACHINE CARRY

- The research / evidence leg
- Drafting and documentation
- Searching and summarising
- Pattern-spotting, for review

STAYS HUMAN

Meaning-making — helping someone make sense of it

Judgement — the integrative call that's in no guideline

The values conversation — what matters to this person, not the average

Accountability — it lands on us — so own it deliberately

Let the machine carry the research leg. Expertise and the patient's values stay human.

THE NEXT MEDICAL PROVIDER — IF WE IMPORT IT

Multi-agent care: the GP as ‘panel director’

.

TODAY · THE NHS REALITY

The overloaded generalist

- ~2,200 patients per FTE GP — and the list is growing
- Fewer FTE GPs each year, rising demand
- Admin tail: referrals, letters, results, QOF

2,200

per FTE GP, today

CO-PILOT AI

The augmented generalist

- Ambient scribe drafts every note — you edit, not write
- AI-triaged inbox and online consultations
- Live, in-consultation decision support

~3,000

per FTE GP (projected) · *if time saved is spent on more patients*

MULTI-AGENT CARE

The panel director

- Cosigns ~200 AI encounters a day (async oversight)
- Supervises concurrent AI consultations — ‘air-traffic control’
- Sees only escalations; runs population-health reviews

~14,000

per ‘director’ (projected) · *one GP directing a virtual clinic*

Arc after Primary VC, ‘The Next Medical Provider’ (primary.vc). UK anchor: ~2,200 patients per FTE GP. Co-pilot and panel-director figures apply the model’s own multipliers to that baseline — illustrative, not forecasts.

THE COUNTER-CASE

But a panel director is not a GP

Three things the multi-agent model quietly gives up — and none of them scale.

CONTINUITY

You cannot know 14,000 people.

More than 15 years with the same GP: ~25% lower mortality, 28% fewer admissions (Sandvik, BJGP 2022). The relationship is the treatment — and relationships don't scale.

ACCOUNTABILITY

Cosigning 200 encounters you never saw.

A 'human in the loop' who scans rather than reasons is a liability sink, not a safeguard. Oversight without time or sight is a signature, not safety (CERSI-AI, 2026).

EQUITY

Volume reaches the wrong people.

A one-question agent serves deprivation, low health literacy and language barriers worst — the inverse care law, now running on GPUs. AI widens the gap before it closes it.

Multi-agent care scales access to information. General practice was never only about information. ***Augment the connection, not the transaction.***

And a registrar who 'directs agents' before they can do the work never builds the judgment to supervise them. *Sources: Sandvik et al., BJGP 2022; CERSI-AI professional liability report, 2026.*

THE AUGMENTED GP

AI will not replace you.

Not augmented by AI — augmented by humanity.

- **Clinical knowledge**

  what training gives you

- **Life experience**

  the non-medical CV

- **Coaching capacity**

  what you've practised all your life

- **Whole-person connection**

  two humans in a room, thinking together

Discussion

1. Who came in worried — and has anything shifted?

2. Which tool in your practice actually gives time back to the room?

3. Who is the named clinical safety officer where you work — and do they know they are?

Dr Selvaseelan Selvarajah · RCGP Council & Co-Chair, RCGP AI Special Interest Group

NHS England