Review of postgraduate medical training

Introduction

The Royal College of Anaesthetists (RCoA) welcomes the opportunity to respond to the Department of Health and Social Care's call for evidence in relation to the review of postgraduate medical training in the UK.

Anaesthesia is the largest single hospital specialty in the NHS and the RCoA is the professional body responsible for the specialty throughout the UK. We are the third largest medical royal college in the UK by membership. With a combined membership of more than 26,000 Fellows and Members, we ensure the quality of patient care by safeguarding standards in the three specialties of anaesthesia, intensive care and pain medicine.

We see this review as an opportunity to promote new ideas alongside highlighting guidance documents we have created over the last few years which promote flexible and innovative approaches to training, that maximise existing resources and encourage autonomy for doctors in training, as well as share initiatives that demonstrate our commitment to advocate for career development opportunities for all.

Theme 1: Is postgraduate medical training meeting the needs and expectations of patients, healthcare services and doctors?

Subtheme 1.1 - Workforce Distribution

NHS waiting lists currently stand at over 7 million in England alone. A key factor limiting the rate at which the NHS can perform operations is the availability of anaesthetists, as most operations require one to take place. Unfortunately, there is currently a 1,900 UK wide shortage of anaesthetists, 15% lower than what is needed. As such there is an urgent need for a viable plan to train and recruit more.

The focus should be on ensuring that medical training posts are aligned with actual training capacity. Approximately 50% of Anaesthetists in training (AiTs) move on to take up consultant posts away from where they have chosen to train, so prioritising training in areas with the infrastructure to support it is key to increasing the number of doctors progressing through the system. Currently the emphasis is to expand posts in areas which do not have the capacity to train the anaesthetists, which is an ineffective strategy. Instead, we need to strengthen training capacity in these areas by investing in trainers first and allocating the additional posts to those areas which have declared capacity to train. Without this foundation, assigning AiTs to regions without sufficient support only leads to wasted opportunities and unfilled training slots.

Additionally, the allocation of posts often occurs without adequate consultation with training schools, resulting in mismatches between posts and local training capacity. Under the leadership of HEE, the workforce plans and requirements of NHS Trusts were not shared with the Royal Colleges. This lack of transparency has hindered efforts to support, update, and improve workforce supply, education, and training. Despite repeated requests, the underlying models of workforce distribution have never been made available, limiting the ability of key stakeholders to contribute meaningfully to effective workforce planning. A more pragmatic and coordinated approach is essential - one that includes better communication and planning with educational bodies before placements are finalised.

Finally, the distribution of healthcare staff and services across the UK continues to fall short of patient needs. Despite longstanding discussions about service reconfiguration, patients in many areas still face significant travel burdens to access care. Any meaningful reform must address both workforce distribution and service accessibility to create a more equitable and efficient healthcare system.

Supporting evidence
The RCoA is currently conducting a national anaesthetic workforce census. Early data indicates that there is considerable capacity to train more anaesthetists. The full findings will be published later this year and shared with national stakeholders.

Training capacity survey (enclosed)
Principles of a training capacity assessment (enclosed)
Anaesthetics competition ratios
Exploring improvements to the national recruitment process in anaesthetics: recognising the person behind the number April 2025
Medical Workforce Census Report 2020
The Anaesthetic Workforce: UK State of the Nation Report 2024

Subtheme 1.2 Experience of being a Resident Doctor

The principles underlying rotational training have recently been brought to the fore. AiTs and trainers alike have raised concerns over the impact frequent rotations have on the educational effectiveness of placements. In addition, the impact of frequent rotations on wellbeing and quality of life for AiTs has been raised as a concern. Our *Minimising the impact or rotational training within the anaesthetic training programme* review looked at the use of rotations in the light of anaesthetic training in 2024 and the requirements of the 2021 Curriculum.

The report makes recommendations for minimising the frequency and negative impact of rotations. In summary these are**:**

- NHS England, HEIW, NES and NIMDTA should implement the recommendations from 'improving the working lives of doctors in training' as a matter of priority

- Departments of Anaesthesia, Clinical Directors and College Tutors should ensure they are implementing best practice in delivering induction and rota management. Departments should also undertake a review of the availability of rest facilities, post-shift accommodation, access to study leave, access to parking, accuracy of payroll and access to hot and cold food 24/7

- Schools of Anaesthesia should review both the number of rotations required to complete each stage of training and the provision and delivery of educational supervision. They should also take steps to give anaesthetists in training as much advance notice of rotations as possible and, where possible, greater choice in their rotations

- NHS England, HEIW, NES and NIMDTA should also ensure appropriate administrative support is provided to their Heads of School and Training Programme Directors

- The RCoA should continue to explore appropriate flexibility within the curriculum and to review the support and training available to College Tutors and Educational Supervisors in the delivery and requirements of the 2021 curriculum. The College should also continue to engage with NHS England's Enhancing Doctors Working Lives Workstream.

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Implementation of the RCoA recommendations is already underway. In terms of enhancing flexibility, the GMC has approved guidance allowing certain elements of the Stage 3 curriculum to be brought forward into ST5, where this supports an AiT to remain in post longer. This is permitted on the condition that all remaining components of the Stage 2 curriculum are completed by the end of ST6.

Further evidence and initiatives undertaken by the RCoA's Education, Training and Examinations Board are outlined below. This work aims to provide improved support for all anaesthetists—both those in formal training and those pursuing alternative pathways to develop their careers.

The rise of Less Than Full-Time (LTFT) training in postgraduate medical education reflects a significant shift driven in part by increasing concerns around burnout and the need for better work-life balance. While LTFT training offers clear benefits, such as improved well-being and enhanced workforce retention, it also presents logistical and cultural challenges that demand careful attention. Addressing these issues will require meaningful reforms and greater flexibility within postgraduate training structures.

The recommendations from *Improving the Working Lives of Doctors in Training* must be implemented in full. One key proposal, the lead employer model, has received broad system-wide support and is recognised as a way to enhance the morale of resident doctors. However, despite this consensus, implementation is not universal across the UK. Under the current system, doctors too often experience delayed or incorrect pay, leading to significant stress, including the risk of defaulting on rent or mortgage payments, and a general sense of instability.

Additionally, a well-supported and well-educated workforce is crucial to a sustainable health system. Doctors who feel valued and empowered are more likely to thrive and reach their full potential. To this end, we have also published guidance focused on maximising the potential of the existing anaesthetic workforce, ensuring all doctors receive the support they need to succeed in their careers.

Supporting evidence

Flexibility for Stage 2 and Stage 3, 2021 Anaesthetics Curriculum (enclosed)
Maximising Career Progression (enclosed)
Minimising the impact of rotational training
Impact of Parenting on Training in Anaesthesia RCoA, March 2025
A qualitative exploration of stressors in anaesthesia training in the UK and mechanisms to improve resident wellbeing, Anaesthesia 2025 (enclosed)
Factors affecting UK anaesthetic trainees' wellbeing and stress: a scoping review, Anaesthesia 2025 (enclosed)
Wellbeing in anaesthesia training
Data from CLWrota which manages the anaesthetic rota for 131 of 182 NHS organisations (enclosed) - this specifically highlights the service provision that anaesthetic residents provide
Independent practice /moving up supervision levels
Best practice for educational support for SAS, Locally Employed and MTI doctors
Guidance for Training Programme Directors on maximising the use of training slots and minimising gaps
Integrated Academic Training and the 2021 Anaesthetics Curriculum
LTFT TPD guidance
Improving the Working Lives of Doctors in Training

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A report on the welfare, morale and experiences of anaesthetists in training: the need to listen
December 2017

Subtheme 1.3 Flexibility in training

Increasing flexibility and recognising time spent outside formal training programmes are key priorities for the College, as we want to ensure that all doctors, regardless of job title, are supported to progress in their careers. The enclosed *Maximising Career Progression* document outlines a mechanism to support anaesthetists to progress and enter training at the appropriate level, obtain a specialist doctor post, or enter the General Medical Council (GMC) Specialist Register. It proposes allowing relevant experience, gained outside a formal training programme, to count towards curriculum progression at a given stage (up to three years at Stage 1, and up to two years each at Stages 2 and 3).

This initiative will ensure that those sitting outside of national training programmes, or working towards a training programme number, can ensure that the time they spend as Locally Employed Doctors (LEDs) or clinical fellows is used to demonstrate the curriculum or work towards practising as a Specialist Doctor, which will ultimately help expand the pool of trainers. In turn, this will boost training capacity and increase the number of autonomously practising anaesthetists, which is key to reducing waiting lists and staffing our hospitals sustainably for the future. It is also fundamentally essential that all doctors can advance in their careers, whether they hold a National Training Number (NTN) or not.

To help address workforce shortages, we have published *Guidance for Training Programme Directors on maximising the use of training slots and minimising gaps*. This guidance offers principles for managing vacancies resulting from, for example, Dual CCT AiTs undertaking ICM placements, statutory leave, and Out of Programme (OOP) time. Reducing rota gaps not only strengthens service provision but also improves the training environment, easing the burden of cross-cover and limiting reliance on locums.

Current recruitment into training is not perceived as supportive. The process is overly complex, poorly communicated, and under-resourced. A radical overhaul is needed. There is a lack of clarity around who is responsible and accountable for recruitment, creating confusion for applicants and stakeholders alike.

National recruitment is often a doctor's first formal interaction with the NHS and their chosen specialty. A poor experience at this stage can create disillusionment and negatively shape their perception of the profession. In contrast, a more personalised and supportive approach would help doctors feel valued from the outset and reduce unnecessary stress and anxiety during a critical transition in their careers. Recognising the high-stakes nature of the recruitment process, our report *Exploring improvements to the national recruitment process in anaesthetics: recognising the person behind the number* indicates that there is scope, and a requirement, to explore improvements to the recruitment process to make it more personalised, particularly at this early stage of applicants' careers. Suggestions for adopting a person-centred approach include:

- Clear, consistent and human-led communication
- Professional, empathetic approach that recognises the individual at the heart of the process
- Accurate, up-to-date information that is easy to find and understand
- Accessible websites that are regularly updated
- Timely responses to enquiries to reduce uncertainty and stress

- Name and contact details for recruitment officers shared to personalise the process and improve accountability.

Supporting evidence
Guidance for Training Programme Directors on maximising the use of training slots and minimising gaps
Flexibility for Stage 2 and Stage 3, 2021 Anaesthetics Curriculum (enclosed)
Maximising Career Progression (enclosed)
Integrated Academic Training and the 2021 Anaesthetics Curriculum
LTFT TPD guidance
Exploring improvements to the national recruitment process in anaesthetics: recognising the person behind the number April 2025

Theme 2: Training capacity, delivery and quality

Subtheme 2.1 – Preparation for future practice

We believe that the current anaesthesia training programme in the UK leading to CCT provides a robust, comprehensive experience across all areas of anaesthetic practice. It also supports the development of professional behaviours and capabilities aligned with the Generic Professional Capabilities framework. The programme is competency-based and spans an indicative seven years, in addition to the two years of Foundation training. This training is often further enriched by additional opportunities such as fellowships; sub-specialty, out-of-programme experiences (OOP), or post-CCT roles; prior to doctors taking up Consultant or SAS appointments.

The programme includes a structured and supportive system of prospective 'formative' assessments, which ensure that AiTs are progressing appropriately in both capability and pace. These are complemented by summative, retrospective assessments at key stages of training and include postgraduate examinations, the Initial Assessment of Competence (IAC), end-of-placement reviews (e.g. Triple C/ESSR), and the Annual Review of Competence Progression (ARCP). Survey data from AiTs supports the quality and effectiveness of this training model.

Supporting evidence
We have started a 10-year cohort study and will be happy to discuss the initial results with representatives from the Statutory Education Bodies in the summer when we have secured publication. We will be following our cohort up at regular intervals over the coming years. We are somewhat disappointed that this project has not received regional (Kent, Surrey, Sussex) or national support from NHSE, but we will be happy to share the results, and they are welcome to get involved if they would like to provide a contribution towards funding for future iterations.

We will also be embarking upon a further two studies; one to look at preparedness for the role of a consultant on the 2021 curriculum and one comparing anaesthetic training programmes across different systems. We will be writing these up for publication but will also be happy to discuss in due course. We would welcome support from NHSE for this work and would be happy to include them in the study group should they wish to sponsor the project.

Subtheme 2.2 – Quality of the learning environment

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Many operating theatre lists are now led and delivered by Consultants and SAS doctors, providing AiTs with valuable opportunities to work directly alongside senior colleagues. This model supports high-quality patient care while also enabling face-to-face, real-time teaching and hands-on clinical experience.

Similarly, Consultant and SAS-led ward rounds in critical care and pain services create rich teaching opportunities. AiTs can present patients, ask clinical questions, and receive immediate, context-specific feedback and instruction. This 'real-time' clinical training is highly effective, allowing a wide range of clinical and professional skills to be developed and assessed, including verbal communication, teamwork, clinical knowledge, and performance.

However, AiTs also benefit from regular opportunities to practise with distant supervision, honing their own technique and decision-making. The College has provided supporting guidance recommending all AiTs should have such opportunities to lead both elective and emergency work suitable for their Stage of training, in turn freeing up training capacity and clinical capacity to provide more patient care.

Supporting evidence
Guidance on supervision levels and practical measures to develop independent practice in training
Data from CLWrota which manages the anaesthetic rota for 131 of 182 NHS organisations (enclosed) - this specifically highlights the service provision that anaesthetic residents provide.

Subtheme 2.3 – Educator capacity

Educator capacity is an increasing concern across the UK. The time allocated for training within Supporting Professional Activities (SPA) has been progressively eroded. It is now common for anaesthetic consultant posts, particularly in Scotland, to be advertised with only 1 PA, which only covers only revalidation, leaving no dedicated time for educational supervision or training activities. A similar trend is emerging in England, where new consultants are often offered just 1.5 SPA which is insufficient to meet the demands of high-quality training delivery. Furthermore, the training time allocation set out in the Enhancing Supervision for Postgraduate Doctors in Training of 0.25 PA per trainee is being routinely undermined by increasing service pressures. As a result, the ability of consultants to act as effective trainers is being compromised, threatening both the quality and sustainability of anaesthetic education.

The RCoA provides representatives, known as AAC assessors, to participate in interview panels for consultant anaesthetist and SAS anaesthetist roles. The college also manages the approval of job descriptions and person specifications for consultant and SAS grade posts in anaesthesia, intensive care medicine and pain medicine. In general, job plans that adhere to the national terms and conditions of service and 2003 consultant contract are less likely to be contentious than those that depart greatly from these. The College, backed by the Academy of Medical Royal Colleges and Chief Medical Officers of all four nations, requires a minimum of 1.5 core SPAs per week for consultants and specialty doctors, to allow maintenance of competence and revalidation. For LTFT posts the current recommendation is a minimum of 1 SPA. Data is enclosed which provides the breakdown of SPA allocation to posts approved by the college since January 2024.

The RCoA maintains a network of Regional Advisers (RAs) and Deputy Regional Advisers (DRAs), who represent the College in matters related to training and standards within their regions. They work closely with Postgraduate Deans, sit on relevant local committees, and provide expert advice to the

College President and Council on regional training and anaesthetic standards. Their contributions significantly enhance the quality of education, training, and assessment both regionally and nationally.

However, we are increasingly seeing these vital roles remain vacant for extended periods, largely because NHS Trusts are unwilling to allocate SPA time. These are senior clinicians and educators who voluntarily contribute to ARCP panels, specialty training committees, and both core and higher recruitment panels.

The reduction of posts previously funded by NHSE has led to a significant erosion of administrative support for Heads of School, Training Programme Directors and College Tutors. This has had a direct impact on the support available to AiTs, including reduced direct access at Annual Review of Competence Progression (ARCPs). To effectively support medical educators, the following factors should be prioritised:

- Nationally standardised SPA time: Trust-allocated SPA time for educational roles should be formally recognised and consistently applied across all regions
- Robust regional administrative support**:** adequate administrative provision for ARCPs and broader School functions, should be ensured including organisation of educational courses and quality assurance reviews

In addition, RAs and DRAs often review job plans to help address workforce issues, serve as external assessors in consultant recruitment processes, and provide an invaluable, cost-effective educational presence in their regions. Largely this work is done on a voluntary basis, yet it plays a crucial role in maintaining high national standards in anaesthetic training and clinical practice.

Supporting evidence
AAC SPA data (enclosed)

Subtheme 2.4 – Equality, diversity and inclusion

There is currently a two-tier system in place that favours doctors with an NTN, who benefit from structured educational support, including study leave, formal supervision, and access to training opportunities. In contrast, those employed in trust grade, LED, Clinical Fellow, or SAS roles often experience inconsistent and limited access to these same resources. It is vital to realise that training doctors outside of structured NTN routes is not a cheaper option to the NHS. To provide the same amount of training, to the same quality requires the same resources.

It is essential that all doctors in training receive appropriate support, regardless of their post. This involves providing support structures for them to ensure their professional development, however, a key part of the solution could be converting non-NTN posts into NTN posts, where they would benefit from a defined, structured curriculum. The national training programme should continue to serve as the gold standard, and as stated, this is not a more expensive option.

Any review of postgraduate training must take into consideration the changing demographics of the doctors who will be responsible for the care of future patients. It is well documented that women already outnumber men in medical school and as this generation graduates into practice, training programmes must adapt accordingly to reflect and match the needs of these doctors. Future training needs to be flexible, support increasing numbers of LTFT trainees, and accommodate

parental, fertility and caring needs. Additionally, it is essential to examine recruitment and examination success in ethnic minority groups.

Supporting evidence
GMC Differential attainment data
Data on reasonable adjustments (enclosed)
RCoA Reasonable Adjustments Policy and Disability
Autonomy for SAS doctors and guidance on progression from specialty grade to specialist (enclosed)

Theme 3: Enabling and reforming postgraduate medical education to achieve the 3 NHS mission shifts

Subtheme 3.1 – Hospital to community

Anaesthesia services well-suited to this model of care include pre-operative assessment and chronic pain management. While training in chronic pain is well-established in community-based settings, similar opportunities are less consistently available in pre-operative assessment. Expanding training in this area would better align with service delivery models and support the development of well-rounded anaesthetists equipped to manage the full patient pathway.

Supporting evidence
Credential in Specialist Pain Medicine
Perioperative Medicine and Health Promotion as a domain of learning at all stages of the 2021 Anaesthetics curriculum
ACSA good department guide

Subtheme 3.2 – Treatment to prevention

The anaesthetics training programme includes a strong emphasis on health improvement conversations during pre-operative assessments. AiTs are encouraged to engage patients in discussions about lifestyle changes, such as weight loss, nutrition, smoking cessation, and alcohol reduction, as part of optimising their health before major surgery. These proactive conversations are a key component of pre-operative planning and play a vital role in improving surgical outcomes and long-term patient wellbeing.

Supporting evidence
Perioperative Medicine and Health Promotion as a domain of learning at all stages of the 2021 Anaesthetics curriculum

Subtheme 3.3 – Analogue to digital

Artificial intelligence (AI) could play a valuable role in several areas of anaesthetic training and practice. Automated transcription of patient consultations would support accurate documentation and reflective learning. AI could also assist in the creation and marking of exam questions, helping to ensure consistency and reduce administrative burden. Additionally, virtual simulation has significant potential in training for critical incidents and airway emergencies, offering a safe and effective environment to develop and assess clinical decision-making and technical skills.

Supporting evidence
Guidance for simulation-based education in anaesthesia training

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Career expectations and system gaps/issues impacting on satisfaction

It is challenging to provide an organisational response to these sections, as the breadth of options makes it difficult to accurately reflect the collective views of our membership. We have encouraged our members to engage individually with the survey to ensure their views are fully represented.

Further ideas or feedback regarding a model/exemplar design for the delivery of postgraduate medical education

There is a need for a more bespoke and transparent system to recognise all available training opportunities and ensure they are equitably distributed among doctors in the workplace. We propose formally recognising departments for the specific training they can provide to each specialty. This would allow a more accurate and fair allocation of training placements.
Colleges, who represent a free and highly cost-effective resource, should play a more central role in the quality assurance process. At present, this contribution is often overlooked within the deanery-led system. Incorporating College oversight alongside existing mechanisms such as the GMC National Training Survey and the National Education and Training Survey (NETS) would provide a more comprehensive and balanced view of training quality and capacity.