

GPwER in Gastroenterology Training Programme – FAQs

The following are FAQs created to support the rollout of the GPwER national training programme.

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Programme

1. What is the GPwER in gastroenterology training programme?

The programme was initially designed in 2023 to enable GPs with an interest in gastroenterology to develop their knowledge and skills in gastroenterology to enable them to work in an extended role at the interface between primary and secondary care. A bespoke programme was developed, including supervised clinical training, a comprehensive education programme, and a competency portfolio, and piloted in the southwest of England.

The first year of training was evaluated independently (the report can be found here: [GPwER Training Programme Evaluation – PCSG](#)). A further regional cohort was recruited in 2024. The roles proved to be extremely popular amongst GPs, and the evaluation highlighted the significant impact that a fully trained GPwER in gastroenterology could have on clinical services whilst the programme was found to be a cost-effective way of achieving this goal.

In October 2024, the BSG (British Society of Gastroenterology) and PCSG (Primary Care Society of Gastroenterology) jointly approved a national competency-based framework for the training of a GPwER. The programme closely aligns with the curriculum and competencies outlined in this document. The national framework can be found here: [The GPwER – PCSG](#).

Based on the findings of the southwest pilot, NHS England launched a national pilot in January 2026 with 28 GPwER trainees nationally. Further funding for a second national cohort has been approved by the NHS and we are looking to recruit a further 28 GPs to the programme for a January 2027 start.

Further details about the programme can be found here: [Training-Programme-Framework-for-enrolled.pdf](#)

2. What does the overall programme look like for the trainee GPwER?

The GPwER training programme is a 2-year course. Year 1 delivers a structured educational programme mapped to the national curriculum as outlined in the 2024 national framework (see above) alongside the student's clinical training (1 session per week in the clinical setting alongside their clinical supervisor); Year 2 continues the same funded course, with ongoing supervised clinical practice, assessment and faculty support, as set out below.

Year 1	Year 2
• Structured 12-month educational programme (3 clinical modules) • Monthly Lunchtime Learning live teaching, workplace-based assessments and CBDs/ROPs • QIP undertaken and end-of-year clinical supervisor report • Access to community support from course faculty	• Continued monthly/2-monthly live teaching sessions and access to the ACA/PCSG portal • Ongoing workplace-based assessment feedback and monitoring, with continued clinical supervision • Continued QIP support and case-based reflection, plus end-of-programme supervisor report • Ongoing access to community support from course faculty

3. Can you explain how the clinical component of the programme works?

The clinical training is delivered within the GP's local gastroenterology department. This training should be carried out in a general gastroenterology outpatient clinic, and the GP will run supervised outpatient clinics seeing a wide range of clinical conditions. The GP will have a nominated clinical supervisor (i.e. Gastroenterologist) who will supervise and support their clinical training.

During the clinical training, the GPwER trainee will complete a number of workplace-based assessments (WPBAs) which will include case-based discussions (CBDs) and reflections on practice. Their clinical supervisor will also complete 2 end of year reports to assess their progress against the programme outcomes.

4. And what about the portfolio and educational programme?

The education programme runs alongside the clinical training, and has been designed specifically to provide the GPwER with the knowledge to succeed within their extended role.

The structured educational training runs over the first 12-months of the programme and continues throughout year 2 with regular educational sessions and ongoing educational support. It is divided into three clinical modules plus a Quality Improvement Project (QIP). Each module maps to the national GPwER in gastroenterology curriculum and is broken into monthly themes linked to common GI presentations (see below).



The three clinical modules as presented on the ACA training portal: Upper GI, Lower GI and Hepato-Pancreato-Biliary Tract Courses.

Module	Duration	Curriculum focus (monthly themes)
1. Upper GI	3 months	Dysphagia, dyspepsia and GORD, endoscopy essentials (including Barrett's oesophagus, H. pylori, upper GI bleeding and cancer)
2. Lower GI	5 months	Weight loss and malabsorption, iron deficiency anaemia, inflammatory bowel disease, change in bowel habit, rectal bleeding
3. Hepato-pancreato-biliary	3 months	Detecting liver disease, steatosis and alcohol-related liver disease, pancreatitis and pancreatic insufficiency
Quality Improvement Project (QIP)	12 months (concurrent)	Case-based discussions and reflective learning, run alongside the three clinical modules in Year 1 and continuing, as part of the same funded 2-year course, into Year 2

5. How is the education programme delivered, and by whom?

The education programme and portfolio are provided by the Advanced Clinical Academy (ACA). Part of the funding allocated to ICBs will need to be passed on to the ACA (see Funding section below for further information).

Further information about ACA and access to the online portal can be found here: [Advanced Clinical Academy](#).

Delivery combines the following elements each month:

- **Lunchtime Learning** live teaching. A 1-hour live teaching session held monthly via Microsoft Teams, delivered by the course tutor and visiting specialists from around the UK, and recorded and edited so trainees who cannot attend live can catch up later.
- **Written assignments.** Short, fully referenced assignments and workbooks appropriate to the month's topic, marked by the course tutor with individual written feedback.
- **Virtual clinic cases.** A minimum of 2 guided, interactive case studies each month, linking to national guidance and other resources.
- **Self-directed learning.** Suggested reading, podcasts and recorded webinars linked to each module.
- **Workplace-based clinical training.** A minimum of one clinic/session per week with a named clinical supervisor, generating the case-based discussions (CBDs), reflections on practice (ROPs) and end of year appraisal reports after years 1 and 2 of the programme. The completion of these workplace-based assessments feed into the overall student assessment.

- **QIP support.** Dedicated educational talks, driver-diagram templates and a project brief proforma, available throughout the programme to support the completion of the required Quality Improvement Project.

6. Will there be ongoing evaluation and monitoring of the trainees on the programme?

Educational progress will be evaluated through the training programme, annual appraisal carried out by the supervising consultant will provide formal evaluation of progress. However, most of the progress monitoring will be done when the GP is in clinic, working alongside their supervisor.

7. Will there be a community of practice to support GPs?

Yes, all the GPs on the programme will be able to connect with one another on the training platform and via a dedicated WhatsApp group. This has proven to be extremely popular with our first cohort of trainees, allowing rapid troubleshooting of programme queries, as well as strong peer support.

8. When does the online programme commence and what is the time commitment?

The formal education programme begins in January 2027 in line with the national cohort start date. GPwER trainees will receive access to preparatory materials and portfolio tools from December 2026.

Based on feedback from previous cohorts, the average monthly educational time commitment is 18 hours (i.e. around 1 session of educational time per week).

9. Is there a qualification on completion of the training?

Completion of the training programme is evidenced by two satisfactory end-of-year supervisor competency reports, a completed portfolio of workplace-based assessments (a minimum of six case-based discussions and twelve reflections on practice), at least 30 patient feedback responses, at least 10 colleague multi-source feedback responses, and a completed Quality Improvement Project (QIP).

Graduates become eligible to apply for Fellowship of the PCSG (FPCSG), a peer-assessed award, granted following portfolio review and panel assessment, that formally recognises and maintains GPwER status in gastroenterology through triennial review and ongoing CPD.

10. Is there a national start date for the programme?

The start date for the programme is January 2027. The final deadline for confirming outstanding GP names to the training programme lead is the 30th December 2026. Any delays to onboarding or confirmation of start dates should be discussed directly with the relevant ICB. Please also inform the training provider.

11. What happens if a trainee drops out of the programme?

We hope that all trainees will complete the full two-year programme. However, we recognise that unforeseen circumstances can arise.

If a GP withdraws from the programme:

- this should be managed locally by the ICB in line with local employment and contractual arrangements;
- the ICB should notify the programme lead (Dr Charlie Andrews – charles.andrews@nhs.net) at the earliest opportunity.

Decisions regarding replacement of a trainee, reallocation of remaining training funding within the agreed envelope, or cessation of participation sit with the ICB.

GIRFT/the programme team does not manage individual employment consequences or make case-by-case funding decisions for trainee withdrawals.

12. Is there a deadline for starting supervised clinics?

There is no fixed national deadline, but local systems should aim to transition from observation to supervised clinics as soon as possible.

Supervision should be in-person in the first year. From year 2, remote supervision can be considered if appropriate.

By mid-year 1, GPs should be delivering ~50% of a consultant's clinical activity, rising to ~90% by the end of year 2.

Funding

13. What is included in the funding that has been provided?

The £38,500 funding that has been provided is intended to cover the cost of training the GPwER. The costings for the training phase already include the standard employer on costs (NI and NHS Pension) within the overall envelope provided to each ICB.

The breakdown is as follows:

Component	Cost per GP	Nature of cost
GP sessional time	£27,000	This funding is designed to cover the GP's sessional time in the hospital conducting supervised clinics: Year 1 funding: £13,500 Year 2 funding: £13,500
Trust/consultant supervision	£7,000	Payment to the supervising NHS Trust, covering approximately ¼ programmed activity (PA) per week: Year 1 funding: £3,500 Year 2 funding: £3,500
Training programme delivery	£4,500	This covers the 12-month online education programme which aligns with the GPwER curriculum, as well as access to and support for the online portfolio over 2 years. This is delivered via the Advanced Clinical Academy (ACA), and will need to be transferred to ACA once the GP commences the programme.
Total per GP	£38,500	

This funding is for the training and development of GPs to build enhanced gastroenterology capability. It is not a service commissioning arrangement, and therefore the programme funding is time-limited to support training only.

Clarifying on-costs and overheads

- On-costs, including statutory employer contributions (National Insurance of 15%, NHS Pension of 23.7%) are included within the £27,000 provided for supporting the GP clinical time.
- Overheads such as rooms, admin support, IT, consumables and utilities are not included in the funding provided and should be factored into local service business cases post-training.

The £27,000 rate (to cover the 2 years of training) is a training allowance, not a service delivery rate, and should not be used as a benchmark for post-training commissioning.

14. Will there be leave entitlements – for example, annual leave, study, sick leave?

This will depend on the form of contract used to employ the GPwER trainee.

If the GP is employed through the ICB or Trust, yes, their leave entitlement should fall within their contractual agreement and policies.

15. How will the GP be paid – by the NHS Trust, the ICB or via their GP practice?

GPs are a heterogeneous group of clinicians with varying contractual arrangements. For example, some are employed as salaried GPs, whilst others are self-employed GP partners or locum GPs.

This means that some flexibility around financial arrangements is necessary. For example, a salaried GP may wish to be paid via their GP practice (providing the practice agrees to this arrangement) whilst others may prefer to be Trust-employed and paid. Arrangements will need to be made at a local level, and successful ICBs will be provided with further guidance around this to ensure that GPwER trainees are paid promptly upon starting the programme.

Contractual/organisational

16. Should we be using an honorary contract or SAS Doctor contract?

We do not mandate or prescribe a specific contractual or employment model for GPwER trainees.

The purpose of any contractual arrangement during the training phase is solely to enable access to supervision, learning opportunities and governance, not to establish employment or commission clinical services.

ICBs may work with local provider trusts to determine the most appropriate arrangement to support training delivery. From experience, the following are likely to be the most appropriate contractual arrangements to use:

- Honorary contracts – commonly used where the GP remains employed by their practice (or works as a locum) and requires access to trust systems, supervision and clinical environments for training purposes.
- SAS Doctor or equivalent fixed-term contracts – may be used locally where systems choose to employ the GP directly for the duration of training; however, this is a local decision and must be managed within the existing training funding envelope.

Key points to note:

- This funding does not include employer on-costs, overheads or employment liabilities beyond those already included within the stated sessional training rate.
- The GPwER programme is not an employment programme and not a service commissioning arrangement.
- Any contractual arrangement should be time-limited to the training period and should not create an expectation of substantive employment post-training.

Post-training, GPs are expected to deliver services under locally commissioned GPwER service contracts, at which point ICBs will determine the appropriate provider, contract form and payment mechanism.

17. Is indemnity covered?

Any contractual arrangement (i.e. Trust-based contract, or honorary contract) should provide cover for work undertaken during training via Crown Indemnity. However, we encourage all GPs undertaking the programme to also contact their Indemnity Provider to let them know they are undertaking this additional work.

Next steps

18. Can you outline what the next steps are?

The programme team's role at this stage is to:

- Provide the national training framework and funding; and
- Oversee programme delivery, participation and outcomes at a national level.

We do **not** manage local onboarding, contracts, or employment arrangements. However, we will provide some support/guidance around contractual and financial arrangements to successful ICBs based on learnings from previous cohorts.

ICBs are responsible for:

- finalising local employment or honorary arrangements with GP practices and/or trusts;
- agreeing any local contracts or variations required to enable training;
- confirming start dates with participating GPs;
- arranging payment of the training provider fee (£4,500) to Advanced Clinical Academy (please liaise directly with the training lead, Dr Charlie Andrews – charles.andrews@nhs.net); and
- managing any local delays or mobilisation issues.

19. Do we need to confirm our nominated GP and consultant supervisor?

Yes. Please return a completed Eol by **12th October 2026** with these names. However, if you are unable to confirm names, we may still consider your Eol submitted by this deadline, but this might reduce your chance of securing a funded place. Once the names are known, please email england.girftgastroenterology@nhs.net with:

- Name and email address of ICB lead contact
- Name and email address of the nominated GP
- Name and email address of the supervising consultant

20. What is the process for selecting a GPwER trainee? Will the GP be employed under the Trust/Provider as a trainee, or under another arrangement?

ICBs and provider trusts have discretion over their recruitment approach. Some areas have found success by recruiting through the Trust and targeting GPs with an existing interest or experience in gastroenterology.

We have generated advertising material and interview proformas to support the recruitment of previous cohorts and can provide these to you should you wish to use them.

Post-training

21. What happens after the training has ended – who will fund the GP after the 2 years, and will there be a job upon successful completion of the training?

Once GPs complete their training, the expectation is that local ICBs will commission and fund ongoing GPwER-led services to:

- Increase system capacity
- Manage appropriate referrals and triage at source
- Support reductions in waiting lists for gastroenterology.

By that stage, commissioning responsibility will sit fully with ICBs.

To ensure sustainability and consistency, it's recommended that:

- Participating ICBs collaborate to agree a single, consistent contracting approach (using the same contract template and service specification).
- A common payment currency is adopted for GPwER activity — ideally aligned to tariff or activity delivered, rather than sessional payments.

While the training phase rightly funds time spent developing skills, once the service becomes operational the focus should shift to outputs rather than inputs.

Purely session-based payment models make it difficult to compare productivity or demonstrate clear impact on referral volumes and waiting lists, particularly where hospitals continue to record and receive payment for outpatient activity in parallel.

Structuring contracts around activity or tariff-linked payments will:

- Ensure funding reflects clinical output and throughput,
- Maintain consistency with existing secondary-care payment mechanisms, and
- Generate comparable data to assess efficiency, outcomes and system impact.

This provides stronger assurance that the GPwER model delivers measurable capacity and value across the pathway.