Royal College of Anaesthetists

10 Year Workforce Plan: RCoA submission

Productivity gains from wider 10 Year Health Plan implementation

Anaesthetists are key to delivering the government's ambition of a 2% year-on-year productivity gain in the NHS. [1] They provide essential and flexible care across a range of hospital settings, and crucially, most operations cannot take place without them. As such, anaesthetist numbers are a fundamental rate-limiting factor to NHS productivity in the surgical pathway.

The consequences of current anaesthetic workforce shortages are dire and likely constitute the main reason why efforts to tackle the surgical backlog have proven so challenging.

We estimate that addressing the current shortfall of 1,766 anaesthetists in England could enable an additional **1.3 million operations and procedures** to go ahead each year. [2] This covers not only elective operations, but also anaesthetic procedures in urgent and emergency care, maternity, and general pain relief services.

Currently, over four in 10 clinical leaders (43%) who responded to the RCoA 2025 census reported operations being postponed on a daily or weekly basis due to anaesthetic workforce shortages. Only 11% reported no delays. [2]

Furthermore, boosting anaesthetist numbers was the most commonly cited factor by clinical leaders that could boost the rate of elective surgery. Almost seven in 10 clinical leaders identified this factor (68%). This is above physical factors such as ward space (identified by 50%) and operating theatres (42%), and other staffing groups such as operating department practitioners (55%) and surgeons (10%). Less than 1% of clinical leaders felt that increasing anaesthesia associate (AA) numbers was an important factor – suggesting there is a very specific need for doctor anaesthetists. [2]

The need for doctor anaesthetists rather than AAs has been reinforced by a separate survey of clinical leaders, which identified only three sites in the UK that are planning to recruit more AAs (between them a total of 7 AAs).

The solution is to train more anaesthetists. There is a shortage of anaesthetists, but there is no shortage in the number of doctors wanting to train to be anaesthetists. Many doctors are eager to specialise in anaesthesia, but there simply aren't enough funded training posts, creating a huge bottleneck between foundation and core training. In 2025, there were 6,770 applications for 539 core (CT1) anaesthetic training posts – a competition ratio of 12.6:1, almost doubling from the previous year (6.5:1 in 2024). [3]

Thankfully, there is ample capacity in the system to train more anaesthetists. Our 2025 census results suggest capacity for 178 additional CT1 anaesthetics posts per year, and 206 additional ST4 posts across the UK. In England, there is capacity for 147 CT1 posts and 171 ST4 posts (on top of the 70 additional places initially granted in 2022 and confirmed for this year). [2]

Anaesthetists in training can deliver rapid expansion of anaesthetic care. It often takes as little as six months from the time they start core anaesthetics training to the point where they are providing a level of independent clinical service with distant supervision. Our 2025 census revealed that CT1-3 anaesthetists work on over 1,000 cases per year. Therefore, training more anaesthetists could rapidly boost NHS productivity. [2]

On top of this, anaesthetists are also essential to wider initiatives to enhance NHS productivity by leading and driving the provision of perioperative care in hospitals. This is outlined in detail in our response to the three shifts section of this consultation.

Actions taken to identify and address gaps in training that support the delivery of the three key shifts

To ensure the anaesthetic workforce can deliver the three shifts, perioperative medicine and health promotion are embedded at every stage of the anaesthetic training curriculum. Completion of Level 1 and 2 training requires mandatory training in perioperative care, with anaesthetists gaining experience across various hospital sites.

Many anaesthetists also complete a Level 3 Special Interest Area (SIA) in perioperative care for a period of three to six months to develop specialist skills. This gives anaesthetists thorough training in the clinical management of patients before and after surgery, and how to develop, lead, deliver, maintain and evaluate these services. [4]

As a result, the anaesthetic workforce is already highly trained, skilled and experienced in managing the delivery of perioperative services, which are key to implementing the 10 Year Health Plan's three shifts.

Modelling assumptions

Anaesthetists are central to the delivery of the ambitions of the 10 Year Health Plan. Without anaesthetists, most operations cannot take place. As such, productivity in the surgical pathway cannot be improved without them. They are also critical for the delivery of the three shifts. It is essential, therefore, to ensure that the NHS has sufficient numbers of anaesthetists to meet its needs.

Workforce modelling

To inform workforce modelling, every five years the RCoA conducts a census to gain an accurate and up-to-date understanding of the state of the anaesthetic workforce across the UK. Total headcount, shortfall, and training capacity figures are drawn from data submitted by clinical leaders who run anaesthetic departments and college tutors, who oversee the education of anaesthetists in training.

The clinical leaders' survey collects counts of anaesthetists broken down by consultants, Specialist, Associate Specialist, and Specialty (SAS) doctors, Locally Employed doctors (LEDs) and anaesthesia associates (AAs). It also collects anaesthetic workforce shortfall figures. Clinical leaders are asked about the funded and aspirational gap at their hospitals. The funded gap represents how many funded but unfilled posts they have. The 'aspirational' gap is where clinical leaders report how many additional staff they would need to meet the demand their hospitals are facing, over and above the number of funded vacancies. These two figures are combined to produce an overall shortfall figure.

The college tutors' survey gathers information on the number of anaesthetists in training (AiTs) and, crucially, on what capacity hospitals would have to take on more AiTs if funding were available.

Our most recent 2025 census shows that the number of anaesthetists has grown moderately, with steady increases seen year on year. Across the UK, there are currently 11,874 consultant and SAS anaesthetists, a 17% increase since our last census in 2020. England has a workforce of 9,981 consultant and SAS anaesthetists, an increase of 18% since 2020. [2]

Despite this growth, and considerable work to improve efficiency, these numbers are still way below what is needed, and demand continues to outstrip supply – likely driven by factors including the UK's growing and ageing population, increasing demand for surgery, and the expanding role of anaesthetists in the delivery of perioperative care.

In total, as reported through the census of those working on the frontline within the NHS, the UK has an overall shortfall of 2,147 consultant and SAS anaesthetists, 15% below what is needed to meet demand. This has worsened from a shortfall of 1,483 (13% below what was needed to meet demand) in 2020. [2]

In England specifically, there is now a shortfall of 1,766 (15%) anaesthetists, compared to 1,165 (12%) in 2020. [2] Unfortunately, given that the number of entry level (CT1) anaesthetic training posts has remained relatively static, and that anaesthetists continue to leave the workforce, without urgent action, the shortfall will likely continue to grow.

A key consequence of the lack of anaesthetists is the inability of the NHS to deliver extra productivity in the surgical pathway – indeed, our clinical leaders' results showed that 89% of NHS sites had experienced delayed surgery due to a lack of anaesthetists, and 43% were experiencing this on a daily or weekly basis. [2]

The shortage of anaesthetists is also contributing to the national shortage of pain medicine specialists, resulting in service shortfalls across many areas of the UK. Many anaesthetists progress to train as specialists in pain medicine, and the RCoA hosts the Faculty of Pain Medicine (FPM), which oversees training, assessment, and professional standards of this profession. A recent Gap Analysis Review conducted by the FPM found that 60% of services are unable to fully meet the core standards for pain management. [5] Four aspects of chronic pain provision were identified as requiring urgent attention: paediatric services, cancer pain, research and development, and outcome data.

To help expand this workforce, future workforce planning must recognise and support training in pain medicine – not only for anaesthetists, but also for other related specialties such as palliative care, neurology, rheumatology and rehabilitation medicine.

Corroborating findings: British Journal of Anaesthesia

Alternative methodologies used to estimate the anaesthetic workforce gap have produced results remarkably similar to ours. A paper published in the British Journal of Anaesthesia last year estimated the workforce gap at around 2,000 by analysing the number of operating theatres in the UK and the average number of anaesthetists needed to staff them. [6]

Future projections: York Health Economic Consortium (YHEC)

In 2021, the RCoA commissioned the York Health Economic Consortium (YHEC) to project future supply and demand for anaesthetists in the UK. [7] YHEC identified three key drivers of increasing demand:

- Demographic change: they predicted the UK's growing and ageing population.
- Expansion of surgical interventions: the availability of new surgical procedures.
- Expansion of anaesthetists' role: anaesthetists' increasing involvement in new services, particularly perioperative care.

YHEC projected a year-on-year worsening of anaesthetic workforce shortfall up to 2040. While the most dramatic end of the YHEC projections appears to have been avoided due to a degree of anaesthetic workforce growth, the factors it identified as increasing demand remain very real – and the need for anaesthetists has increased and will undoubtedly increase further.

The three shifts

The 10 Year Health Plan for England sets out the government's ambition to reinvent the NHS. Key to this are three shifts: hospital to community, analogue to digital, and sickness to prevention. Anaesthetists are essential to the successful delivery of these changes.

Anaesthetists are the largest single group of hospital doctors. They are a highly skilled and flexible workforce who are central to the delivery of care across a wide range of hospital settings, including operating theatres, intensive care units, emergency departments, pain services, and maternity wards. Crucially, they lead the delivery of perioperative care - which encompasses the care patients receive before, during and after surgery. Interventions during this period are key to tackling avoidable inefficiencies across the surgical pathway, including:

- **Unnecessary operations:** operations benefit most patients, but about one in seven patients regret their operation. [8] Non-operative options – such as physiotherapy for knee pain - may be more suitable and can be provided in community settings.
- **Extended hospital stays:** with poor preparation and planning, patients can stay up to 1-2 days longer than necessary in hospital after surgery, delaying their return to the community. [9]
- **Cancellations and postponements:** 9% of elective surgical appointments are postponed and 10% are cancelled, undermining productivity and leaving gaps on lists that could have been used to reduce waiting lists. [10]

- **Complications:** Complications, many of which are avoidable, occur in around 12% of operations, incurring unnecessary expense and demands on resources. [11]
- **Readmissions:** nearly 12% of readmissions to hospital are preventable, when these patients could have been managed in the community. [12]
- **Care failures:** NHS England compensation payments due to care failures have reached a record sum of £3 billion – 1.7% of the entire NHS budget. [13]
- **Avoidable future health service demand:** opportunities to embed prevention and long-term behavioural change (e.g. through 'teachable moments') at critical points in the surgical pathway are too often missed.

In this submission, we will set out how initiatives that anaesthetists drive and manage can tackle these inefficiencies and deliver the three shifts.

From sickness to prevention

The 10 Year Health Plan rightly acknowledges that secondary prevention could bring rapid health and economic impacts. Anaesthetists are already playing a leading role in this work through the conversion of waiting lists into 'preparation lists'.

Many patients on the surgical waiting list are in an avoidably poor state of health. They may have unaddressed comorbidities (such as diabetes or high blood pressure), unhealthy lifestyle behaviours (such as smoking, excess drinking, poor diet, low physical activity), or are becoming increasingly frail. However, time on the waiting list provides an opportunity to better prepare patients for surgery through the delivery of secondary prevention.

Anaesthetists have been driving initiatives such as early screening of surgical patients. This involves assessing their health status and unhealthy behaviours as soon as they join the waiting list. These poorly managed health conditions and unhealthy behaviours can impact patients' suitability for surgery and the success of any prospective operation. If patients are found to have addressable health issues, they are offered targeted support. This can be through medical optimisation to address issues including anaemia and diabetes, or 'prehabilitation' programmes, which can provide support for exercise, smoking cessation, improved nutrition and much more.

Referral to surgery is also a unique 'teachable moment' to embed change. It is a time when patients are highly motivated to improve their health, and are in contact with senior doctors, such as anaesthetists, who can deliver positive health messages and help coordinate a range of services to support health optimisation. Utilising this moment has been demonstrated to lead to long-term behaviour change. For example, research shows that patients in prehabilitation programmes report positive lifestyle behavioural changes, with 48%-75% increasing physical activity, 43% stopping smoking, and 40% reducing alcohol consumption. [14]

Preparing patients for surgery has also been shown to reduce complications by up to 50% and length of stay by 1-2 days, supporting patients' long-term recovery and decreasing the risk they will have to return to hospital for further treatment. [9] As a result, such programmes could, and should, be a key pillar of secondary prevention. Anaesthetists have the skills, training and depth of experience to manage and deliver these services.

Once qualified, some anaesthetists choose to specialise in pain medicine. Pain medicine specialists are doctors who are specially trained, qualified and revalidated so that they can offer

integrated, expert assessment and management of acute and chronic pain conditions. Through various workstreams, they are already contributing to the delivery of the 10 Year Health Plan shifts, including prevention.

Chronic pain affects one in three people over the age of 16, and one in five children, impacting their quality of life and placing significant strain on both health and social care services. [15] Pain medicine specialists are essential not only in managing pain but also in preventing it from becoming chronic. They treat patients experiencing acute pain using a combination of physical, psychological, and interventional approaches. Through comprehensive assessments and personalised treatment plans, they support patients to manage their pain, improve function, and reduce the risk of it becoming chronic.

These interventions can significantly enhance patients' long-term health outcomes and overall quality of life. To support this work, Getting It Right First Time (GIRFT) is collaborating with the Faculty of Pain Medicine and British Pain Society to develop a structured model of care. This aims to ensure patients receive personalised, holistic, and evidence-based support. [15]

From hospital to community

By shifting care from hospitals to the community, the 10 Year Health Plan outlined how "personalisation and convenience will become the default". [1] Improving perioperative care is essential to deliver this shift. Interventions before and after surgery are helping to reduce the demand for hospital services and provide care in the community.

As outlined above, anaesthetists are helping to transform waiting lists into 'preparation lists.' Key to this is supporting patients to address unhealthy behaviours through targeted prehabilitation interventions such as smoking cessation, exercise programmes, psychological preparation, and dietary advice. Critically, these services can be provided in the community. Examples include local stop smoking services or exercise classes at leisure centres. Anaesthetists are key to coordinating this by identifying patients who require support through early screening and then referring them to appropriate services. As such, patients can be supported in their own communities to prepare for surgery and improve their outcomes in a convenient setting that fits around their lives.

For example, Manchester University NHS Foundation Trust refers cancer patients to the Prehab4Cancer programme, which provides free exercise, nutrition and wellbeing support in leisure facilities across Greater Manchester. [16] Sherwood Forest Hospitals have also partnered with Nottinghamshire County Council and 'Active Notts' to deliver a range of community-based prehabilitation services, such as the Healthy Life Programme, which gives patients access to a personal trainer, local gyms and swimming pools.

Other perioperative interventions are already delivering the 10 Year Health Plan's ambition to shift care away from hospitals. By shortening the length of hospital stay and preventing readmissions, they are reducing demand on hospitals and supporting patients to recover in the community.

Increased use of day case surgery is a critical initiative being driven forward with the support of anaesthetists. Day case surgery is where patients arrive at hospital, have their operation, and leave on the same day. Over the past five years, the number of operations delivered as day

cases has grown significantly, facilitated by perioperative teams led by anaesthetists. For example, Laparoscopic Cholecystectomy (surgery to remove the gallbladder) previously required patients to stay in hospital for 2-3 days but is now widely delivered as a day case operation. Day case rates increased from 16% in 2008/9 to 64.8% by 2023, with many centres already achieving rates above 75%. [17] Many other procedures are now routinely delivered as day cases, with the British Association of Day Surgery (BADS) directory of procedures continually growing to reflect this shift. This is essential to reduce hospital stays and enable patients to return to the community more quickly.

Poor discharge planning can result in patients staying in hospital longer than medically necessary and heightens the risk of hospital readmissions. Anaesthetists are leading perioperative care teams to work with patients to plan discharge arrangements before patients have their surgery. This enables patients to return to the community far faster and has been shown to reduce readmission rates by 11.5%. [12]

Anaesthetists are also coordinating support for patients to Drink, Eat, and Mobilise (DrEaM) as soon as possible after surgery. DrEaMing within the first 24 hours of surgery reduces the length of hospital stay by 37.5%, enabling patients to return to the community sooner. [18]

In relation to anaesthetists who specialise in pain medicine, many pain services are already delivered in community-based settings, such as GP practices or community healthcare centres – and this has increased over time. They work in partnership with primary and community care professionals to help develop local care pathways that support integrated, patient-centred management of pain. In doing so, pain medicine specialists are already embodying the shift from hospital to community.

By further supporting sustainable models of working across all levels of care, such as community, primary, specialist, and mental health services, the workforce plan can help maximise the reach and impact of pain medicine expertise. This will enhance the quality, accessibility, and continuity of pain management for patients within their own communities.

From analogue to digital

Perioperative care teams across the UK have already started developing and implementing digital innovations that can be scaled to deliver the shift from analogue to digital.

Digital platforms for early screening bring together patients' health information as soon as they join the waiting list. For example, Guys and St Thomas' NHS Foundation Trust, East Kent Hospitals University NHS Foundation Trust and various trusts in the North-East of England are either developing or already utilising such digital platforms. These integrate patients' health information from numerous sources, such as their primary care records and surgical waiting lists, into a digital platform accessible to anaesthetists and other medical staff. This enables anaesthetists to swiftly assess patients' health status and triage them onto appropriate care pathways. Lower-risk patients can follow simpler care plans, while higher-risk patients can be identified and offered support to improve their health before surgery. As a result, this serves to streamline patient care and reduce delays.

As leaders of perioperative care teams, anaesthetists are vital to integrate and scale new technologies such as this into clinical pathways.

Culture and values

Positive workplace culture and strong leadership are key to empowering staff to deliver the best quality care.

Improving retention and staff wellbeing

The RCoA 2025 census revealed that one in five anaesthetic staff (20%) do not expect to still be working in the NHS in five years, and a further 21% are unsure. Aside from pay, the top three factors that would encourage them to stay were improved ability to progress in their career/ training, more flexible working hours and changes to pension taxation regulations. [2]

A lack of career progression and training is likely contributing to poor wellbeing among LEDs. In the 2025 census, LEDs consistently reported the lowest scores across wellbeing measures. Life satisfaction averaged 6.1 (on a scale from 0, not at all, to 10, completely), compared to 7.0 for the overall anaesthetic workforce. Sense of life being worthwhile scored 6.5, versus 7.5 overall. Happiness averaged 6.2, compared to 7.0 for the wider workforce. [2]

These findings suggest a link between career development opportunities and staff wellbeing and retention. To address this, we must invest in training and career progression pathways – and the most important way of doing this would be funding more specialty training posts in anaesthesia.

The support and rigour of the anaesthetic curriculum within national training programmes equips doctors to become consultant anaesthetists with the professional and speciality-specific capabilities to lead across diverse clinical settings. Stage 3 training specifically prepares anaesthetists for leadership roles, management responsibilities, and the ability to teach, train, and supervise others. SAS doctors are also a vital part of the trainer workforce. However, to ensure we have enough trainers to meet future demand, we must train more anaesthetists.

Other pathways exist, for example, the portfolio pathway – which is important – but should not be viewed as a replacement for national training programmes. Nor would it be cheaper to provide training in such a way. To provide the same quantity and quality of training costs the same amount, whether within national training programmes or outside them.

Additional comments

Anaesthetists are critical to delivering the 10 Year Health Plan's productivity targets and three shifts. As the largest single group of hospital doctors, they enable almost every operation, and through perioperative care, they contribute to secondary prevention and help reduce demand on hospitals.

However, England faces a shortfall of 1,766 anaesthetists - 15% below what is needed to meet demand - preventing around 1.3 million operations and procedures annually. This is severely undermining NHS productivity. In our census, 43% of clinical leaders who responded reported daily or weekly postponements of operations due to a lack of anaesthetic staff, while 68% identified increasing anaesthetist numbers as the top priority for boosting elective activity. [2]

The solution is to train more anaesthetists. Demand for training posts far exceeds supply, with a huge bottleneck between foundation and core training. In 2025, 6,770 applicants competed for just 539 core anaesthetic training places – a ratio of 12.6:1, nearly double that of 2024 (6.5:1 ratio). At higher anaesthetic training, 699 applicants applied for 423 posts (1.6:1 ratio). [3]

There is considerable capacity within the training system to accommodate extra posts. Our 2025 census indicates capacity for 147 additional CT1 posts and 171 ST4 posts in England - beyond the 70 extra places granted in 2022 and maintained this year. [2] We just need government funding.

Anaesthetists already embody the prevention-focused, community-integrated, digitally enabled NHS envisioned in the 10-Year Plan. As such, investment in their training is essential to transform the NHS.

References

[1] Department of Health and Social Care, "10 Year Health Plan for England: fit for the future," Gov.UK, 2025.

[2] Royal College of Anaesthetists, "Anaesthetic Workforce Census 2025: Key Interim Findings," RCoA, 2025.

[3] NHS England, "Competition Ratios for 2025," NHS England, 2025. [Online]. Available: https://medical.hee.nhs.uk/medical-training-recruitment/medical-specialty-training/competition-ratios/2025-competition-ratios. [Accessed 05 11 2025].

[4] Royal College of Anaesthetists, "2021 Curriculum for a CCT in Anaesthetics," RCoA, 2021.

[5] Faculty of Pain Medicine, "Gap Analysis of UK Pain Services 2025," FPM, 2025.

[6] S. B. Hanmer, M. H. Tsai, D. M. Sherrer and J. J. Pandit, "Modelling the economic constraints and consequences of anaesthesia associate expansion in the UK National Health Service: a narrative review," *British Journal of Anaesthesia,* vol. 132, no. 5, pp. 867-76, 2024.

[7] C. Collins and N. Hex, "Demand and Capacity Analysis for the UK Anaesthetic Workforce 2020-2040," York Health Economics Consortium, 2021.

[8] C. Snowden and M. Swart, "Anaesthesia and Perioperative Medicine: GIRFT Programme National Specialty Report," NHS England, 2021.

[9] Centre for Perioperative Care, "Impact of perioperative care on healthcare resource use," CPOC, 2020.

[10] NHS England, "Postponements and Cancellations Audit," NHS England, 2025.

[11] M. Bolliger, J. Kroehnert, F. Molineus, D. Kandioler, M. Schindl and P. Riss, "Experiences with the standardised classification of surgical complications (Clavien-Dindo) in general surgery patients," *Eur Surgery,* vol. 50, no. 6, pp. 256-261, 2018.

[12] C. E. Jones, R. H. Hollis, T. S. Wahl, B. S. Oriel, K. M. F. Itani, M. S. Morris and M. T. Hawn, "Transitional care interventions and hospital readmissions in surgical populations: a systematic review," *American Journal of Surgery,* vol. 212, no. 2, pp. 327-35, 2016.

[13] L. Darzi, "Independent investigation of the NHS in England," Department of Health and Social Care, 2024.

[14] L. Pearce, "Surgery school speeds up patients' recovery," *Nursing Standard,* vol. 35, no. 8, pp. 54-56, 2020.

[15] Getting it Right First Time, "Chronic Pain," 2025. [Online]. Available: https://gettingitrightfirsttime.co.uk/medical_specialties/chronic-pain/. [Accessed 05 11 2025].

[16] L. Terry, "Prehab4Cancer programme cuts treatment time for cancer patients," CLAD news, 29 03 2022. [Online]. Available: https://www.cladglobal.com/news.cfm?codeid=349298#:~:text=The%20wider%20impact%20of%20the,over%20the%2012%20week%20period. [Accessed 08 09 2025].

[17] D. Bunting, K. Russon, A. Wheeler, I. Smith, D. McWhinnie, M. Skues, C. Hammond, M. Deakin and G. Toogood, "Laparoscopic Cholecystectomy," The British Association of Day Surgery, 2024.

[18] NHS England, "Commissioning for quality and innovation (CQUIN): 2023/24 guidance," NHS England, 2023.