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Anaesthetic Training in the United Kingdom: A Narrative Review of Current Provision and Future Challenges

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Abstract

UK anaesthetic training is undergoing significant change at a time of wider scrutiny, with postgraduate medical training under national review. This narrative review describes recent reforms, evaluates the rationale and evidence behind these and examines pressures facing future training delivery. Literature was identified through searches of MEDLINE, Embase and ERIC, supplemented by reference list searching and targeted searches of relevant institutional websites. The 2021 curriculum restructured training into three stages and introduced more holistic, supervision-level workplace assessment in response to concerns about the 'tick-box' nature and lenient judgements of the former system. International evidence suggests supervision-based ratings attribute more score variation to trainee ability, but whether such ratings predict subsequent independent clinical performance remains uncertain. Reviews of the specialty examinations raised concerns about assessor variability and reliability in the structured oral examination (SOE). This component will be removed in redesigned examinations from 2027, whose ability to predict clinical performance has not yet been evaluated. Several challenges to future training delivery are identified. Training bottlenecks have shifted towards core entry, increasing the importance of selection methods, particularly if run-through training is introduced. The indicative seven-year programme is longer than in several comparable systems, with no direct evidence that this confers benefit. Competency-based progression could reduce reliance on fixed training duration, but this has not been demonstrated. Less-than-full-time (LTFT) working for higher trainees has increased threefold since 2017 to 48.5%, with implications for training duration, rota organisation and workforce planning, although available evidence does not suggest poorer examination or consultant appointment outcomes. Expansion of trainee numbers will increase demands on educator capacity, while opportunities for progressive autonomy may be narrowing. Proposed responses to these issues include training place expansion, run-through training, slot-sharing and a shorter programme, but evidence for their effects on training quality remains limited. Addressing these training pressures matters given a consultant workforce shortage that is projected to grow.

Categories: Medical Education, Anesthesiology
Keywords: anaesthesia training, competency-based assessment, curriculum, medical education, supervision

Introduction And Background

Why review anaesthetic training now?

Postgraduate anaesthetic training provides the consultant workforce for the largest single hospital specialty in the NHS [1], and the past five years have brought substantial change. The 2021 curriculum introduced a new structure to training and a more holistic method of portfolio assessment, built on supervision-level ratings and entrustable professional activities [2]. The Fellowship of the Royal College of Anaesthetists (FRCA) examination process has undergone both internal and independent review, with a new format planned for introduction in 2027 [3,4]. Beyond anaesthesia, postgraduate medical training in England is itself under review by NHS England, with initial findings recently published [5].

The environment in which training is delivered is changing too. Rising rates of trainees working less-than-full-time (LTFT) reflect a specialty-wide shift in working patterns [6]; this has brought both benefits and challenges for training delivery. A shift towards increasingly consultant-delivered care has implications for training opportunities in independent practice [7].

The stakes for getting anaesthetic training right are significant given the current and projected anaesthetic workforce shortage. The senior anaesthetic workforce comprises consultants and Specialist, Associate Specialist and Specialty Doctor (SAS) doctors. The UK is currently short of 2,256 of them, 16% below requirement and up from a shortfall of 1,483 in 2020 [8]. Royal College of Anaesthetists (RCoA) modelling has projected this shortage could reach as high as 11,000 by 2040 [9].

Barriers to progression through training and readiness for consultant practice are important to consider. Some of these obstacles are new, such as the perceived erosion in autonomous practice; others are familiar, such as training bottlenecks and non-clinical stressors such as examinations and portfolio requirements. Many of these issues are not unique to anaesthesia, and lessons here have wider applications to other specialties. This narrative review outlines recent changes to postgraduate anaesthetic training and examines key challenges to its future delivery, including proposed solutions, the strength of the evidence supporting

them and the outcome measures against which that evidence has been judged. Particular attention is given to whether current assessment and selection methods identify readiness for progression and independent practice, and whether expansion of training can be reconciled with increasing LTFT working, finite educator capacity and opportunities for progressive autonomy.

Review

Methods

A narrative review of postgraduate anaesthetic training in the UK was undertaken. Literature was identified through searches of MEDLINE and Embase (via Ovid) and ERIC, last run on 2nd October 2026. Searches were not restricted by publication date and were limited to English-language publications.

Searches paired terms for the specialty ("anaesthesia", "anaesthetics", "anaesthesiology") and for training ("postgraduate medical education", "specialty training", "residency", "trainee", "curriculum") with "United Kingdom", "UK" and "NHS". Each theme of the review was then searched against the specialty and training terms: "entrustment", "entrustable professional activities", "supervision levels", "workplace-based assessment", "competency-based medical education", "clinical competence" and "holistic assessment"; "examinations", "FRCA", "structured oral examination", "examination reliability"; "recruitment", "selection" and "competition ratios"; "training duration" and "length of training"; "less than full-time training" and "part-time training"; "educational supervisor", "trainer", "supervision capacity"; and "clinical autonomy", "independent practice" and "progressive independence". Searches of these themes were run without the UK terms. Evidence from other specialties and healthcare systems was included where UK anaesthesia-specific evidence was unavailable, but its applicability to UK anaesthetic training may be limited, and this limitation is discussed where such evidence is used.

Reference lists of relevant articles were searched for additional material. Primary studies, systematic reviews, national survey and registry data, and institutional and professional publications were all eligible. Records were screened on title and abstract by the single author, with full texts obtained where relevance was unclear, and selection was made on relevance to the themes above rather than against predetermined eligibility thresholds. The websites of the Royal College of Anaesthetists, the Association of Anaesthetists, the General Medical Council (GMC) and NHS England were searched for curricula, workforce reports, guidance and professional commentary; these were used to describe the structure and governance of training and identify stated positions rather than as evidence of effect.

Evidence was considered in relation to study design, sample size, methodological limitations and applicability, alongside the reported findings. As this was a narrative review, no formal risk-of-bias assessment was used. Where studies disagreed, all findings are reported and any disagreement examined. The scope of this review was deliberately focused on the Certificate of Completion of Training (CCT) pathway, the route through an approved UK training programme to specialist registration and consultant practice. It does not address undergraduate education, the Portfolio Pathway, or the Physician Assistants in Anaesthesia (PAA) curriculum. The 2021 curriculum and the FRCA examinations apply across the UK, but workforce expansion, funding and recruitment policy are devolved; the policy commitments discussed apply to England unless otherwise stated.

The current delivery of anaesthetic training in the UK

The UK Training Pathway Since the 2021 Curriculum Change

The 2021 curriculum reorganised the four levels of the 2010 curriculum into three stages, with recruitment at Core Training 1 (CT1) and Specialty Training 4 (ST4) [2]. Stage 1 (CT1-3) covers core training, including mandatory obstetric anaesthesia and intensive care placements; around one-third of trainees complete it through the Acute Care Common Stem pathway, which adds six-month placements in acute internal medicine and emergency medicine [8]. Stage 2 (ST4-5) introduces specialty areas such as cardiac and neuroanaesthesia, and Stage 3 (ST6-7) introduces Special Interest Areas (SIAs) and prepares trainees for consultant practice. Extending Stage 1 to three years moved higher specialty recruitment from ST3 to ST4 and provided an additional year within core training.

Entrustment and Supervision Levels: Improving the Validity of Workplace Assessment?

Beyond the structure of training, the 2021 curriculum organised assessment around 'Domains of Learning' with a Holistic Assessment of Learning Outcomes (HALO) providing a summative judgement of achievement within each Domain. HALOs draw on multiple sources of evidence, including Workplace-Based Assessments (WPBAs), logbook data and trainer reports [2].

A key change to the way trainees were assessed was the move to supervision-level ratings. Previously, performance was graded against the standard expected at a trainee's stage of training, but weaknesses in this approach have been observed. Across 331 mini-clinical evaluation exercises involving 61 trainees and 58 assessors, roughly half of the specialists involved conceded that scoring a trainee in person had probably made them more lenient, and no trainee's overall performance was rated unsatisfactory [10]. More fundamentally, when the sources of score variation were separated, differences between trainees explained just 4%, while differences in assessor stringency accounted for 40% and the particular case being observed a

further 41%. Scores therefore reflected who was marking, and what was being marked, far more than the ability of the trainee.

The 2021 curriculum has now introduced supervision-level ratings as the means of WPBA. Assessors must grade trainees on the level of supervision they would require if the case was repeated, ranging from a supervisor being physically present (level 1) to independent practice (level 4). Entrustable Professional Activities (EPAs) were introduced, which integrate evidence from multiple assessments, with their assigned supervision levels, to determine whether a trainee is ready for increased autonomy in a particular area, for example, providing anaesthesia for caesarean section [2]. The rationale is that describing the supervision a case would require allows a more honest approach than delivering a verdict on the trainee.

Evidence supporting this change exists, although little of it is UK-based. In a qualitative study of training stressors, UK residents reported that the new entrustment ratings clarified the path to greater independence and supported them in taking on more responsibility [11]. A study from Australia and New Zealand showed that rescoring WPBAs by the independence a trainee demonstrated, rather than by performance against expectation, raised the proportion of score variation attributable to trainee ability from 9% to 21% and reduced that attributable to assessor stringency from 29% to 18% [12]. Adjusting each score for the supervision a case would typically require improved this to 28%, although the expected levels were derived retrospectively and no general method for applying them more widely was established.

WPBAs often show poor agreement between assessors: in a video-based study, nine surgical faculty rating the same six operations showed only modest agreement whether or not an entrustment scale was used [13]. These assessors scored recorded cases with no prior knowledge of the trainee, unlike supervisors in practice, so the comparison may understate how entrustment ratings perform in use. Even so, a sufficient number of WPBAs is needed to overcome this inter-assessor variation: estimates from large anaesthetic datasets suggest that somewhere between 9 and 20 assessments are required before a progression decision can be considered reliable [14,15]. The move towards holistic assessment and away from fixed numerical targets was intended, in part, to address concerns about the perceived ‘tick-box’ nature of WPBAs [16], but this creates a tension with the WPBA volume the reliability data suggest are required. Programmes using competency-based evaluation also used significantly more assessment tools (mean: 9.1 versus 7.0, p=0.03) [17], which may work against the intended reduction in administrative burden.

Assessing performance in the workplace appears inherently difficult, and current approaches have important limitations. Among 26 senior anaesthetists across 21 European countries, 10 had signed off trainees whom they would not want anaesthetising a member of their own family [18]. A systematic review of competency-based medical education in anaesthesia, drawing on 23 studies, found that entrustment scales were supported and that workplace-based assessment tools could be made reliable, but that demonstrated benefit extended no further than the acquisition of individual competencies, with little evidence that they improved feedback or informed progression decisions [19]. The review itself found limited evidence across the core components of competency-based education and was restricted to English-language publications, so an absence of demonstrated benefit is not the same as evidence of no benefit. It does, however, highlight the need for well-designed predictive validity studies, examining whether supervisor ratings forecast trainee progression and patient outcomes.

Examination Reform

The FRCA examinations are taken in two parts. The Primary, sat during Stage 1, comprises written, clinical and oral components; the Final, sat during Stage 2, comprises written papers and a structured oral examination (SOE). Concerns regarding the reliability and validity of these examinations for assessing clinical performance prompted both an internal RCoA review and an independent review led by Professor John McLachlan in 2023 [3,4].

The independent review, using a screening test analogy, found that those who passed were considered deserving of a pass (i.e. few false positives) but that some candidates failed despite being considered clinically at the required level (i.e. false negatives) [4]. This rested on the views of those interviewed rather than on any independent measure of clinical performance, which is itself why the review went on to call for concurrent and predictive validity studies. It also identified overlap in the assessment of knowledge across written and clinical formats, arguing that knowledge could be assessed more appropriately in written examinations, allowing clinical assessments to focus more specifically on clinical reasoning and performance.

The SOE format was particularly singled out for critique, although the reviews disagreed on proposed reform. The independent review judged the SOE too short to overcome high assessor variability and suggested its possible removal, given the poor reliability of the format [4]. The internal review argued for the retention of the SOE in the Final examination, arguing that it allowed greater assessment of decision-making, a key skill of these more senior candidates, and that rotating candidates through three pairs of examiners should limit bias [3]. Yet, the same review accepted that the SOE was subjective, that candidate experience might not be equivalent and that its 0-2 marking scheme discriminated poorly between borderline and excellent performance. Looking at evidence from other specialty oral examinations, qualitative data of the MRCGP oral examination suggested this was a valid assessment of knowledge, but less so on decision-making, the key metric the internal review hoped this format would interrogate [20].

In response to these reviews, the FRCA examination format is to change from July 2027 [21]. The two components of the Primary will be an Applied Knowledge Test (AKT) and a Clinical Anaesthetic Sciences Examination (CASE), and for the Final, an Applied Knowledge Test and a Final Clinical Performance Examination (FCPE). Both SOEs will ultimately be removed despite disagreement between the reviews over their value and before the predictive validity studies recommended by the independent review had been undertaken. Going forward, such studies will need to evaluate whether assessment in the new examination format predicts workplace performance.

What is clear from both these reviews and qualitative studies is the emotional and financial burden these examinations can have. Trainees describe the breadth of the syllabus, consequences of failure and examination fees as substantial stressors [11], while the independent review highlighted the potential for examination failure to disrupt training progression, careers and personal lives [4]. Whether the revised examination format will reduce this burden remains to be seen. In England, the financial barrier has been partly addressed, with funding agreed for the first two attempts at each Royal College examination for trainees from April 2026 [22].

Future challenges for UK anaesthetic training

Training Bottlenecks and Competition: A Shifting Pattern

Competition for anaesthetic training places represents a particular problem in the context of the ongoing consultant workforce shortage, and the recent NHS England review identified bottlenecks across postgraduate medical training as requiring urgent attention [5]. Historically, higher specialty entry represented a particularly consequential bottleneck: in 2021, approximately two-thirds of applicants for ST3 anaesthetic training were unsuccessful [23]. A national survey of that cohort found that 78% reported disruption to life plans from this interruption in training and 9% had considered leaving medicine permanently [24]. Qualitative work has similarly identified competition for higher-training posts as a major source of stress and low morale among anaesthetic trainees [11].

The situation at higher specialty entry has since improved: in the UK, competition ratios at ST4 entry (formerly ST3) have fallen from 2.67:1 in 2021 to 1.65:1 in 2025. This coincides with expansion in higher training posts since 2021. In contrast, competition for CT1 posts has risen more than threefold over the same period, from 3.6:1 to 12.6:1 [23,25]. The CT1 ratio should be interpreted cautiously given the ability to apply across multiple specialties. Nonetheless, this shifting pattern represents a new challenge, with expansion at CT1 level required if demand is to be met.

Both the government and the RCoA have set out plans to expand training capacity. As part of the June 2026 agreement struck between resident doctors and the government following industrial action, the government has committed to a minimum of 4,000 additional training posts in England across all specialties over three years, with emphasis on focusing these at CT1/ST1 level where possible [22]. Additionally, the RCoA has identified the theoretical capacity to introduce 175 extra core and 201 additional higher training places per year [8]. The pace of training place expansion must be balanced against factors such as educator capacity and adequate clinical exposure.

The introduction of run-through training from CT1-ST7, with removal of the ST4 recruitment stage, has also been proposed [11,26]. Gale et al. identified ST4 applications as a major non-clinical stressor, which some residents perceived as a tick-box exercise lacking benefit for their clinical progression [11]. The authors did, however, report that some residents valued the natural break in training. Whilst Out of Programme (OOP) activities may reduce the need for this, the benefits and disadvantages of removing ST4 recruitment require further evaluation.

As competition shifts to core entry, the criteria on which applicants are selected become increasingly important, particularly if run-through training is to be considered. A study linking national selection and training records of 2,782 doctors entering core anaesthetic training between 2012 and 2016 showed that how an applicant scored at shortlisting and at interview related to how they subsequently fared at Annual Review of Competence Progression (ARCP), after accounting for other factors [27]. The use of ARCP as an outcome measure and the authors' inability to access Primary FRCA scores weaken the conclusions, since ARCP mostly detects weak performance rather than discriminating across the range.

More importantly, the recruitment process has changed since this study to now solely comprise the Multi-Specialty Recruitment Assessment (MSRA) examination and an interview [28]. Evidence for the MSRA is building, with its clinical and situational judgement papers carrying predictive information in 10 specialties and, separately, in core psychiatry [29,30]. Again, what was predicted was examination or ARCP outcomes, rather than how the doctor performed at work. An evaluation of the assessment in anaesthetics is now under way at the College [31]. This should provide important evidence on whether current selection methods identify applicants likely to progress successfully, although outcome data beyond ARCP and examination scores would be needed to answer this fully.

Duration of Training

Duration of training is an important consideration in addressing consultant workforce shortages. The indicative seven-year duration of anaesthetic specialty training is longer than several comparable systems,

including Australia (five years) and the USA (four years) [32,33]. The difference with the US is more pronounced because US residency is entered directly from medical school, whereas UK and Australian specialty training each follow two postgraduate years. A retrospective cohort study in 2015 showed that the reality in the UK is often longer than seven years, with mean training durations of 8 years and 5 months for full-time trainees and 10 years and 8 months for those training LTFT [34].

There is limited evidence that longer training translates into better clinical performance or patient outcomes. Indirect evidence from a Finnish helicopter service study showed that among 1,638 pre-hospital anaesthetics delivered by 32 doctors, 30-day mortality fell from 38% in the group with the lowest prior case volume to 26% in the group with the highest (adjusted odds ratio (OR): 0.59, 95% confidence interval (CI): 0.38-0.94) [35]. The exposure measured was case volume rather than training duration; the two are likely related but are not interchangeable. Applicability to UK anaesthetic training is further limited by the pre-hospital, non-UK setting. There were also possible confounders present, with the introduction of a standard operating procedure for airway management at some bases during the study period difficult to account for.

The Association of Anaesthetists has argued that time spent in training is a ‘poor single metric’ for judging a senior anaesthetist’s readiness [26]. The shift to competency-based training, as has occurred with the 2021 curriculum, was intended to tie training progression to demonstrated capability rather than years of training, but a survey of all 36 European national anaesthetic programmes found that those using competency-based approaches still worked to fixed training lengths [17]. The authors attributed this to the impracticalities of organising rotation durations around this system. Ultimately, there is no longitudinal evidence that a shorter programme would produce equivalent training outcomes.

Rising Rates of Less-Than-Full-Time (LTFT) Working

The increasing adoption of LTFT working is likely to further prolong training duration. GMC survey data of anaesthetic higher trainees has shown an almost threefold increase in LTFT working in the UK, from 16.5% in 2017 to 48.5% in 2026 [6]. This is well above the figure across all specialties of 25.6%. The same data show that the most common reasons given by anaesthetic trainees include childcare (62.2%) and a better work-life balance (58.2%). Other benefits may include staff retention; some residents described LTFT working as what kept them in the specialty [11].

The trend towards LTFT working appears unlikely to have peaked. Among 338 respondents (62%) of 548 doctors starting UK anaesthetic training in August 2024, 76% expected to spend at least part of their training working LTFT [36]. A UK-wide survey of 783 trainees, albeit predominantly in medical specialties, found that 62% hoped to work LTFT as consultants too, with fewer than 1 in 10 planning to work full time [37]. If these intentions play out, the implications extend beyond training with more doctors required to deliver the same service, so a shortfall expressed in whole-time equivalents understates the number who must be trained.

Beyond these workforce implications, another question is whether LTFT training delivers equivalent results. Comparing outcomes between LTFT and full-time anaesthetic trainees, Randive et al. showed no significant difference in rates of substantive consultant appointment and no association with extra time taken to pass examinations or complete competency requirements [34]. A major limitation, however, was the exclusion of trainees who left training. In a retrospective cohort study using UKMED data of all UK postgraduate examinations across specialties between 2014 and 2020, LTFT status was independently associated with higher odds of passing written and clinical examinations (24% and 14%, respectively) [38]. These findings are associations, and neither analysis can fully control for confounding factors that may relate both to those who train LTFT and to the outcomes measured. Trainees themselves report some negatives; data across several medical specialties showed that 32% of those working LTFT reported their training had been negatively affected [37]. The authors acknowledge that trainees with a particular interest in the subject may be over-represented.

Less-than-full-time working also creates practical challenges for training delivery. The current system of extending training time pro rata for reduced working time will extend training duration and can make organising rotations more complex for Training Programme Directors [39]. Training providers told the recent NHS England review that rising LTFT working was making rotas harder to staff and learning opportunities harder to share equally [5]. Without efficient allocation of LTFT posts, or recruitment that accounts for rising LTFT rates, rota gaps may appear, shifting the balance from training to service provision [39].

Several approaches could mitigate these pressures [26]. ‘Slot sharing’, where two LTFT trainees occupy a single training number, could reduce rota inefficiency and increase training capacity, although the additional supervisory burden of a larger trainee body requires evaluation [40]. The June 2026 agreement between the government and resident doctors may also facilitate more rapid progression for LTFT trainees by introducing 12-month annual reviews as the default, possibly allowing progression at the same annual pace if required competencies are achieved [22]. Questions remain about whether the ARCP is a sufficient assessment tool to support this, given that annual review at reduced hours relies on a smaller body of evidence. A more radical proposal would be to shorten training to six years by making the subspecialty component of Stage 3 an optional post-CCT fellowship, producing broadly competent generalists sooner. Whether this would shorten time to consultant appointment, rather than relocating the same training into an unprotected fellowship year, remains untested [26].

Educator Capacity

The move towards holistic, supervision-level assessment within the curriculum places significant demands on educators to engage in observation, supervision and regular feedback to make a reliable judgement on competence. There is some evidence that this may already be falling short: analysis of 618,695 trainee anaesthetic sessions across 91 UK Trusts in 2014-2015 found a median of 2.6 supervised sessions per week, below the three recommended, with senior trainees receiving even fewer [41].

Educational capacity may be particularly limited in some areas of practice. Only 22% of 369 UK consultants and specialists surveyed were confident performing all Plan A regional blocks, and even fewer (19.5%) were confident teaching them [42]. Consultant workforce shortages are likely to compound this, and residents have described a perceived decline in consultant enthusiasm for teaching since the pandemic [11]. Data from the GMC's 2026 trainer survey suggests a largely positive picture from the trainer perspective, with 76% of anaesthetic trainers feeling they had enough designated time for the role [43]. But again, there were signs of strain appearing, with 20% feeling burnt out to a 'high or very high degree' [43].

Expanding trainee numbers without a corresponding investment in trainers would therefore pose a risk to the supervision on which the curriculum depends. National workforce planning has set out targets for training posts without setting out how the additional educators are to be recruited [44]. Resourcing departments appropriately appears to make a difference: educator confidence in delivering regional training was strongly associated with the presence of a departmental regional lead with dedicated paid time (OR: 7.27, 95% CI: 2.64-22.0) [45].

Opportunities for Independent Practice

If supervision-level ratings are used to gauge progression towards independence in the new curriculum, trainees must be given opportunities to demonstrate this. Indeed, RCoA guidance published in 2024 emphasises the importance of encouraging progressive autonomy, including opportunities for trainees to undertake suitable elective work with indirect supervision from early in training [7]. However, recent RCoA commentary suggests opportunities for independent practice are declining, driven by a move towards consultant-delivered care and a lower appetite for risk [46]. Although increased supervision was an important response to previously unsafe levels, there is concern that this may now have resulted in an 'overcorrection'.

The tension between supervision and autonomy is not new, with concerns raised as early as 2002 about the impact increased supervision would have on trainees' ability to make independent decisions [47]. Excessive elective supervision is also inconsistent with the reality of looking after higher-risk patients out of hours with only indirect supervision [11]. Residents also feel that entrustment is conferred disproportionately fast in certain specialties such as obstetric anaesthesia [11].

There is evidence to support and guide progressive increases in trainee independence. Weller et al. analysed 7,748 WPBAs and found that trainees needed progressively less supervision as they advanced through the programme, supporting the validity of supervision level as a marker of developing competence, although neither patient safety nor clinical outcomes were examined [14]. Marty et al. found good agreement between trainees and supervisors on when independence is appropriate across a set of proposed EPAs, with differences only in the most junior trainees, who favoured independence earlier [48].

In keeping with this evidence, RCoA guidance recommends designated trainee-led elective lists with indirect supervision from CT1 onwards, increasing incrementally up to at least two indirectly supervised lists in Stage 3 [7]. However, these are consensus recommendations, and no evidence assessing the effect of designated independent lists on trainee progression or patient outcomes was identified.

Limitations and Future Study

The scope of this review was deliberately focused, with particular attention to the UK CCT pathway. Several relevant areas not covered include the rising contribution of the Portfolio Pathway to specialist registration [9], educational theory and the growing influence that artificial intelligence is likely to have on training.

This review draws on a heterogeneous evidence base, ranging from national datasets and retrospective cohort studies to qualitative work, College reports and professional commentary. A reliance on observational studies reflects a key finding that a relative lack of longitudinal study exists, although one such study of the 2024 training cohort is ongoing [36]. Evidence from other specialties and healthcare systems was included where UK anaesthesia-specific evidence was unavailable, but its applicability to UK anaesthetic training may be limited. Future research should examine how changes to the training structure, approach to assessment and examination formats impact trainee progression and readiness for independent consultant practice, as well as clinical outcomes.

Conclusions

UK anaesthetic training is changing in both how trainees are assessed and the environment in which training is delivered. Supervision-level and entrustment-based assessment was introduced by the 2021

curriculum, and non-UK evidence suggests this attributes more of the variation in scores to differences between trainees than to the system it replaced, and that enough such assessments can support a sufficiently reliable training progression decision. Whether those decisions predict independent clinical performance or patient outcomes has not been established. Similarly, the introduction of the new FRCA examination formats aims to more accurately reflect relevant clinical capabilities, but further predictive studies are needed to demonstrate this. A recurring theme of this review is that reforms to assessment, examination and selection have largely been evaluated against other educational outcomes, such as examination results or ARCP decisions, rather than subsequent workplace performance.

Future challenges include producing a sufficient number of competent and independent consultant anaesthetists while maintaining training quality. With competition rising at core entry recruitment, and a possible switch to run-through training in the future, results from ongoing study into the selection process at this level will be increasingly important. Rising rates of LTFT working will extend an already long training programme, and whether the competency-based training model of the 2021 curriculum can mitigate this is unclear. The planned trainee expansion will require a corresponding increase in educator capacity, and these educators will need to address concerns about opportunities for trainees to develop autonomy. Future research should therefore focus on whether changes to training structure, selection, assessment and progression translate into better subsequent clinical performance and on how such performance can best be measured.

Additional Information

Author Contributions

All authors have reviewed the final version to be published and agreed to be accountable for all aspects of the work.

Concept and design: Matthew King

Acquisition, analysis, or interpretation of data: Matthew King

Drafting of the manuscript: Matthew King

Critical review of the manuscript for important intellectual content: Matthew King

Disclosures

Conflicts of interest: In compliance with the ICMJE uniform disclosure form, all authors declare the following: **Payment/services info:** All authors have declared that no financial support was received from any organization for the submitted work. **Financial relationships:** All authors have declared that they have no financial relationships at present or within the previous three years with any organizations that might have an interest in the submitted work. **Other relationships:** All authors have declared that there are no other relationships or activities that could appear to have influenced the submitted work.

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