Supervision Levels

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Background

Suggested that

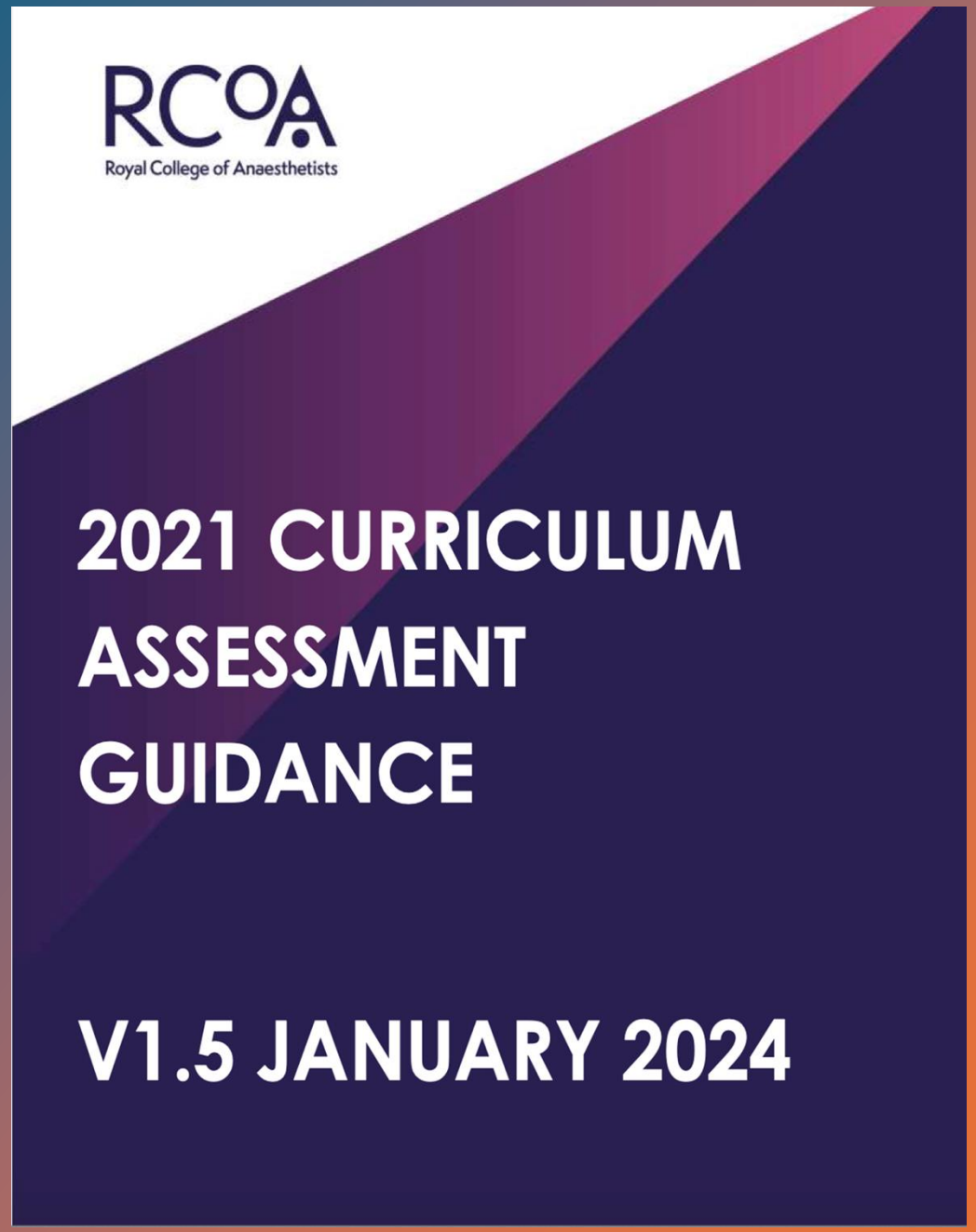
- Entrustment formats may have advantages in terms of authenticity and rigour
- Asking assessors to entrust responsibilities for patient care may link the assessor's judgment more closely to their own duty to uphold standards
- Research indicates such considerations can enable assessors who are might feel otherwise unwilling or unable to fail unsafe or underperforming learners.

(Yepes-Rios et al 2016)

Designing and maintaining postgraduate assessment programmes

Working with doctors Working for patients

General Medical Council

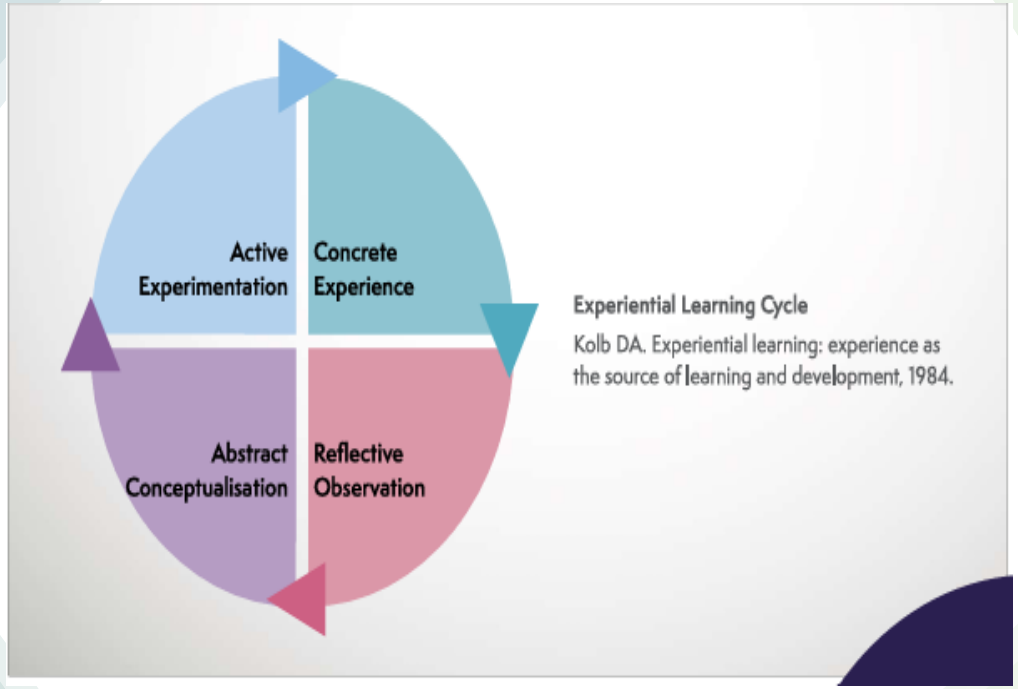


Philosophy of Assessment

- to improve practice by concentrating on the educational potential of assessment through reflection and analysis
- de-emphasising the collection of evidence of achievement
- intentionally weighted towards formative development where we give an account of practice to enable improvement rather than accounting for practice or quantifying achievement
- learner is expected, and should feel confident, to demonstrate a journey of progression

How

- The process that underpins that learning is an experiential cycle of concrete experience, reflective observation and abstract conceptualisation.
- The expectation is that the performance of the anaesthetist in training will improve through repeated cycles of experience, reflection, conceptualisation, and application.
- expert trainer enables reflection and conceptualisation within this cycle, focusing the learner on analysis of their performance in a developmental conversation.



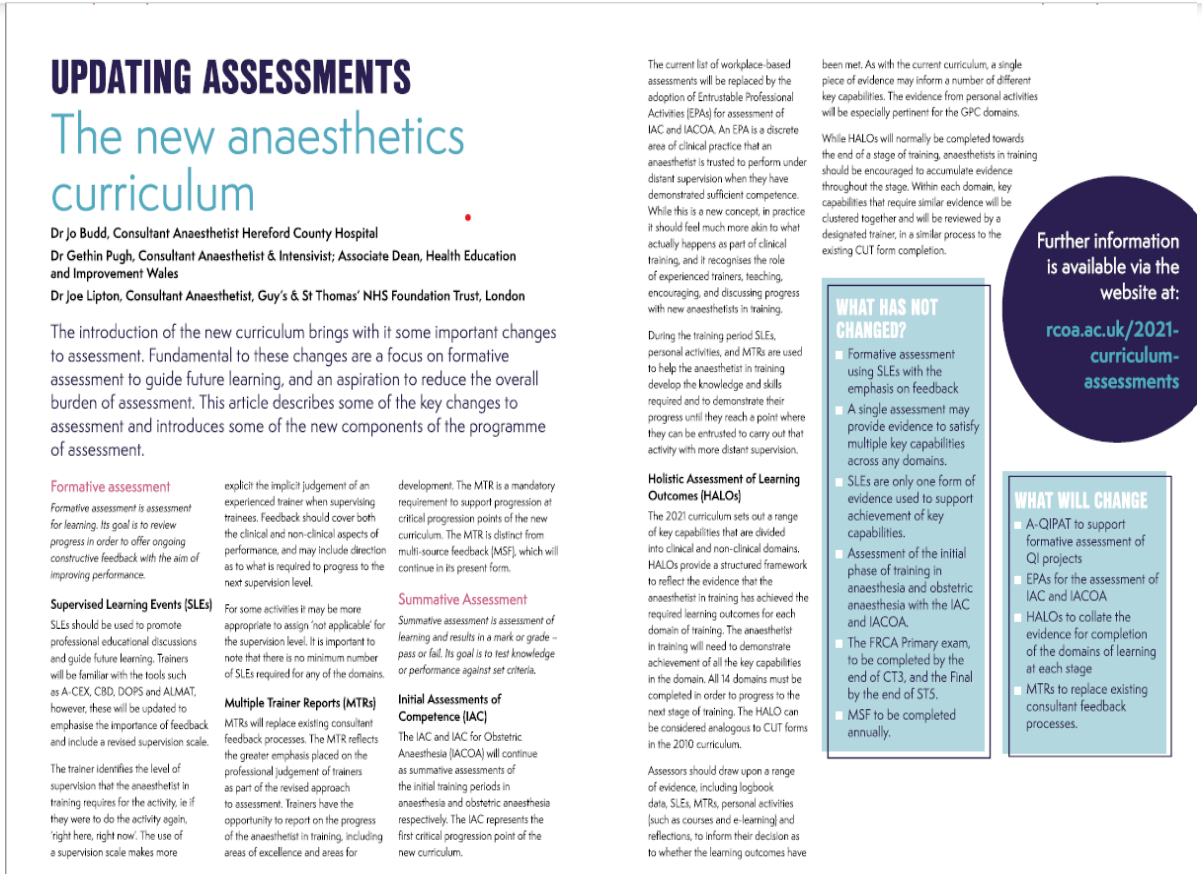
Assessment Strategy for 2021 Anaesthetics Curriculum

Version 1.3

What do assessments do?

- Assess trainee's actual performance in the workplace
- encourage the development of the anaesthetist in training as an adult responsible for their own learning
- enhance learning by providing formative assessment
- enabling the anaesthetists in training to receive immediate feedback, understand their own performance, and identify areas for development
- inform the ARCP process, identifying any requirements for targeted or additional training

Supervised learning events (SLEs)



UPDATING ASSESSMENTS

The new anaesthetics curriculum

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The introduction of the new curriculum brings with it some important changes to assessment. Fundamental to these changes are a focus on formative assessment to guide future learning, and an aspiration to reduce the overall burden of assessment. This article describes some of the key changes to assessment and introduces some of the new components of the programme of assessment.

Formative assessment

Formative assessment is assessment for learning. Its goal is to review progress in order to offer ongoing constructive feedback with the aim of improving performance.

Supervised Learning Events (SLEs)

SLEs should be used to promote professional educational discussions and guide future learning. Trainers will be familiar with the tools such as A-CEX, CBD, DOPS and ALMAT, however, these will be updated to emphasise the importance of feedback and include a revised supervision scale.

The trainer identifies the level of supervision that the anaesthetist in training requires for the activity, ie if they were to do the activity again, 'right here, right now'. The use of a supervision scale makes more explicit the implicit judgement of an experienced trainer when supervising trainees. Feedback should cover both the clinical and non-clinical aspects of performance, and may include direction as to what is required to progress to the next supervision level.

For some activities it may be more appropriate to assign 'not applicable' for the supervision level. It is important to note that there is no minimum number of SLEs required for any of the domains.

Multiple Trainer Reports (MTRs)

MTRs will replace existing consultant feedback processes. The MTR reflects the greater emphasis placed on the professional judgement of trainers as part of the revised approach to assessment. Trainers have the opportunity to report on the progress of the anaesthetist in training, including areas of excellence and areas for development. The MTR is a mandatory requirement to support progression at critical progression points of the new curriculum. The MTR is distinct from multi-source feedback (MSF), which will continue in its present form.

Summative Assessment

Summative assessment is assessment of learning and results in a mark or grade – pass or fail. Its goal is to test knowledge or performance against set criteria.

Initial Assessments of Competence (IAC)

The IAC and IAC for Obstetric Anaesthesia (IACOA) will continue as summative assessments of the initial training periods in anaesthesia and obstetric anaesthesia respectively. The IAC represents the first critical progression point of the new curriculum.

The current list of workplace-based assessments will be replaced by the adoption of Entrustable Professional Activities (EPAs) for assessment of IAC and IACOA. An EPA is a discrete area of clinical practice that an anaesthetist is trusted to perform under distant supervision when they have demonstrated sufficient competence. While this is a new concept, in practice it should feel much more akin to what actually happens as part of clinical training, and it recognises the role of experienced trainers, teaching, encouraging, and discussing progress with new anaesthetists in training.

During the training period SLEs, personal activities, and MTRs are used to help the anaesthetist in training develop the knowledge and skills required and to demonstrate their progress until they reach a point where they can be entrusted to carry out that activity with more distant supervision.

Holistic Assessment of Learning Outcomes (HALOs)

The 2021 curriculum sets out a range of key capabilities that are divided into clinical and non-clinical domains. HALOs provide a structured framework to reflect the evidence that the anaesthetist in training has achieved the required learning outcomes for each domain of training. The anaesthetist in training will need to demonstrate achievement of all the key capabilities in the domain. All 14 domains must be completed in order to progress to the next stage of training. The HALO can be considered analogous to CUT forms in the 2010 curriculum.

Assessors should draw upon a range of evidence, including logbook data, SLEs, MTRs, personal activities (such as courses and e-learning) and reflections, to inform their decision as to whether the learning outcomes have been met. As with the current curriculum, a single piece of evidence may inform a number of different key capabilities. The evidence from personal activities will be especially pertinent for the GPC domains.

While HALOs will normally be completed towards the end of a stage of training, anaesthetists in training should be encouraged to accumulate evidence throughout the stage. Within each domain, key capabilities that require similar evidence will be clustered together and will be reviewed by a designated trainer, in a similar process to the existing CUT form completion.

WHAT HAS NOT CHANGED?

- Formative assessment using SLEs with the emphasis on feedback
- A single assessment may provide evidence to satisfy multiple key capabilities across any domains.
- SLEs are only one form of evidence used to support achievement of key capabilities.
- Assessment of the initial phase of training in anaesthesia and obstetric anaesthesia with the IAC and IACOA.
- The FRCA Primary exam, to be completed by the end of CT3, and the Final by the end of ST5.
- MSF to be completed annually.

Further information is available via the website at: rcoa.ac.uk/2021-curriculum-assessments

WHAT WILL CHANGE

- A-QIPAT to support formative assessment of QI projects
- EPAs for the assessment of IAC and IACOA
- HALOs to collate the evidence for completion of the domains of learning at each stage
- MTRs to replace existing consultant feedback processes.

- Trainers were familiar with A-CEX, CBD, DOPS and ALMAT, however, these were updated to include a supervision scale.
- The trainer identifies the level of supervision that the anaesthetist in training requires for the activity.
- The aim was that use of a supervision scale makes more explicit the implicit judgement of an experienced trainer.
- Feedback should cover both the clinical and non-clinical aspects of curriculum

What are supervision levels?

1, 2a, 2b, 3, 4

Table 3 – The levels of supervision

1	Direct supervisor involvement, physically present in theatre throughout
2A	Supervisor in theatre suite, available to guide aspects of activity through monitoring at regular intervals
2B	Supervisor within hospital for queries, able to provide prompt direction/assistance
3	Supervisor on call from home for queries able to provide directions via phone or non-immediate attendance
4	Should be able to manage independently with no supervisor involvement (although should inform consultant supervisor as appropriate to local protocols

The trainer should identify the level of supervision that the anaesthetist in training requires for that activity at the time the SLE is completed. This is the supervision level the anaesthetist in training would require if they were to repeat that same activity 'right here, right now'.

Why?

- As training moved toward competency-based progression, especially with the 2021 curriculum, there was a need for a clearer, shared language about how independent a trainee can safely be, at any given stage
- Supervision levels emerged to:
  - ❑Standardise expectations across hospitals
  - ❑Protect patients while allowing graded independence
  - ❑Help trainers decide when a trainee is ready to “step up”
- They align with broader NHS training principles and are used alongside assessments like capabilities in practice (CiPs).

How it's applied in training

Supervision levels are not just theoretical—they're actively used in day-to-day training decisions.

Matching trainee to case complexity

A junior trainee (early stage) might:

- Only manage simple elective cases
- Require Level 1–2 supervision

A senior trainee might:

- Run emergency lists or complex cases
- Work at Level 2–3 supervision

Supervision levels are indicative of:

Capability-based progression

Instead of just “time served,” trainees must demonstrate they can safely perform tasks with less supervision.

For example:

- Managing a routine general anaesthetic may progress from Level 1 → Level 3 over time
- Managing major trauma may remain at Level 2a or 2b even for senior trainees

Context matters

Supervision level isn’t fixed—it changes depending on:

- Patient complexity (ASA status, comorbidities)
- Procedure type
- Time of day (overnight vs daytime)
- Trainee experience

A trainee might be:

- Level 3 for a straightforward case
- Level 1 again for a difficult airway

Let's consider some examples

Example 1: First few months of training

A new trainee inducing anaesthesia for a routine hernia repair:

- Consultant is standing next to them
- Level 1 supervision

They talk through each step:

- Drug choice
- Airway management
- Monitoring

Let's consider some examples

Example 2: Trainee (3-6 months) in the Same case:

- Consultant steps out but stays nearby
- Trainee pre-assess, induces and maintains anaesthesia independently
- Level 2a/2b supervision: Consultant may pop in periodically or be called if needed.

Example 3: Trainee doing independent 1st on call overnight (9-24 months)

Emergency appendicectomy:

- Consultant at home but available by phone and can come in
- Trainee runs the case by consultant, discusses perioperative plan
- Level 3 supervision

Consider a complex case. Major emergency vascular

Consultant present throughout key parts

- Back to Level 1 or 2a, despite seniority

Why this system matters

- Patient safety: ensures appropriate oversight
- Clarity: everyone understands expectations
- Progression: gives trainees a roadmap toward independence
- Consistency: reduces variation between hospitals

Think of supervision levels as a sliding scale, not a ladder:

- *You don’t permanently “unlock” a level*
- *You move up or down depending on the situation*

How supervision levels inform ARCP

At ARCP, panels look for evidence that a trainee:
Need less supervision over time
Can handle greater complexity safely
Early training (CT1–CT2)
• Most work at Level 1–2b
• Goal: safe basic anaesthesia with close supervision
ARCP Outcome 1 = progressing normally
Trainee **not expected** to be independent yet

How supervision levels inform ARCP

CT3/4 and early registrar training years in Stage 2

- Increasing Level 2b → Level 3 work
- Start managing:
  - Emergency cases
  - On-call work
  - Elective cases

👉 ARCP looks for:

- Evidence trainee can function with indirect supervision
- Safe decision-making

How supervision levels inform ARCP

Higher training (Stage 3)

- Majority of work at Level 3
- Consultant steps back significantly

To complete training trainee:

- must demonstrate that he/she can perform with distant supervision (Level 3) consistently

End of training (CCT readiness)

- Essentially functioning like a new consultant
- Level 4 (independent) in most areas

More examples

Obstetric anaesthesia
Early placement: Epidural placement → Level 1
Mid-placement: Epidurals + simple C-sections → Level 2a/2b
End Placement: Running labour ward overnight → Level 3, triple C
ICU (critical care)
Stage 1, early stage 2:
Managing intubation/ventilation in patient on ICU/Resus → Level 1–2a/2b
Stage 3:
Leading ward rounds, escalation decisions → Level 3 plus
Regional anaesthesia
First nerve blocks → Level 1/ 2a
Competent practitioner → Level 2b/3
Advanced blocks independently → Level 3/4

“How much do I need to watch this trainee to keep the patient safe?”

Trainer should consider:

- Technical skills
- Situational awareness
- Decision-making
- Ability to recognise and manage complications

Positive Vs Negative signals

Strong signals for progression

- “Minimal input required”
- “Recognises own limitations”
- “Appropriate escalation”
- “Safe decision-making at distance”

Concerning signals

- “Needs frequent prompting”
- “Fails to recognise deterioration”
- “Overconfident / delayed escalation”
- “Requires direct supervision for routine cases late in training”

CT1 managing induction for laparoscopic appendicectomy

- **Trainee conducted GA for ASA 1 patient undergoing laparoscopic appendicectomy, including pre-op assessment, induction, airway management, and emergence.**
- **Structured and systematic approach to pre-operative assessment, no significant comorbidities and formulated an appropriate anaesthetic plan. Induction was performed safely with good attention to pre-oxygenation and drug dosing. Airway management was achieved with minimal prompting, with appropriate positioning and confirmation of endotracheal tube placement.**
- **Intraoperative management was stable, demonstrated situational awareness, adjusting volatile agent and analgesia appropriately. Emergence was well managed with good communication with the theatre team.**
- **Prompting was required to optimise neuromuscular blockade and its monitoring and planning for PONV prophylaxis.**
- **Supervision level justification:**
- **This performance is consistent with Level 2A supervision – the trainee is developing independence but benefits from close supervision and intermittent input at key stages.**

Action plan:

- **Continue to consolidate routine GA skills**
- **Focus on independent decision-making around antiemetics and NMB choice and monitoring**
- **Repeat similar cases with decreasing prompts**

Spinal anaesthesia for hip fracture (CT4/ST4) for ACEX

- Trainee demonstrated good communication and consent-taking, clearly explaining risks and benefits of spinal anaesthesia to the patient. Aseptic technique was appropriate throughout.
- Spinal insertion in lateral position, required some redirection but was ultimately successful. The trainee appropriately assessed block height and recognised the need for additional analgesia/sedation intraoperatively.
- They showed good awareness of haemodynamic effects and treated hypotension promptly and appropriately.

Supervision level:

Level 2B – able to perform independently with supervisor available in the hospital.

Development points:

- Improve first-pass success with spinal technique considering variations in spinal anatomy
- Anticipate hypotension earlier and pre-emptively manage
- backup plan for additional analgesia if necessary

The Senior Registrar ST 6/7 for ACEX

- Out of hours case (you are at home)
- Elderly, ASA 3 patient
- Emergency Laparotomy / bowel resection (perforation)
  - Trainee has called you to inform you about the case + discussed plan, risk discussion with NOK along with surgical team.
- Appropriate monitoring, fluid resuscitation, inotropes etc.
- Patient has a brief cardiac arrest intra-op (VT) - treated appropriately
- Patient goes to ICU post op - ultimately dies a few weeks later

Supervision Level:

4, trainee is functioning at near-consultant level but appropriately seeks senior input in high-risk scenarios.

Action plan:

- Continue to refine independent decision-making in complex emergency cases
- Develop confidence in leading perioperative team fully autonomously

Difficult airway (CT4)

The trainee recognised difficulty with laryngoscopy but was initially slow to call for help. With prompting, he/she transitioned to an alternative airway plan and successfully secured the airway.

Trainee demonstrated knowledge of the difficult airway algorithm but required guidance in its timely application.

Supervision level:

Level 2A for this scenario – requires direct / local supervision for airway management in potentially difficult cases.

Action plan:

- **Simulation training for difficult airway scenarios**
- **Emphasis on early escalation and declaring difficulty**
- **Repeat supervised airway cases**

Phrases trainers can consider to use when explaining supervision levels

🔷 **When Describing performance**

- “Demonstrated a structured and systematic approach”
- “Maintained situational awareness throughout”
- “Required minimal prompting”
- “Appropriately escalated concerns”
- “Anticipated and managed complications effectively”

🔷 **When Linking to supervision**

- “Consistent with Level X supervision”
- “Able to perform with indirect or remote supervision”
- “Would benefit from continued close supervision in…”

🔷 **When Development framing**

- “Next step is to develop greater independence in…”
- “Focus on anticipating rather than reacting to…”

Entrustment rating = the level of supervision the trainee would need if they were to do the same case again

It *does not* need to be the level of supervision that was actually provided for the case.

Level 1 - Direct supervisor involvement, physically present in theatre throughout

A quick coffee from the theatre coffee room between cases

Level 2a - Supervisor in theatre suite, available to guide aspects of activity through monitoring at regular intervals

Time to enjoy a decent coffee within the theatre complex

Level 2b - Supervisor within hospital for queries, able to provide prompt direction/assistance

Time for a leisurely trip to Costa

Level 3 -Supervisor on call from home for queries, able to provide directions via phone or non-immediate attendance

A relaxing coffee on your sofa at home

Level 4 - Should be able to manage independently with no supervisor involvement
(although should inform consultant supervisor as appropriate to local protocols)

Tuck yourself in; the trainee is working at the level expected of a consultant