Royal College of Anaesthetists

enventure research

Anaesthetic Workforce Census 2025

Improving Productivity: Perioperative Care, IT, & Pensions

Contents

1 Executive summary

Background

Improving the productivity of NHS services is high on the agenda of each of the four UK nations – and anaesthetists are vital to achieve it. Without anaesthetists, most operations could not happen, women would go without epidural pain relief, and many of those enduring chronic pain would continue to suffer. As such, a large amount of NHS productivity is dependent on the productivity of the anaesthetic workforce.

In April 2025, working with Enventure Research, the Royal College of Anaesthetists (RCoA) surveyed anaesthetists and physician assistants in anaesthesia (PAAs) working in the UK, as part of the RCoA Workforce Census 2025. As part of this, respondents were asked about three areas that relate to their productivity: their involvement in perioperative care, the IT systems they use, and the impact of the current pension taxation regime.

Methodology and response summary

The RCoA Workforce Census 2025 involved three large surveys, one that went to clinical leaders in anaesthesia, one that went to college tutors, and one that went to the wider anaesthetic workforce. The results displayed in this report largely come from the survey of the wider anaesthetic workforce – although a few key results from the other two surveys are incorporated at certain points.

The survey of the wider anaesthetic workforce was conducted online between 24 March and 5 May 2025 as part of the RCoA Workforce Census 2025. Email invitations and reminders were sent to all members and PAAs who had provided their email address to the College and opted in to receiving relevant survey work.

In total, 2,797 responses were received, representing a 15% response rate. For the purposes of analysis, responses from Crown Dependencies and student PAAs have been excluded.

The survey adopted a self-selecting approach, meaning participants opted in voluntarily. As such, findings should be interpreted with this mind. However, results have been weighted by staff group to be representative of the workforce profile.

Summary of key findings

Perioperative care services

- Pre-existing evidence shows that the provision of better perioperative care – all the care that patients receive around their operation – can increase NHS productivity by reducing rates of surgical cancellations and complications and shortening the length of time patients need to spend in hospital.
- 78% of anaesthetic staff reported personally delivering at least one perioperative care service, rising to 90% if preoperative assessment on the day of surgery is included in the analysis.
- 85% of anaesthetic staff reported delivering preoperative assessment on the day of surgery, making it the most common perioperative activity.
- 65% reported personally delivering shared decision making, while 34% deliver preoperative assessment in the days or weeks ahead of surgery, 31% enhanced care services, and 29% enhanced recovery services.

- A further 19% reported delivering medical optimisation ahead of surgery, 15% reported involvement in early assessment, 16% in discharge planning and 6% in prehabilitation.
- 24% of anaesthetic staff reported management or supervisory responsibility for at least one perioperative care service, including 33% of consultants, 26% of autonomous SAS doctors and 24% of non-autonomous SAS doctors.
- The specific services that anaesthetic staff most commonly reported managing or supervising were enhanced recovery services (reported by 9%) and preoperative assessment on the day of surgery (8%).

Digital systems

- 89% of anaesthetic staff said improved IT systems would increase their productivity, including 46% who believed the improvement would be "big".
- The most problematic areas of current IT systems were identified as the loading speed of computers (rated "poor" or "very poor" by 58% of anaesthetic staff) and the ability of software to quickly and easily provide patient information (44%).
- 57% of clinical leaders reported that paper patient records are still in use in their hospitals, suggesting many organisations have not yet fully transitioned to digital systems.

Pension taxation

- 57% of all anaesthetic staff were dissatisfied with the current pension taxation regime – including 75% of consultants and 49% of specialty, associate specialist and specialist (SAS) doctors.
- 29% of consultants and 14% of SAS doctors (26% combined) reported that they were reducing their working hours due to pension taxation at the time of the survey.
- Of those consultants and SAS doctors who were reducing their hours, on average they said they would work an extra 2.5 additional programmed activities (PAs) per week if pension taxation were not an issue. Securing that extra time would equate to an estimated 7,826 extra PAs per week across the UK – a potential 5.5% increase in anaesthetic capacity.
- This increase in PAs would enable almost 10,000 additional patient cases per week across the UK, equivalent to around 450,000 additional cases per year.
- 24% of all anaesthetic staff who were considering leaving the NHS or unsure about staying said that reform of pension taxation would make them more likely to remain, rising to 49% among consultants.

2 Introduction

Improving the productivity of health services is high on the agenda of each of the four UK nations – and anaesthetists are vital to achieve it. Without anaesthetists, women in labour would go without epidural pain relief, and many of those enduring chronic pain would continue to suffer – making anaesthetists vital to those areas of NHS function.

An even greater proportion of anaesthetists' time is spent in the surgical pathway. Importantly, most operations cannot proceed without an anaesthetist, and anaesthetists make large contributions to safe and seamless patient care before and after surgery. Their input is therefore fundamental, not only to individual patient outcomes, but also to wider NHS efficiency and system performance.

However, a range of structural and operational issues can limit anaesthetists' ability to maximise their clinical contribution. These barriers can restrict available clinical time, reduce efficiency, and constrain system capacity at a time of sustained demand and workforce pressure.

The list of factors that contribute to, or detract from, the productivity of the anaesthetic workforce is long, however this report examines the following three selected issues:

- The role of anaesthetists in perioperative care – essentially, all the care that patients receive around their operation. Good perioperative care can reduce surgical cancellations and complications, support faster recovery, and minimise the amount of time patients need to spend in hospital.
- The impact of digital systems, including issues relating to speed, usability, functionality and integration across platforms.
- The influence of the current pension taxation regime, which may disincentivise additional work and reduce available NHS capacity.

By examining these issues, the report aims to provide evidence to inform practical, actionable solutions to improve productivity within anaesthesia and across the wider surgical pathway.

3 Methodology

Questionnaire design

The Workforce Census 2025 was developed collaboratively by the Royal College of Anaesthetists (RCoA) and Enventure Research. It involved three large surveys, one that went to clinical leaders in anaesthesia, one that went to college tutors, and one that went to the wider anaesthetic workforce. The details of these are provided below.

A mix of closed, multiple-response, numeric and open-ended questions were used to ensure comprehensive data collection.

Administration and promotion

Clinical leaders' and college tutors' surveys

Headcount, demographic and training-related data were collected through the RCoA Census 2025 surveys completed by clinical leaders and college tutors across NHS hospitals in England, Scotland and Wales, and HSC hospitals in Northern Ireland.

- The clinical leaders' survey collected headcounts for consultants, SAS doctors, locally employed doctors (LEDs) and physician assistants in anaesthesia (PAAs), alongside information on funded vacancies, workforce shortfalls, and on whether patient records were still held in paper format.
- The college tutors' survey gathered information on numbers of anaesthetists in training (AiTs) and LEDs, training capacity and related educational roles.

Both surveys were administered online via personalised email invitations, with weekly reminders issued to encourage completion. A 100% response rate was achieved among college tutors and 97% among clinical leaders.

Following fieldwork, the data was checked for completeness and consistency before analysis.

Data from these surveys contributed to this report in terms of assessing the extent to which patient records are still held on paper and understanding the numbers of anaesthetists affected by pension taxation.

Survey of the wider anaesthetic workforce

The survey was hosted online by Enventure Research and administered to members of the RCoA and physician associates in anaesthesia (PAAs) who had previously provided an email address and opted in to receive survey communications. Only those with a registered email address were invited to take part.

Each participant received a unique personalised survey link. This prevented duplicate submissions, ensured that only intended recipients could respond, and allowed monitoring of response rates without compromising anonymity.

The initial invitation to participate in the survey was followed by four reminder emails, spaced strategically over the fieldwork period, to encourage maximum participation. This follow-up process was key to enhancing response rates and ensuring representation across the membership.

The survey was optimised for desktop and mobile devices to support accessibility. Participation was voluntary and respondents were informed about the purpose of the research and confidentiality before beginning the survey.

Data collection took place over a defined fieldwork period. All responses were securely captured, and the dataset was subsequently cleaned to remove incomplete or invalid cases and ensure routing logic had operated as intended.

Almost all the findings presented in this report come from this survey.

Interpreting the findings

Percentages in figures

Percentages in tables and charts may not always sum to 100% for the following reasons:

- Only the most common responses may be shown.
- Some questions allowed respondents to select multiple answers.
- Percentages are rounded to the nearest whole number, so totals may appear as 99% or 101%.
- Values below 0.5% are shown to one decimal place.

A dash (–) is used in tables where no respondents selected a particular answer option. For headcount data based on clinical leaders' and college tutors' submissions, 0 indicates that no individuals were recorded in a given category.

Base sizes in figures

For each chart or table in the report, base sizes have been provided to show the number who responded to the question being analysed and which specific group of respondents answered the question. The percentages shown in the figures are of the total number of people answering each question or the total number of people in a subgroup answering each question.

In some cases, subgroups have been omitted from tables and charts where base sizes are fewer than 10.

Means

Mean scores represent the arithmetic average. They are calculated by summing all reported values and dividing by the number of valid responses. Means offer a sense of typical responses but can be influenced by outliers or small base sizes, where even a few extreme responses can disproportionately affect the result.

Subgroup analysis

Subgroup analysis has been undertaken where base sizes were sufficiently robust. Where numbers were too small for reliable analysis, subgroups have been combined where appropriate or excluded from charts to avoid misinterpretation.

Only statistically significant differences at the 95% confidence level, tested via a z-test, are commented on in the report. This means that we can be confident that if we repeated the same survey, 95 times out of 100, we would get similar findings.

Demographic information

Demographic data collection was limited to just UK nation, gender, and broad age categories (e.g. 40-49) to preserve respondent anonymity. More detailed demographic information regarding ethnicity, sexual orientation, and disability status was not recorded as, in combination, such data may have allowed identification of specific individuals.

Confidence in the anaesthetic workforce survey data

The RCoA Census anaesthetic workforce survey received 2,797 valid responses. Although the survey was voluntary and not a random probability sample, the response volume provides substantial insight

into the UK anaesthetic workforce. For the purposes of this report responses from Crown Dependencies and student AAs have not been included, providing a base size of **2,787 responses**.

For context, if the responses had been drawn from a random sample of a population of 18,000, the notional margin of error would be approximately ±1.7% at the 95% confidence level. Because this was a self-selecting sample, this figure should be treated only as a broad reference point, as self-selection may introduce response bias.

Nevertheless, several factors support confidence in the findings:

- Respondents represent a broad cross-section of the anaesthesia workforce, including consultants, SAS doctors, AiTs, PAAs, and LEDs, and responses were received from all UK regions and nations.
- A comprehensive promotion campaign helped encourage widespread engagement across different staff groups and demographics.
- Responses were thoroughly cleaned and validated, and routing logic verified by Enventure Research.
- Results were **weighted by staff group** using data from the clinical leaders' and college tutors' surveys, improving representativeness of the UK anaesthetic workforce.
- All data handling complied with the Market Research Society Code of Conduct and UK GDPR, and limitations are clearly stated in this report.

Although some bias is possible due to the voluntary nature of the survey, the scale, breadth and quality assurance applied to the data provide a strong basis for the conclusions presented.

Confidence in the clinical leaders' and college tutors' surveys

In comparison, the findings from the college tutors' survey are based on a 100% response rate across the UK and there was only one detailed survey completed by respondents.

Two versions of the clinical leaders' survey were used: a full version collecting detailed demographic data and a shorter version collecting headline counts only. As a result, some sites did not provide full demographic breakdowns; therefore, totals have been estimated using scaling based on sites with complete data. This assumes comparability between responding sites, which may not necessarily be the case, so figures should be interpreted as estimates.

A high response rate was achieved from clinical leaders (97% of sites across the UK). College tutors returned a 100% response rate, and only one version of the survey was used.

4 Overview of respondents

A total of **2,797 full responses** were received to the **anaesthetic workforce survey**, representing a **response rate of 15%** from RCoA members and PAAs who had provided their email address to the College and opted in to receiving relevant survey work. In addition to these, 1,104 partial responses were submitted. These partial responses have not been included in the analysis. Responses from student PAAs and respondents in Crown Dependencies have also not been included in the analysis.

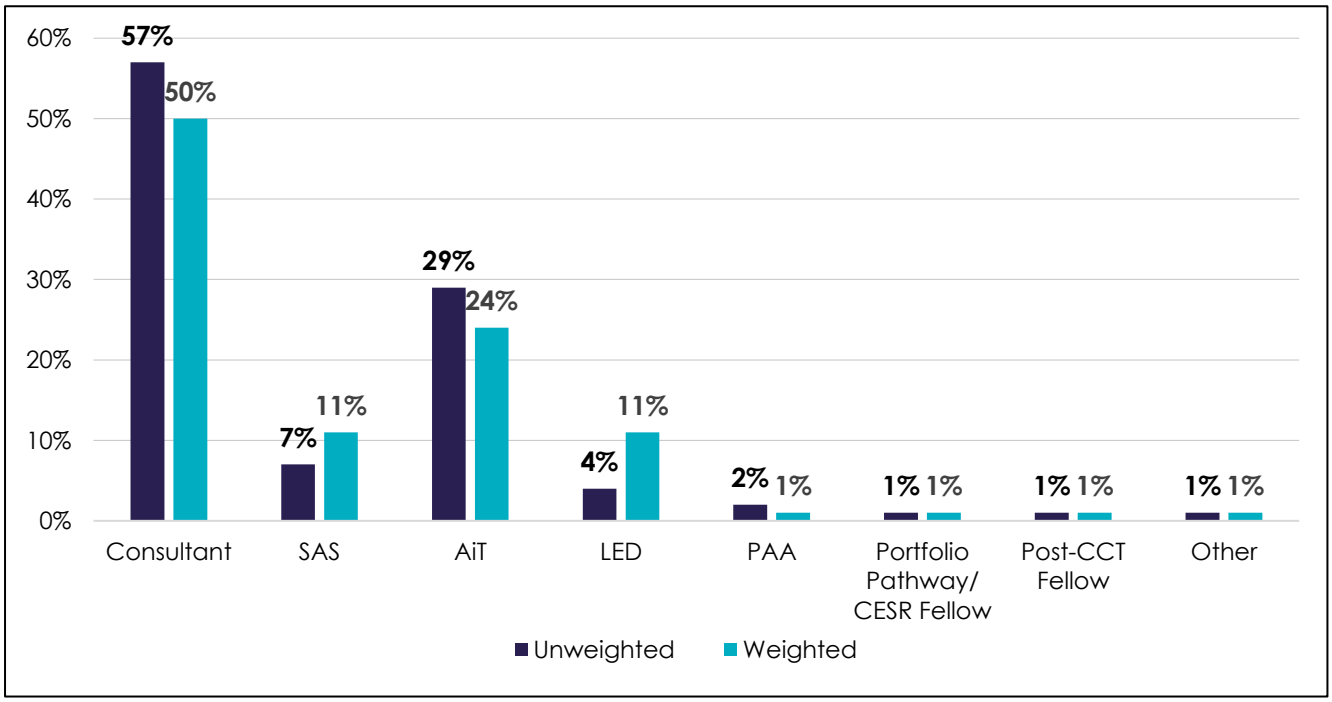
Respondents provided demographic information across several key areas, including professional staff group, UK devolved nation, gender, and age group. To improve the representativeness of the results, data was weighted by professional staff group using headcount information from the RCoA's clinical leaders and college tutors survey.

This section shows the unweighted and weighted respondent profiles.

Staff group

Respondents included consultants, SAS doctors, fellows, AiTs, LEDs and PAAs. In the unweighted sample, consultants and AiTs were over-represented, whilst LEDs and SAS doctors were under-represented.

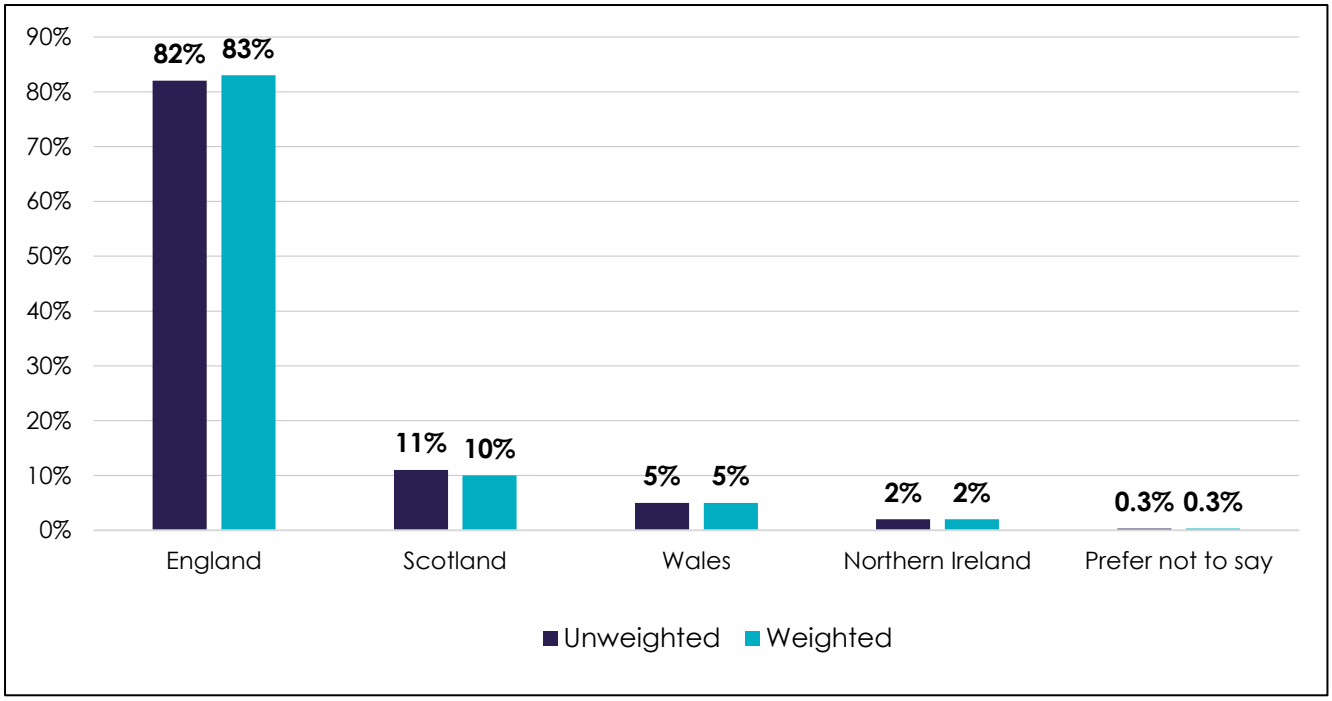
Figure 1 – Respondent staff group
Base: 2,787 (Excluding student AAs and Crown Dependency responses)



Devolved nation

Responses were received from anaesthetic staff practising in all four UK nations, with the largest proportion working in England (83% in the weighted sample). A further 10% were working in Scotland, whilst 5% were working in Wales and 2% in Northern Ireland in the weighted sample.

Figure 2 – UK devolved nation
Base: 2,787 (Excluding student PAAs and Crown Dependency responses)



Gender

Around six in ten (58%) respondents reported their gender as male and four in ten (41%) as female. By staff group, the gender split: consultants (58% male and 40% female), AiTs (56% male and 44% female), SAS doctors (68% male and 31% female), LEDs (52% male and 48% female), and PAAs (55% male and 45% female). For portfolio pathway/CESR fellows the figures were 55% male and 45% female, and for post-CCT fellows, 54% male and 38% female.

Figure 3 – Staff group by gender
Base: 2,787(Excluding student PAAs and Crown Dependency responses)

Response	Male	Female	Other	Prefer not to say
Overall	1,618 58%	1,150 41%	2 0.1%	18 1%
Consultant	810 58%	561 40%	2 0.1%	12 1%
AiT	379 56%	299 44%	-	2 0.3%
SAS doctor	209 68%	96 31%	-	2 1%
LED	166 52%	151 48%	-	-

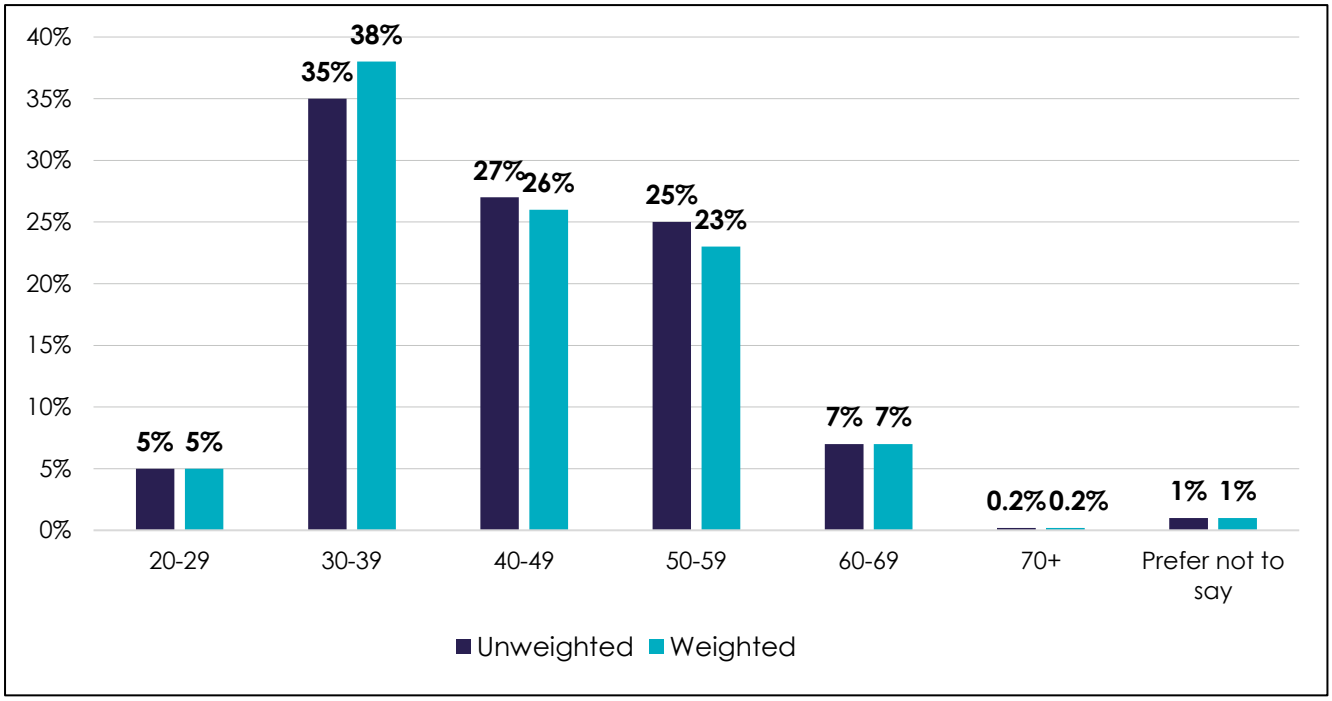
Response	Male	Female	Other	Prefer not to say
PAA	18 55%	15 45%	-	-
Portfolio Pathway/CESR Fellow	17 55%	14 45%	-	-
Post-CCT Fellow	8 54%	5 38%	-	1 8%

Age

The majority of respondents were aged 30–49, accounting for 65% of the total, including 38% who were aged 30–39 and 26% aged 40–49. A further 23% were aged 50–59, showing strong representation from mid-to-late career professionals. Younger respondents (aged 20–29) made up 5% of the sample, while 7% were aged 60–69.

Figure 4 – Age group

Base: 2,787 (Excluding student PAAs and Crown Dependency responses)



5 Perioperative care services

Introduction

Pre-existing evidence shows that the provision of better perioperative care – all the care that patients receive around their operation – can increase NHS productivity by reducing rates of surgical cancellations and complications and shortening the length of time patients need to spend in hospital.

Anaesthetists are heavily involved in both the provision, management, and supervision of perioperative care services – and the Census sought to quantity this.

Key findings

- 78% of anaesthetic staff reported personally delivering at least one perioperative care service, rising to 90% if preoperative assessment on the day of surgery is included in the analysis.
- 85% of anaesthetic staff reported delivering preoperative assessment on the day of surgery, making it the most common perioperative activity.
- 65% reported personally delivering shared decision making, while 34% deliver preoperative assessment in the days or weeks ahead of surgery, 31% enhanced care services, and 29% enhanced recovery services.
- A further 19% reported delivering medical optimisation ahead of surgery, 15% reported involvement in early assessment, 16% in discharge planning and 6% in prehabilitation.
- 24% of respondents reported management or supervisory responsibility for at least one perioperative care service, including 33% of consultants, 26% of autonomous SAS doctors and 24% of non-autonomous SAS doctors.
- The specific services that anaesthetic staff most commonly reported managing or supervising were enhanced recovery services (reported by 9%) and preoperative assessment on the day of surgery (8%).

The importance of perioperative care

Health systems across the UK face a number of avoidable inefficiencies in the surgical pathway:

- Postponements and cancellations: 9% of elective operations are postponed, and 10% are cancelled. [1]
- Long hospital stays: surgical patients often remain in hospital one to two days longer than necessary. [2]
- Complications: 12% of operations result in complications, many of which are preventable. [3]
- Readmissions: over 11.5% of readmissions are preventable. [4]
- Unnecessary operations: operations benefit most patients, but about 1 in 7 patients regret their operation. [5]

Addressing these challenges is essential to improving NHS productivity and patient outcomes.

Anaesthetists are integral to delivering solutions through their leadership and involvement in perioperative care – all the care that patients receive before and after their operation, from the moment surgery is first considered through to full recovery.

Turning waiting lists into preparation lists

A key perioperative intervention involves turning waiting lists into preparation lists. Many patients arrive in hospital for their operation in an avoidably poor state of health, increasing the risk of postponement or surgical complications. Common drivers include smoking, excess alcohol consumption, unmanaged comorbidities (such as diabetes or anaemia), and frailty.

Early assessment (also known as early screening) of patients soon after they are referred to surgery enables these issues to be identified and addressed. This may include medical optimisation, prehabilitation programmes (for example, for exercise, smoking cessation, improved nutrition), and advice on preparation for operations and procedures.

Evidence shows that early assessment combined with medical optimisation/prehabilitation can:

- Reduce complications by up to 50% [2]
- Shorten hospital stays by 1–2 days [2]
- Support long-term lifestyle improvements in up to 75% of patients [6]
- Deliver cost savings for hospitals.

In general, the earlier a patient is screened the better as it allows sufficient time for health behaviours and co-morbidities to be tackled. Anaesthetists also play a key role closer to surgery, including on the day itself, ensuring patients are in a fit state to undergo their operation and to consider how the anaesthetic may interact with their particular health status.

Shared decision making

Patients are not always actively involved in decisions about their care. This can result in unnecessary operations, inefficient use of NHS resources and surgical regret (reported by 14% of patients who had had an operation). [5]

Shared decision making ensures patients understand the benefits, risks, alternatives and the option of no treatment to make sure that they make the right decision for themselves (supported by frameworks such as BRAN). Evidence shows that embedding shared decision making:

- Improves patient understanding of their treatment and satisfaction with their care
- Reduces surgical regret
- Reduces litigation costs, as patients are 80% less likely to sue [7]
- Leads to around 10% of patients deciding not to proceed with surgery, freeing capacity for those in greater need. [8]

Discharge planning

Poor discharge planning can extend hospital stays unnecessarily and increase the risk of readmissions, for example due to uncoordinated transport or unclear recovery notes or advice.

Planning discharge early, ideally before admission, improves outcomes. The IDEAL framework offers a structured approach to ensure clinicians include patients and their families; discuss care plans; educate patients; assess clinical staff performance; and listen to patients' preferences and concerns. Evidence shows that effective discharge planning:

- Reduces readmissions by around 11.5% [4]
- Improves patient outcomes
- Frees up bed capacity.

Facilitating fast recovery

While rest is important after surgery, early mobilisation, hydration and nutrition are critical to ensure a fast recovery. Supporting patients to drink, eat and mobilise (DrEaM) as soon as possible after surgery forms part of enhanced recovery programmes. Evidence shows that DrEaMing in the first 24 hours after surgery results in an average 37.5% reduction in length of hospital stay. [9]

Enhanced care services

Traditionally, after surgery care has involved a binary choice between a standard ward and an intensive care unit (ICU), if the patient is in a critical condition. However, not all patients requiring additional monitoring need full ICU support.

Enhanced care units provide an intermediate level of care, allowing hospitals to tailor resource provision to patient need, preventing avoidable and costly ICU admissions.

Personal provision of perioperative care services

Respondents were asked whether they personally delivered the aforementioned perioperative care services. The chart shows the proportion reporting personal delivery of at least one service, both overall and excluding preoperative assessment on the day of surgery.

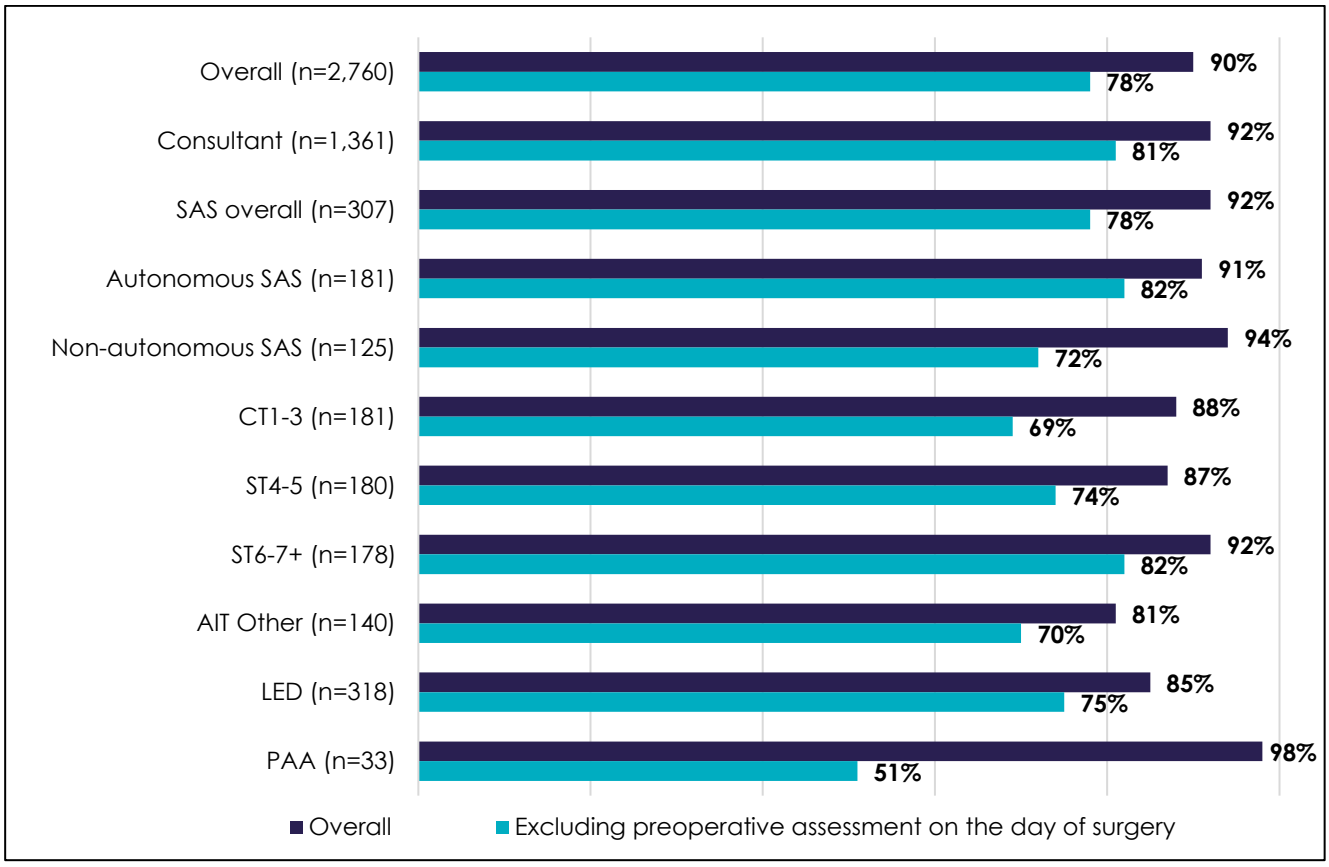
78% of anaesthetic staff reported personally delivering at least one perioperative care service, rising to 90% if preoperative assessment on the day of surgery is included in the analysis.

There was strong engagement across most staff groups. For consultants, 81% reported personally delivering at least one perioperative care service, rising to 92% if preoperative assessment on the day of surgery is included. For autonomous SAS doctors the figures were 82% and 91% respectively, and for non-autonomous SAS doctors 72% and 94% (78% and 92% SAS overall). For LEDs the figures were 75% and 85%.

Among AiTs, involvement remained widespread but varied slightly by training stage. 69% of CT1-3 AiTs reported personally delivering at least one perioperative care service, rising to 88% if preoperative assessment on the day of surgery is included. For ST4-5s the figures are 74% and 87% respectively, and for ST6-7+ AiTs, 82% and 92% respectively. For other AiTs, the figures were 70% and 81%.

For PAAs, 98% personally delivered at least one service, and this fell to 51% when preoperative assessment on the day of surgery is excluded.

Figure 5 – Any personal provision of perioperative care services by staff group
Base: Shown in chart (Those working in the NHS, excluding student PAAs and all Crown Dependency responses)

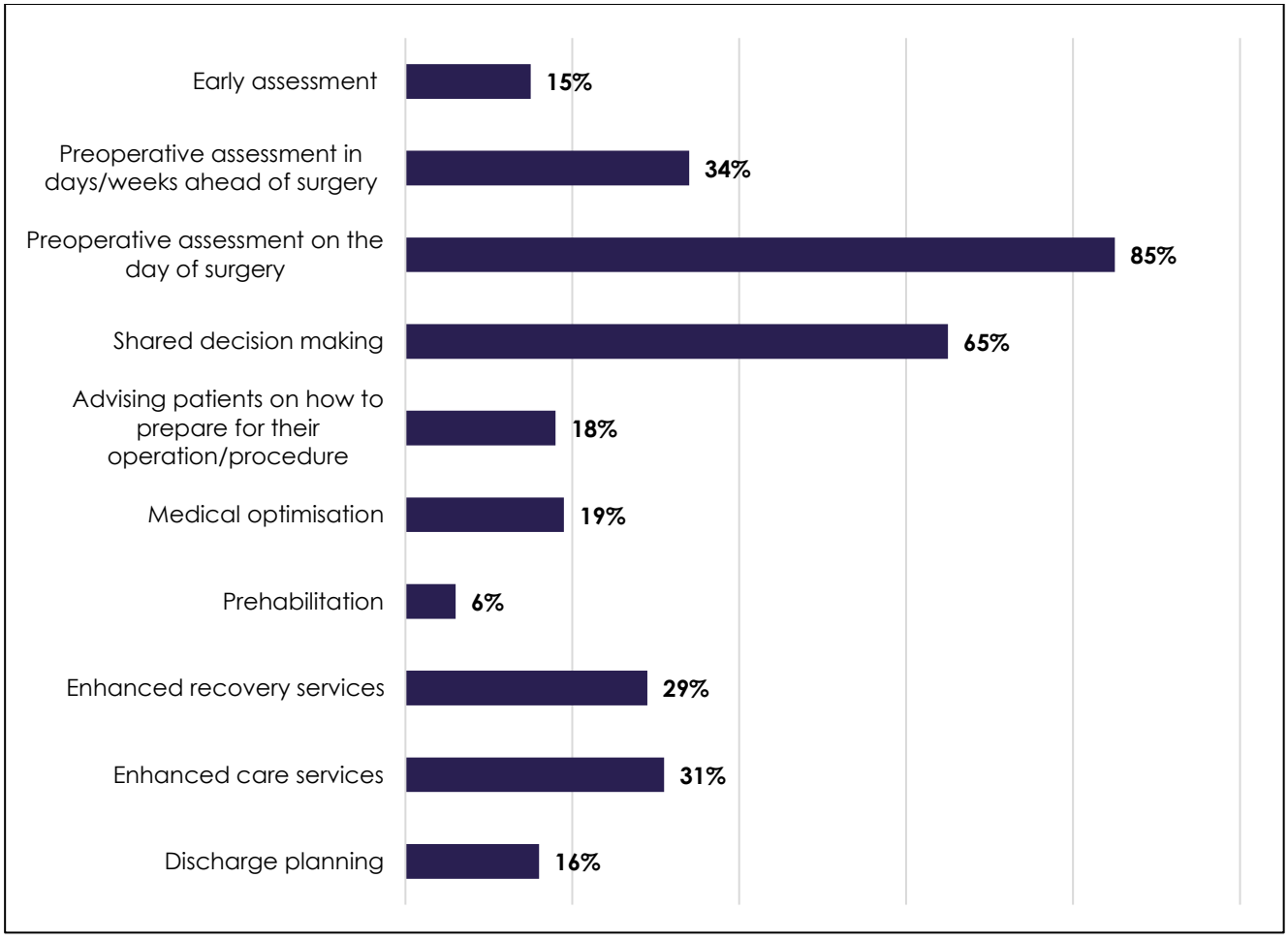


Breaking the figures down by type of service shows that preoperative assessment on the day of surgery is by far the most commonly delivered service, reported by 85% of respondents. This reflects the central role anaesthetists play in assessing patients' anaesthetic needs, and confirming their fitness for surgery immediately prior to procedures.

Shared decision making was also widely delivered, with 65% of respondents reporting personal involvement. Some services are delivered less frequently. These include preoperative assessment in the days or weeks ahead of surgery, reported by 34% of respondents, and enhanced recovery services, reported by 29%. 19% reported involvement in medical optimisation and 18% in advising patients on how to prepare for their operation or procedure, while 15% reported involvement in early assessment and 16% in discharge planning.

Prehabilitation programmes were the least commonly delivered service, with just 6% of respondents reporting involvement.

Figure 6 – Personal provision of perioperative care services
Base: 2,760 (Those working in the NHS, excluding student PAAs and all Crown Dependency responses)



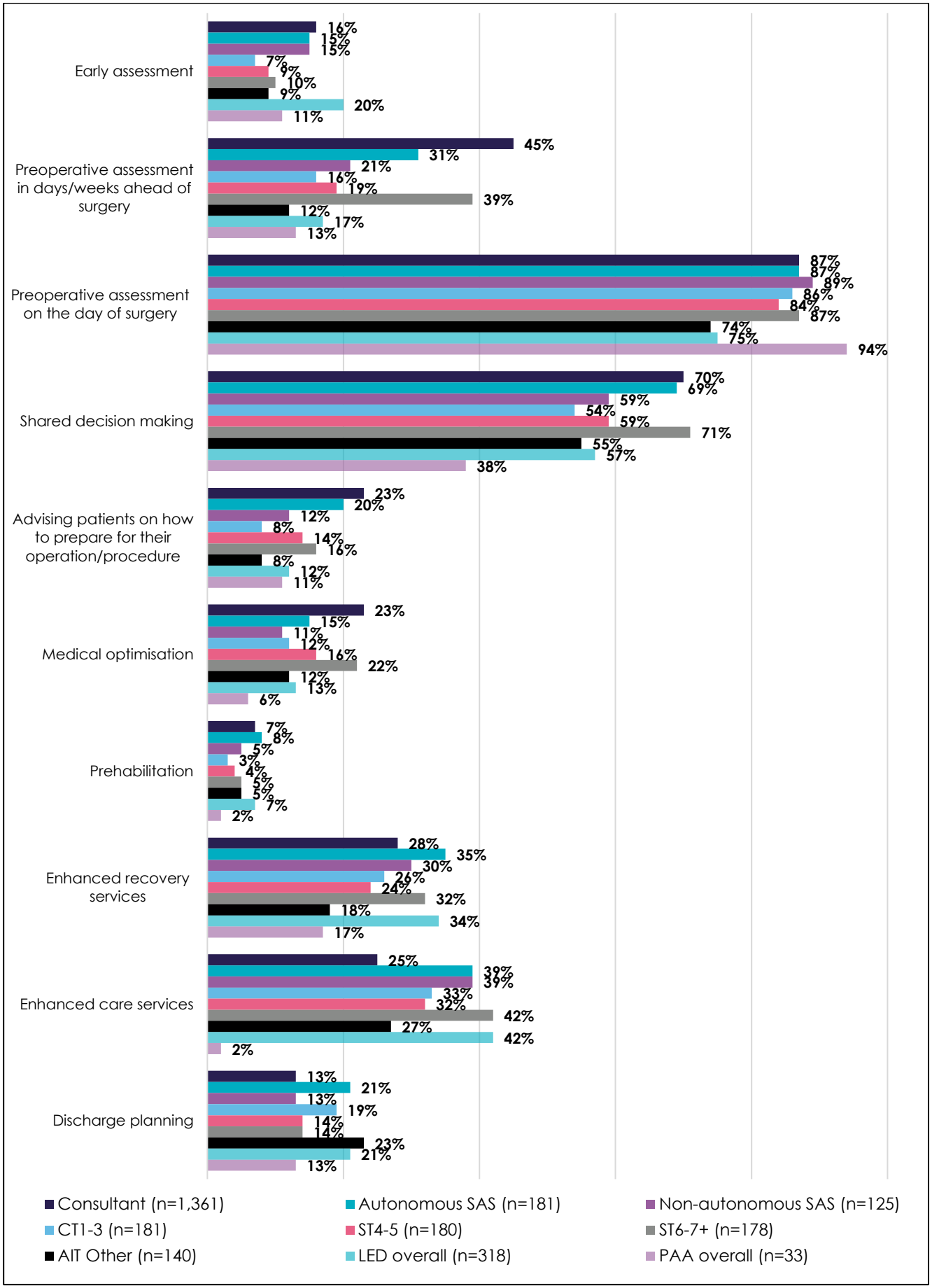
When examined by staff group, preoperative assessment on the day of surgery remains the most widely delivered service across all roles, with consistently high levels of involvement – 87% of consultants, 87% of autonomous SAS doctors, and 89% of non-autonomous SAS doctors reported delivering this service. Among AiTs the figures were, 86% for CT1-3s, 84% for ST4-5s, 87% for ST6-7+s, and 74% for other AiTs. For LEDs the figure was 75% and for PAAs it was 94%.

The next most commonly delivered service for all staff groups was shared decision making. This was reported by 70% of consultants, 69% of autonomous SAS doctors, and 59% of non-autonomous SAS doctors. Among AiTs the figures were, 54% for CT1-3s, 59% for ST4-5s, 71% for ST6-7+s, and 55% for other AiTs. For LEDs the figure was 57% and for PAAs it was 38%.

Further details are provided in Figure 7 overleaf.

Figure 7 – Personal provision of perioperative services by staff group

Base: Shown in chart (Those working in the NHS, excluding student PAAs and Crown Dependency responses)



Management and supervision of perioperative care services

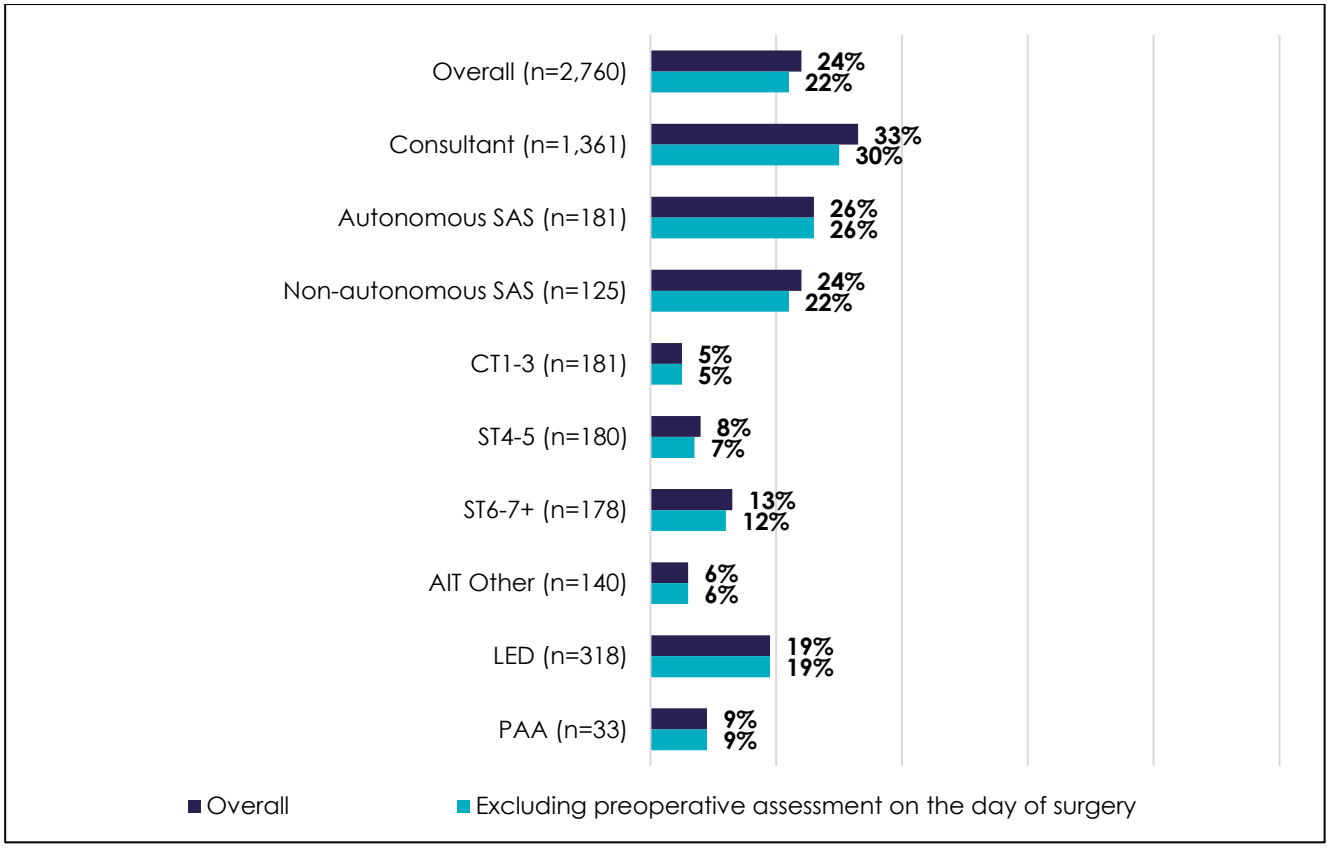
Anaesthetists are not only involved in delivering perioperative care services, they also play an important role in their management and supervision. As such, respondents were also asked about those kinds of involvement.

Overall, 22% of anaesthetic staff reported having management or supervisory responsibility in at least one perioperative care service – rising to 24% if preoperative assessment on the day of surgery is included.

Consultants were the most likely to report management or supervisory responsibilities, with figures of 30% and 33% respectively. Among SAS doctors, involvement in management or supervision was also notable. For autonomous SAS doctors the figures were 26% whether or not preoperative assessment on the day of surgery was included. For non-autonomous SAS doctors, the figures were 22% and 24% respectively. For LEDs the figures were both 19%.

AiTs were much less likely to hold management or supervisory roles. For CT1-3s the figures were 5% in each case, for ST4–5s they were 7% and 8%, for ST6–7+s 12% and 13%, and for other AiTs 6% in each case. PAAs were 9% in each case.

Figure 8 – Any management/supervision of perioperative care services by staff group
Base: Shown in chart (Those working in the NHS, excluding student PAAs and all Crown Dependency responses)

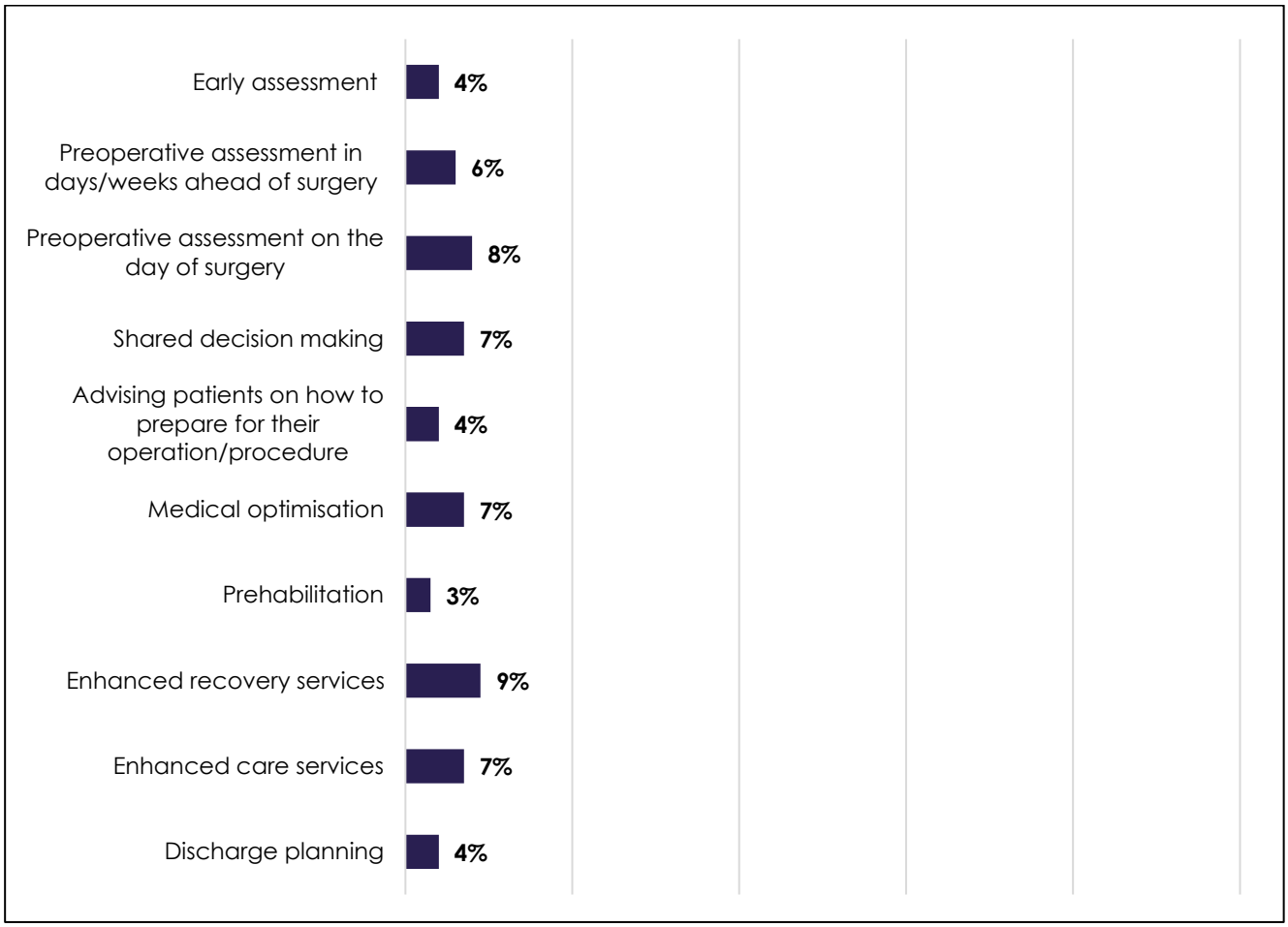


Breaking the figures down by type of service shows that 9% of respondents managed or supervised enhanced recovery services and 8% did so for preoperative assessment on the day of surgery. Shared decision making, medical optimisation, and enhanced care services were each supervised by 7% of respondents.

A slightly smaller proportion reported supervising preoperative assessment in the days or weeks ahead of surgery (6%), while early assessment, discharge planning and advising patients on how to prepare for their operation or procedure were each overseen by around 4% of respondents.

Prehabilitation programmes were the least commonly supervised service, with just 3% reporting management or oversight responsibilities in this area.

Figure 9 – Management/supervision of perioperative care services
Base: 2,760 (Those working in the NHS, excluding student PAAs and all Crown Dependency responses)



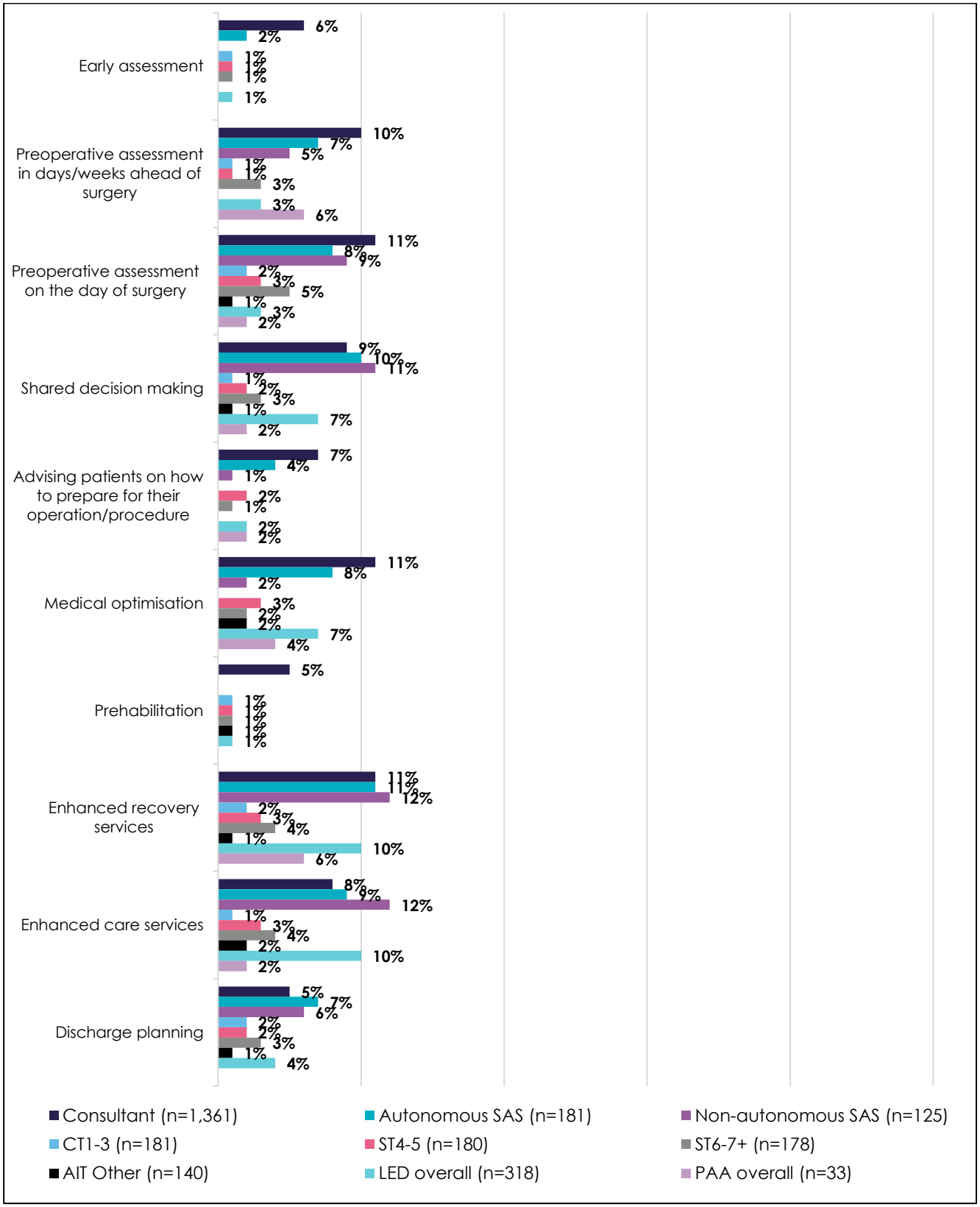
When examined by staff group, 11% of consultants, 11% of autonomous SAS doctors, and 12% of non-autonomous SAS doctors reported managing or supervising enhanced recovery services. Such roles were also reported by 2% of CT1-3s, 3% of ST4-5s, 4% of ST6-7+s, and 1% of other AiTs. Among LEDs the figure was 10% and among PAAs 6%.

Regarding preoperative assessment on the day of surgery, management or supervision was reported by 11% of consultants, 8% of autonomous SAS doctors, and 9% of non-autonomous SAS doctors. It was also reported by 2% of CT1-3s, 3% of ST4-5s, 5% of ST6-7+s, and 1% of other AiTs. Among LEDs the figure was 3% and among PAAs 2%.

Further details are provided in Figure 10 overleaf.

Figure 10 – Management/supervision of perioperative services by staff group

Base: Shown in chart (Those working in the NHS, excluding student PAAs and Crown Dependency responses)



6 Digital systems

Introduction

When IT systems are slow to load, require repeated logins, or lack integration across platforms, clinicians lose valuable time that could otherwise be spent delivering care. Limited access to accurate, real-time information can also lead to duplication of work, such as repeating tests that have already been performed, or missing opportunities to intervene early. For example, if key risk factors such as smoking status are not easily visible, patients may miss preoperative support, potentially resulting in surgical complications, prolonged hospital stays, and increased system costs.

Ensuring that digital systems are efficient and fit for purpose is therefore central to improving both anaesthetic productivity and wider NHS performance.

Key findings

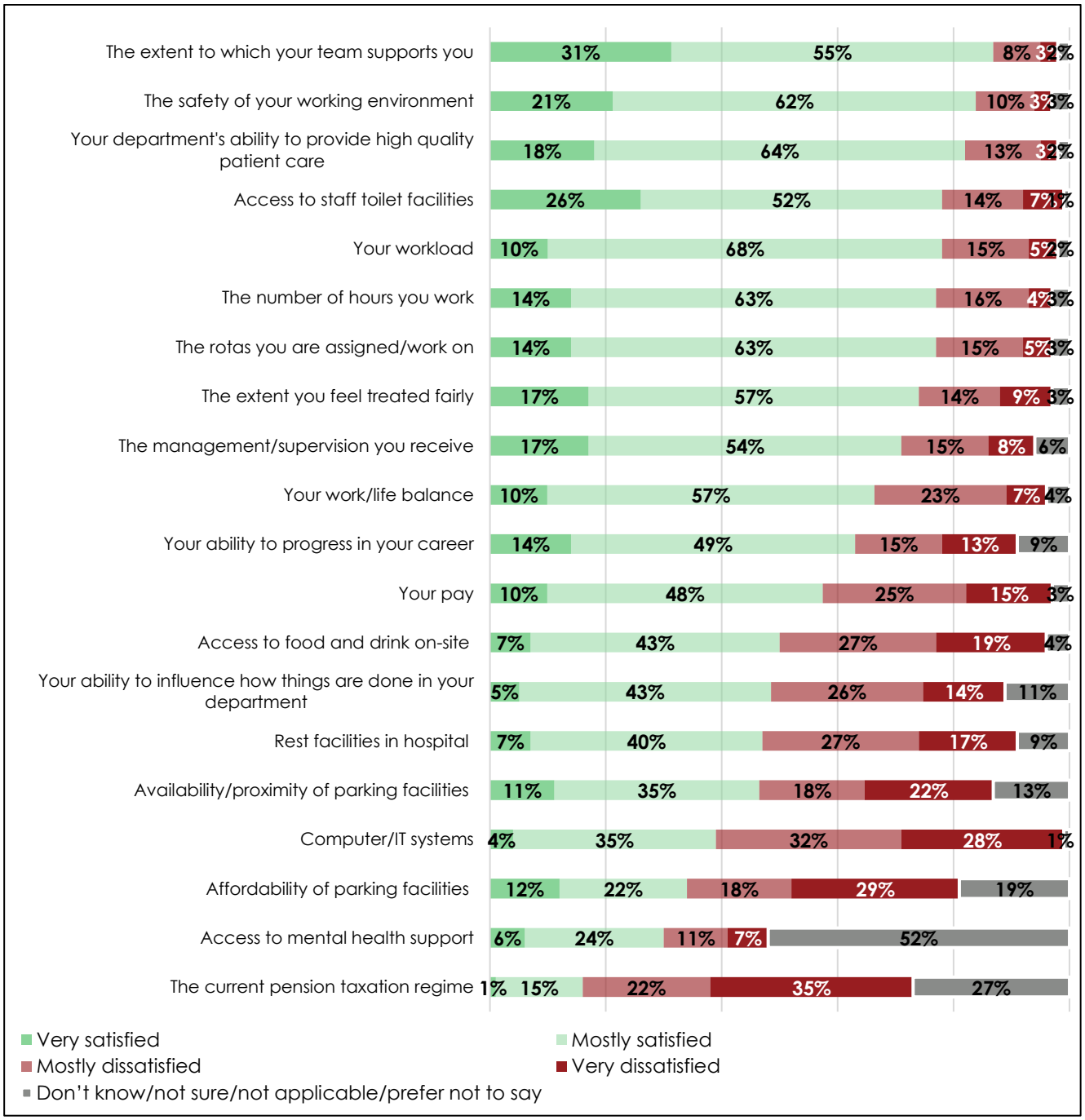
- 89% of anaesthetic staff said improved IT systems would increase their productivity, including 46% who believed the improvement would be "big".
- The most problematic areas of current IT systems were identified as the loading speed of computers (rated "poor" or "very poor" by 58% of anaesthetic staff) and the ability of software to quickly and easily provide patient information (44%).
- 57% of clinical leaders reported that paper patient records are still in use in their hospitals, suggesting many organisations have not yet fully transitioned to digital systems.

Satisfaction with IT systems

Respondents in the wider anaesthetic workforce survey were asked to rate their satisfaction or dissatisfaction with a range of aspects of their working life.

Overall dissatisfaction was highest with computer/IT systems (60%), with 28% "very" dissatisfied and 32% "mostly" dissatisfied. It also recorded the second smallest proportion saying "very" satisfied (4%), after the current pension taxation regime, which is explored in the subsequent chapter in this report.

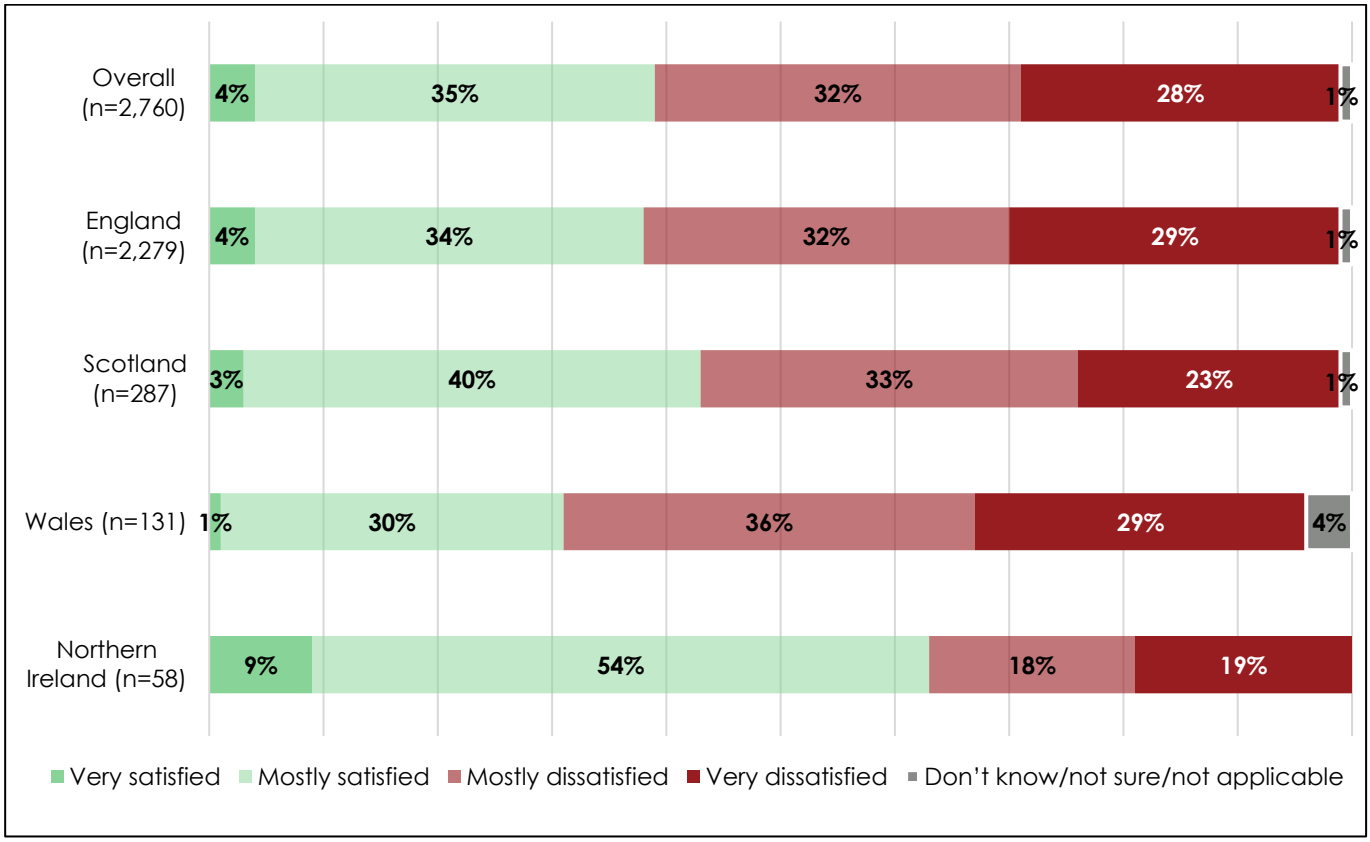
Figure 11 – Levels of satisfaction with factors of working life
Base: 2,760 (Those working in the NHS, excluding student PAAs and Crown Dependency responses)



England, Scotland and Wales show relatively similar distributions with dissatisfaction (61%, 56% and 65% respectively) outweighing satisfaction (38%, 43% and 31% respectively). Northern Ireland stands out with a larger proportion of respondents reporting satisfaction with IT systems (63%). This may reflect the better functioning (although still imperfect) IT systems in Northern Ireland – an idea which receives some support in subsequent sections of this report.

Figure 12 – Satisfaction with computer/IT systems by UK nation

Base: Shown in chart (Those working in the NHS, excluding student PAAs and Crown Dependency responses)



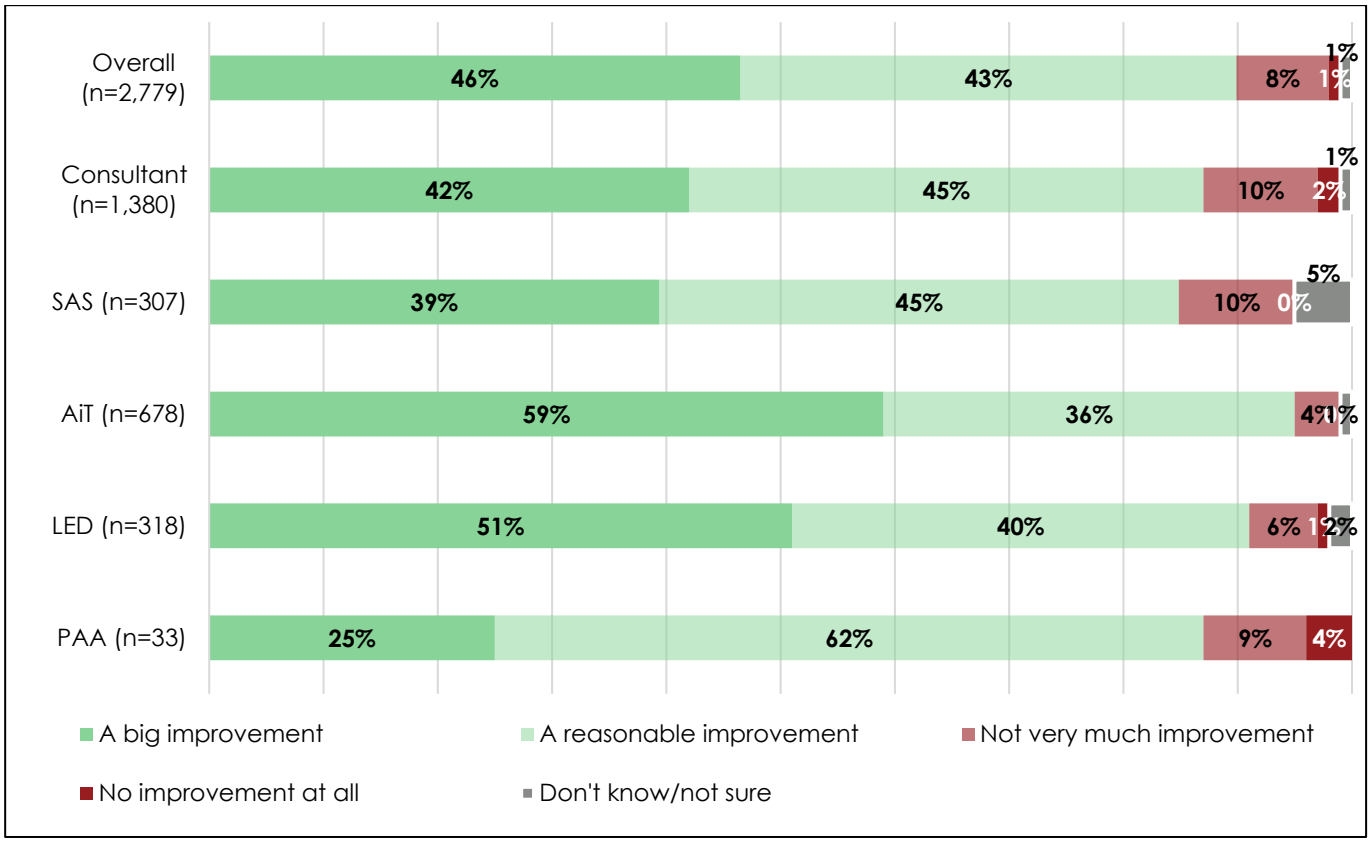
Overall productivity boost

Respondents were asked to what extent they believed their personal productivity would improve if their hospital's computer/IT systems were better. Across the UK, there was strong consensus that better digital systems would enhance productivity.

Overall, almost nine in ten anaesthetic staff (89%) felt their productivity would improve to at least some extent, including 46% who anticipated a "big" improvement and 43% who expected a "reasonable" improvement. Only a small minority (9%) believed improvements would make little or no difference.

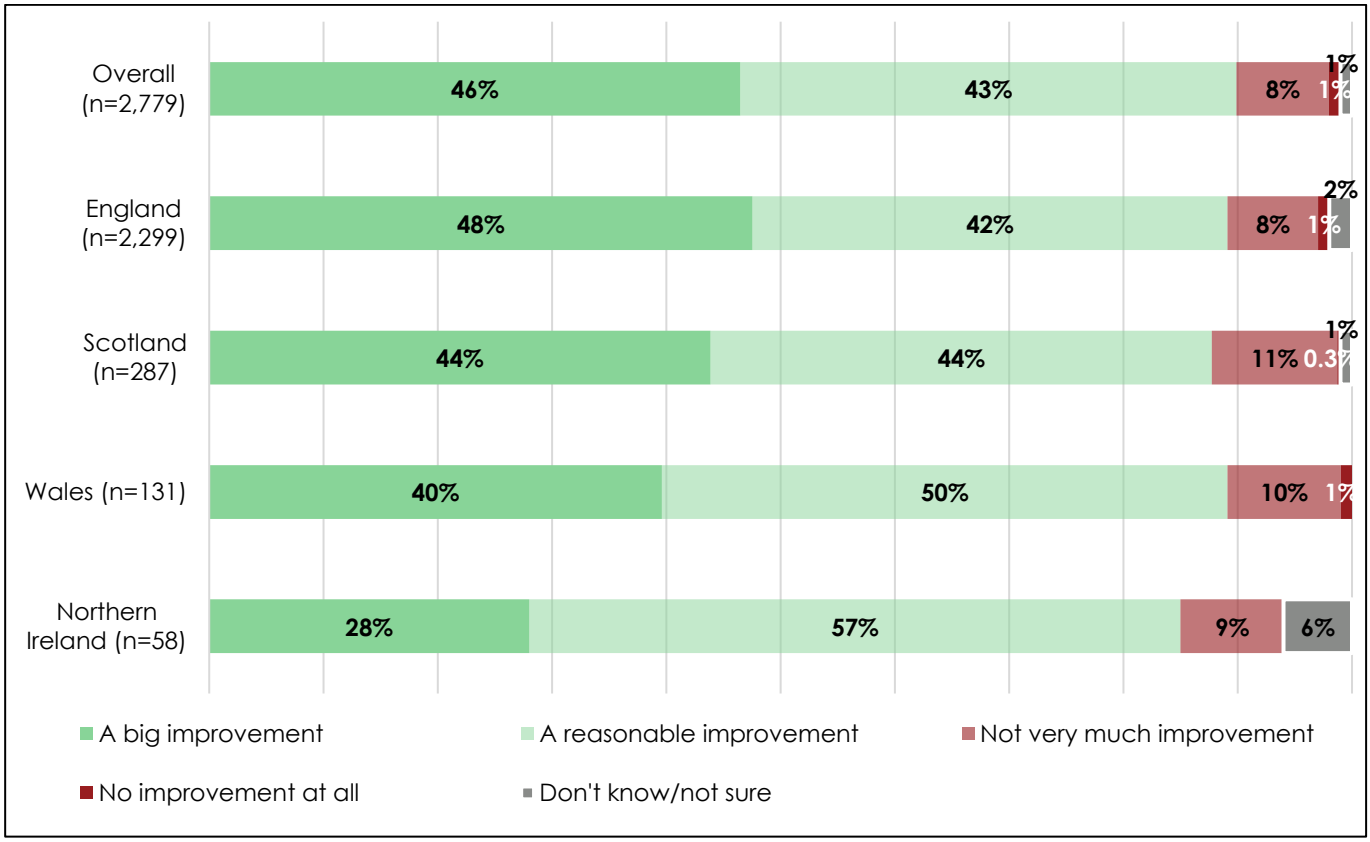
AiTs were most likely to feel that better IT systems would make a "big" improvement to their productivity (59%) and over half (51%) of LEDs felt the same. Smaller proportions of consultants (42%), SAS doctors (39%) and PAAs (25%) thought that better IT systems would make a "big" improvement to their productivity.

Figure 13 – Views on whether better IT systems would improve productivity by staff group
Base: Shown in chart (Those working in the NHS or private sector, excluding student PAAs and Crown Dependency responses)



Across each of the four UK nations, broadly similar numbers reported that better IT systems would make a big or a reasonable improvement to their productivity when those categories were combined – 90% for England, 88% for Scotland, 90% for Wales, and 85% for Northern Ireland. There were bigger differences if only the area of "big" improvements were looked at, with 48% selecting this in England, 44% in Scotland, 40% in Wales, and 28% in Northern Ireland. This provides further evidence of better functioning (although still imperfect) IT systems in Northern Ireland than in other UK nations.

Figure 14 – Views on whether better IT systems would improve productivity by UK nation
Base: Shown in chart (Those working in the NHS or private sector, excluding student PAAs and Crown Dependency responses)



Adequacy of aspects of IT systems

Respondents were asked to rate the adequacy of several aspects of IT systems within the hospital in which they work. The findings indicate widespread concern about the performance and functionality of core digital infrastructure.

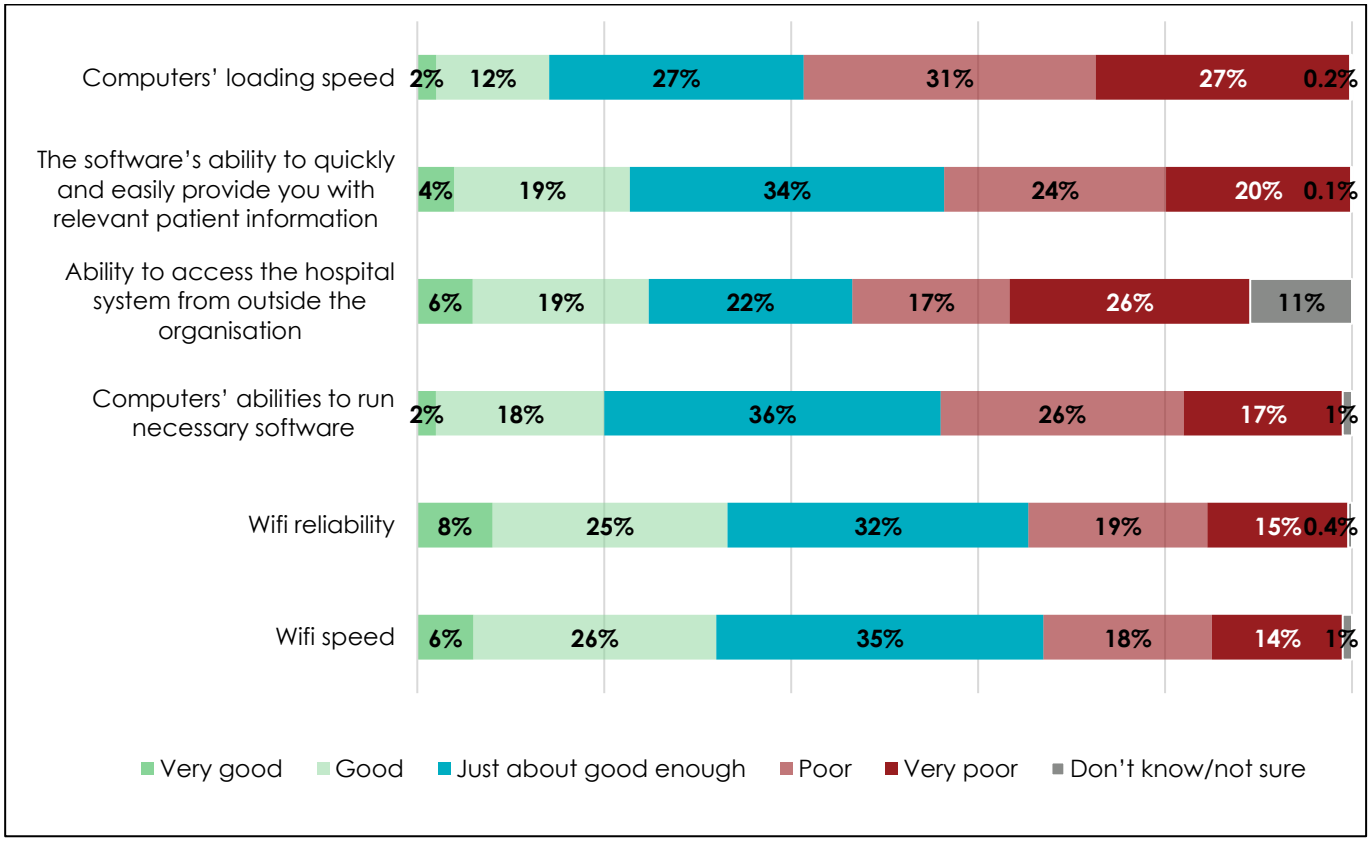
Nearly six in ten (58%) anaesthetic staff viewed computers' loading speed negatively, with 31% giving "poor" and 27% "very poor" ratings, making this the weakest-performing area overall. The next weakest area was the software's ability to quickly and easily provide relevant patient information, with 44% giving negative ratings (20% "poor", 24% "very poor").

Following that, other areas of weakness included the ability to access the hospital system from outside the organisation, with 43% giving negative ratings (17% "poor", 26% "very poor"), and computers' ability to run necessary software, which also received 43% negative ratings (17% "poor", 26% "very poor").

While Wifi reliability and speed were viewed somewhat more favourably than other areas, they still attracted reasonable proportions of negative ratings – 34% (19% "poor", 15% "very poor"), and 32% (18% "poor", 14% "very poor"), respectively.

Across all areas though, there were at least some respondents giving "very good" and "good ratings", and even more selecting "just about good enough". This indicates that some areas of the NHS are performing well in terms of their IT systems and may provide example systems and infrastructure that other areas may wish to replicate.

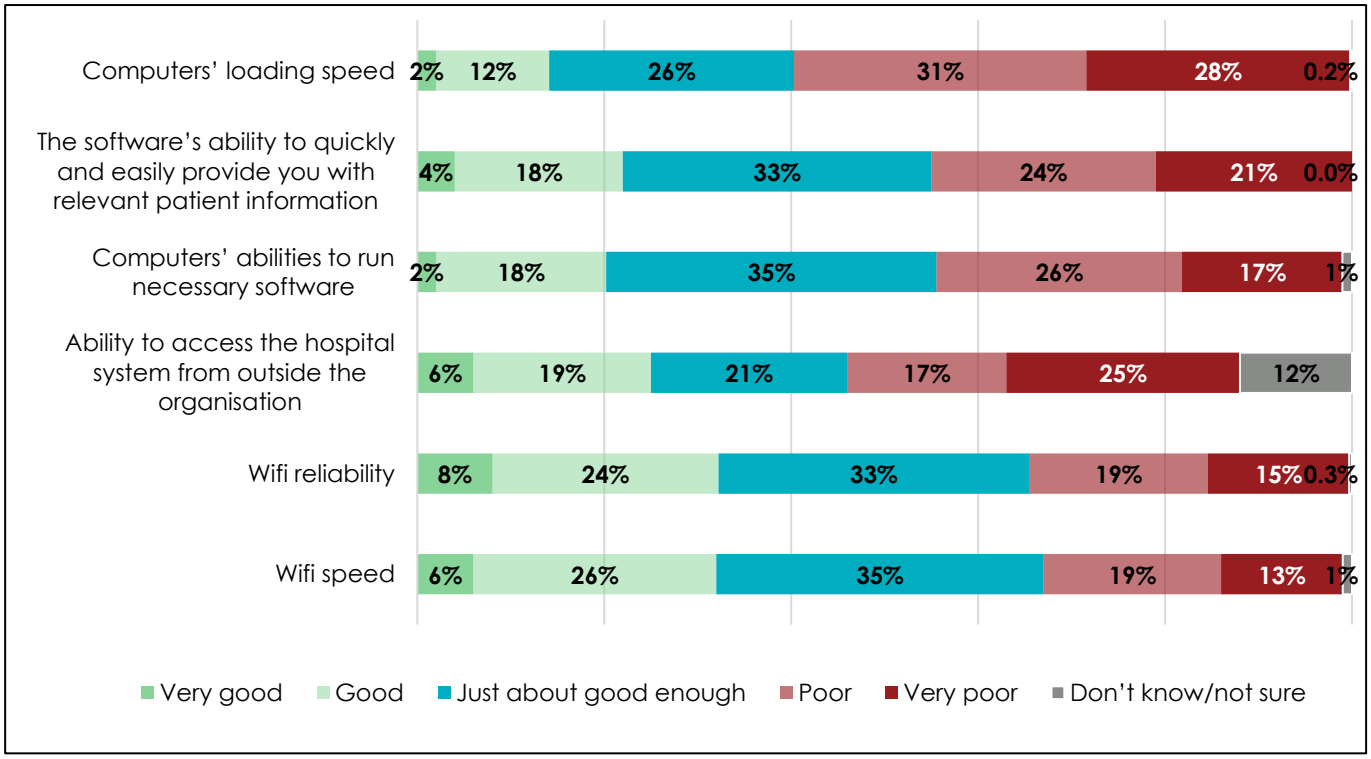
Figure 15 – Ratings of adequacy of aspects of IT systems
Base: Shown in chart (Those working in the NHS or private sector, excluding student PAAs and Crown Dependency responses)



Among those working in England, perceptions of IT system adequacy broadly reflect the UK-wide pattern.

Computers' loading speed was again the weakest area, with nearly six in ten respondents (59%) giving negative ratings, including 31% as "poor" and 28% as "very poor". As per the rest of the UK, the next weakest area was the software's ability to quickly and easily provide relevant patient information where 45% gave negative ratings (24% "poor", 21% "very poor").

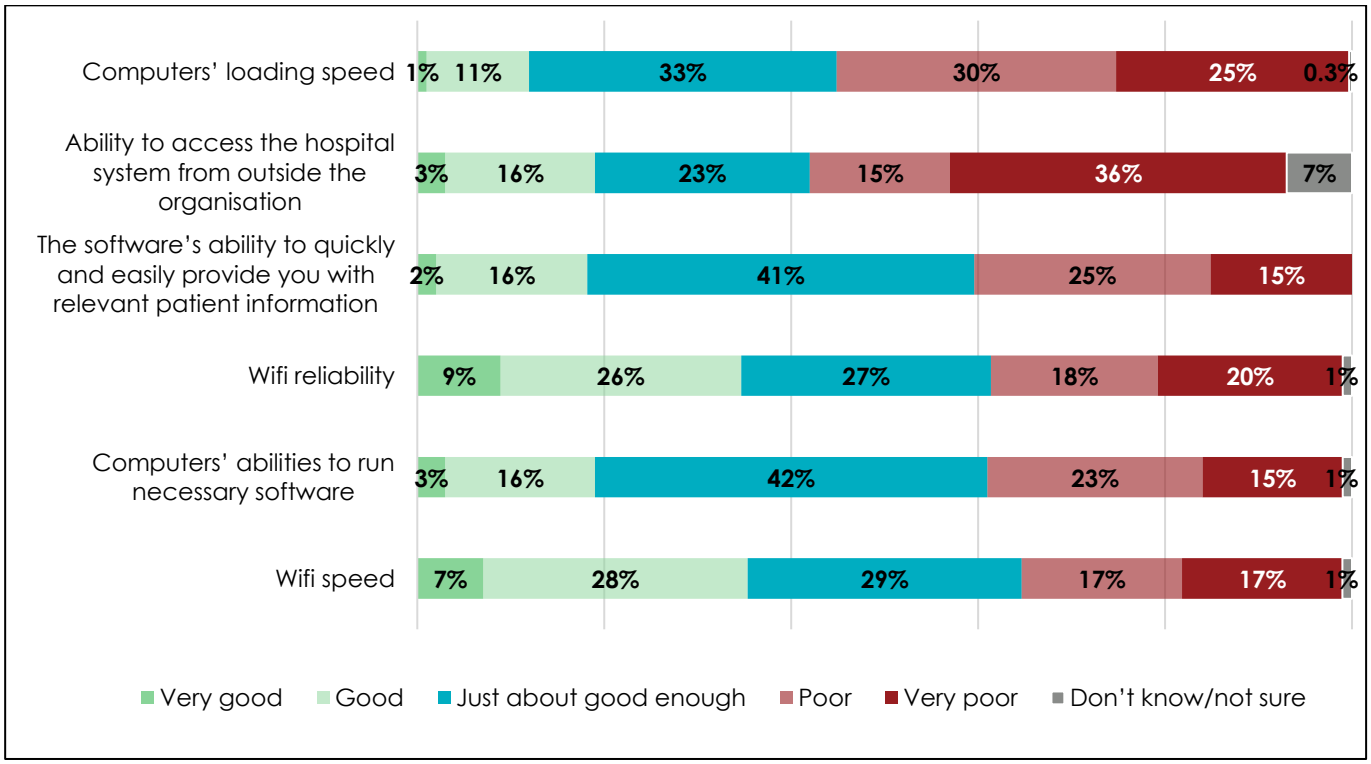
Figure 16 – Ratings of adequacy of aspects of IT systems – England
Base: 2,299 (Those working in the NHS or private sector in England, excluding student PAAs)



In Scotland, as elsewhere, computers' loading speed again stands out as the biggest area of concern. A majority (55%) gave negative ratings, including 30% as "poor" and 25% as "very poor".

In slight contrast to UK wide and England figures, the next biggest area of concern was remote access. Over half (51%) gave negative ratings to their ability to access hospital systems from outside the organisation, including 15% selecting "poor" and 36% as "very poor".

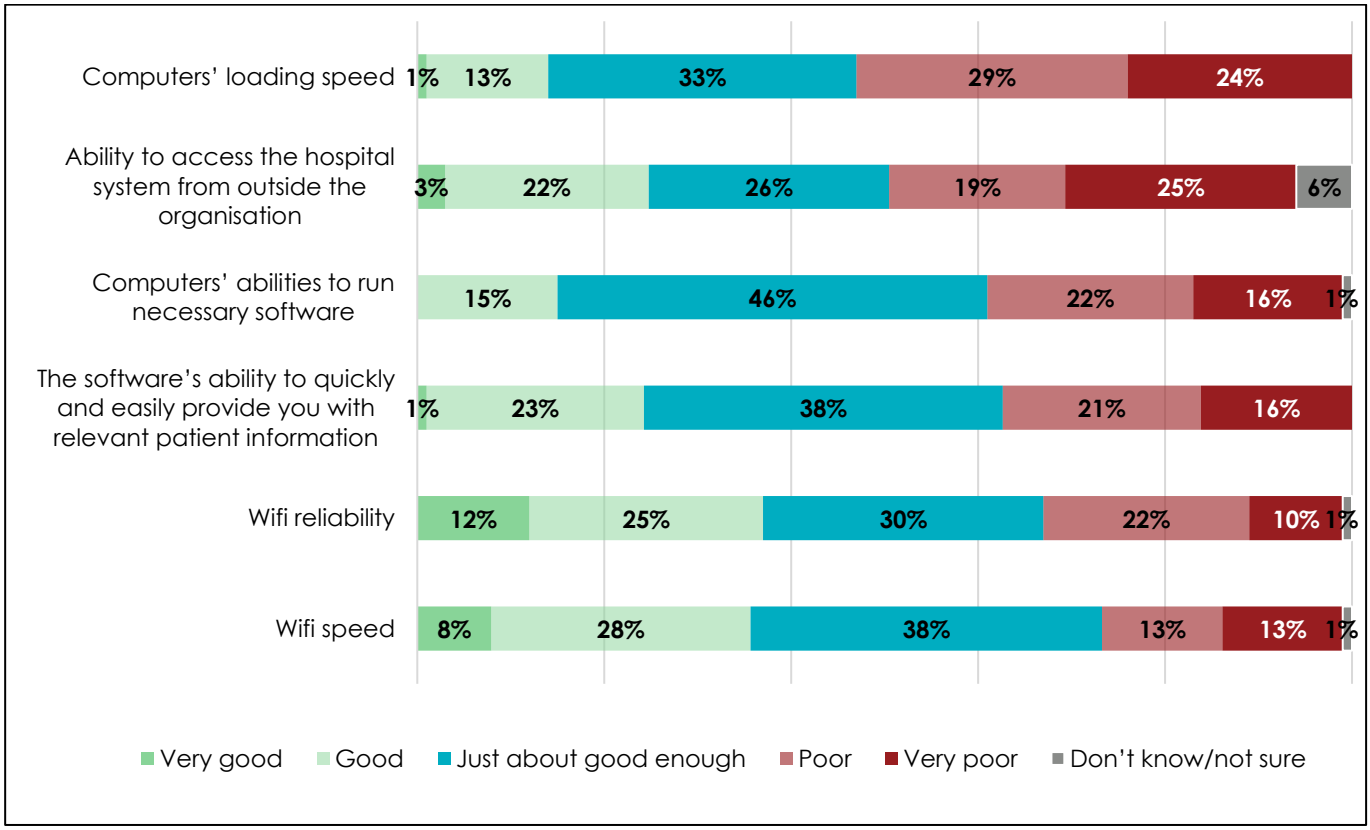
Figure 17 – Ratings of adequacy of aspects of IT systems – Scotland
Base: 287 (Those working in the NHS or private sector in Scotland, excluding student PAAs)



In Wales, computers' loading speed was also the weakest-rated area. Over half of respondents (53%) rated loading speed negatively, with 29% selecting "poor" and 24% "very poor".

As in Scotland, remote access was the next biggest problem with 44% giving negative ratings, including 19% "poor" and 25% "very poor".

Figure 18 – Ratings of adequacy of aspects of IT systems – Wales
Base: 131 (Those working in the NHS or private sector in Wales, excluding student PAAs)

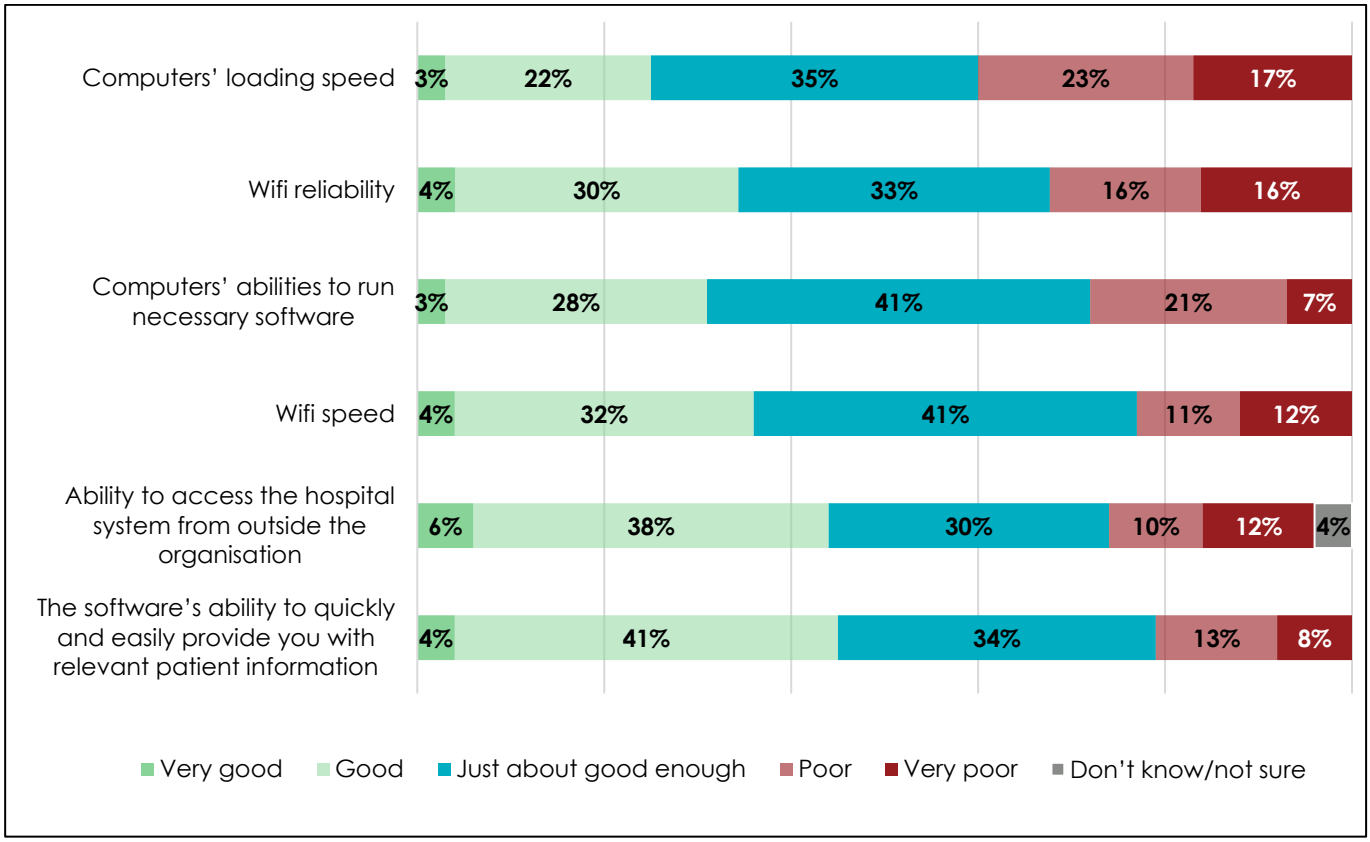


In Northern Ireland, respondents' ratings of IT adequacy appeared somewhat more positive overall than in other UK nations, although substantial minorities still had concerns.

Computers' loading speed still attracted the most negative reviews – although unlike in the other UK nations, at 40%, these did not constitute a majority. These broke down as 23% selecting "poor" and 17% "very poor". The next biggest area of concern was wifi reliability, with 32% negative ratings (16% "poor", 16% "very poor").

However, it must be noted that, in Northern Ireland, majorities rated every area as "just about good enough," or better. This may indicate that the adoption of certain IT systems in Northern Ireland's health service may provide lessons or templates for the rest of the UK.

Figure 19 – Ratings of adequacy of aspects of IT systems – Northern Ireland
Base: 58 (Those working in the NHS or private sector in Northern Ireland, excluding student PAAs)



Paper records

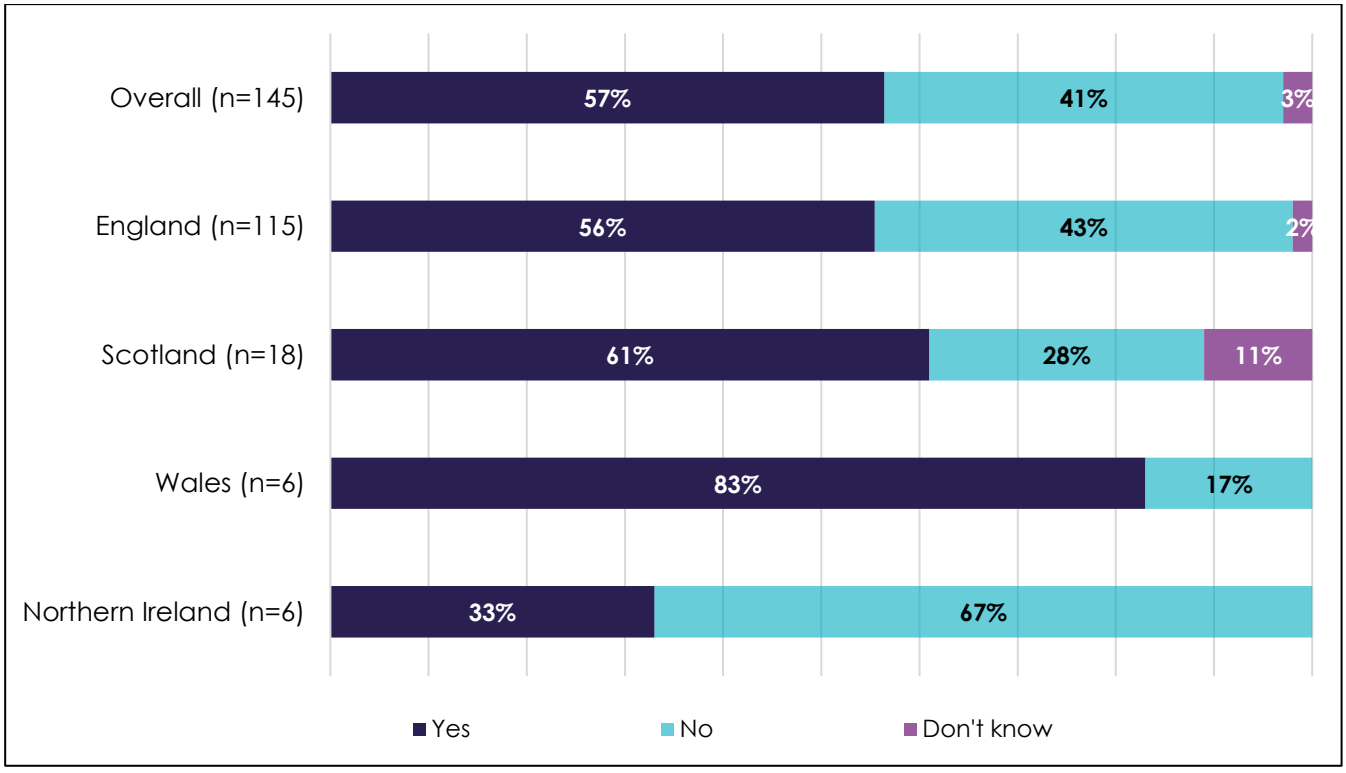
Clinical leaders were asked whether patient records in their organisation were still held in paper format. Overall, a majority (57%) reported that at least some paper records were still in use, while 41% said they were not. A small minority (3%) were unsure.

In England, 56% reported that paper records were still used, compared to 43% who did not.

In Scotland, 61% reported that paper records were still used, compared with 28% who said they were not. However, the Scottish base size is relatively small, and findings should therefore be interpreted with caution.

In Wales, 83% reported that paper records were still held – the largest percentage of any UK nation - compared with 17% who said they were not. In Northern Ireland, only 33% reported that paper records were still held – the lowest percentage of any UK nation – and 67% said they were not. However, the results of both of these nations should be treated with even more caution due to the very small number of respondents.

Figure 20 – Patient records in paper format by UK nation
Base: Shown in chart (Clinical leaders in the full survey)



7 Pension taxation

Introduction

Another factor influencing anaesthetists' productivity is the current pension taxation regime. The interaction between pension tax rules and the NHS Pension Scheme has historically resulted in some doctors facing large and, at times, unpredictable tax bills. This has created uncertainty about the financial benefit of undertaking additional work and, in some cases, has discouraged clinicians from increasing their hours.

While it is right that high earners should contribute more in tax than lower earners, it is important to highlight the impact the current regime may be having on NHS capacity.

In the RCoA's 2020 Census, it was estimated that 1,133 consultants (14.4%) were reducing their working hours due to pension taxation. In addition, of the 341 consultants and 45 SAS doctors who retired in the year preceding the Census, 82 (22%) were reported to have retired for this reason. At that time, pension taxation appeared to be having a significant impact on workforce capacity.

Following sustained advocacy from the RCoA and others, changes to pension taxation rules were announced in the March 2023 Budget. The then Chancellor, Jeremy Hunt, stated that these reforms would prevent over 80% of NHS doctors from incurring a pension tax charge. Despite these changes, pension taxation has continued to be cited anecdotally as a concern.

The Workforce Census 2025 therefore sought to assess the current impact of pension taxation on anaesthetists' working patterns and retirement decisions, and to quantify the extent to which it may still be affecting anaesthetists' working lives and constraining NHS productivity.

Key findings

- 57% of all anaesthetic staff were dissatisfied with the pension taxation regime – including 75% of consultants and 49% of SAS doctors.
- 29% of consultants and 14% of SAS doctors (26% combined) reported that they were reducing their working hours due to pension taxation at the time of the survey.
- Of those consultants and SAS doctors who were reducing their hours, on average they said they would work an extra 2.5 additional programmed activities (PAs) per week if pension taxation were not an issue.
- Securing that extra time would equate to an estimated 7,826 extra PAs of anaesthetic time per week across the UK – a 5.5% increase in capacity. It would also enable almost 10,000 additional patient cases per week across the UK, equivalent to around 450,000 additional cases per year.
- 24% of all anaesthetic staff who were considering leaving the NHS or unsure about staying said that reform of pension taxation would make them more likely to remain, rising to 49% among consultants.

Satisfaction with pension taxation

After computer/IT systems, the next biggest area of dissatisfaction in the working lives of anaesthetic staff was pension taxation - which also has a big impact on productivity.

As outlined in Figure 11 earlier, satisfaction with the pension taxation regime was notably low, with 16% "very" or "mostly" satisfied. Conversely, 57% were "very" (35%) dissatisfied and "mostly" (22%) dissatisfied.

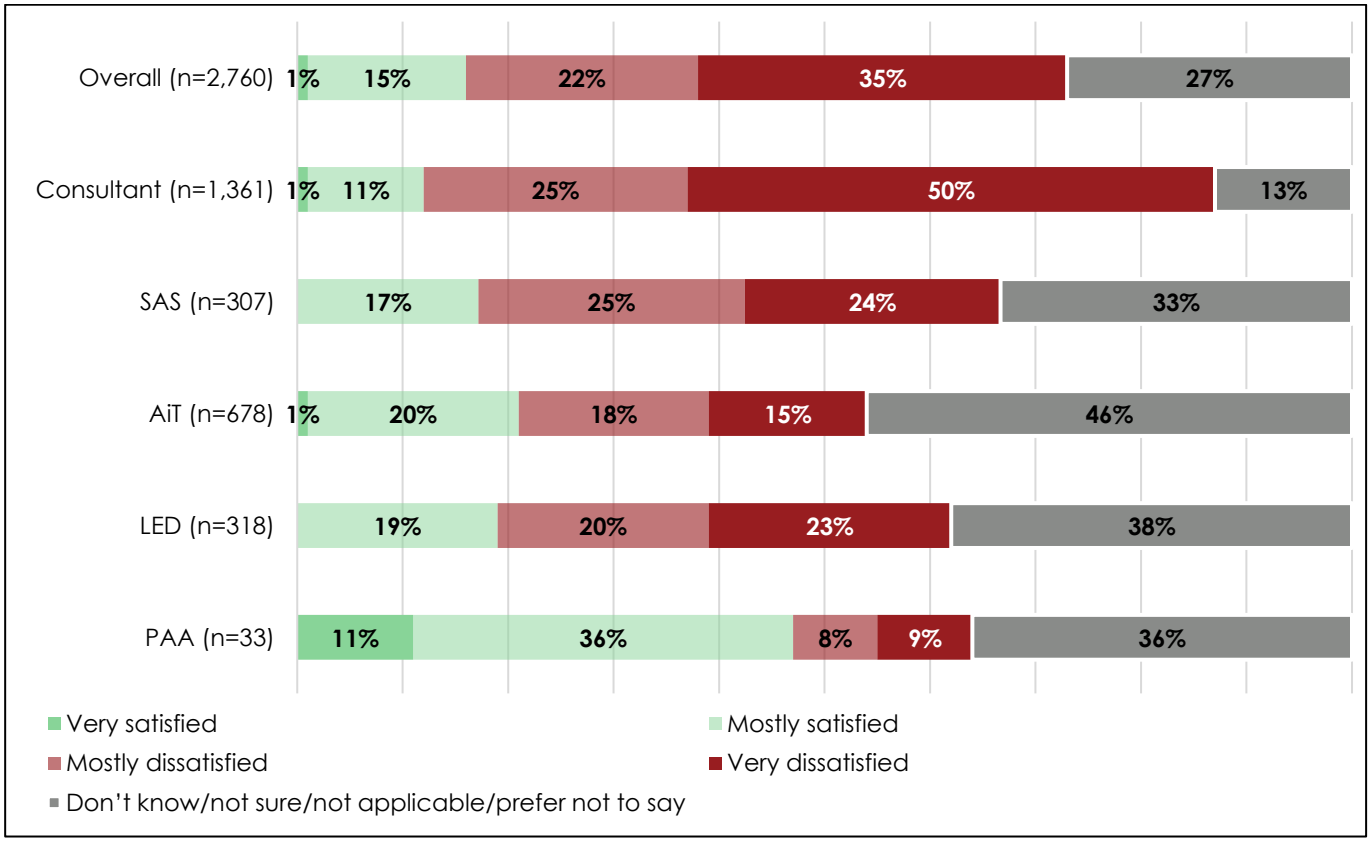
These findings suggest that, despite recent policy changes, pension taxation continues to be perceived as problematic for those working in the NHS. This may be negatively influencing morale and, as we will go on to demonstrate, workforce capacity too.

Levels of satisfaction with the current pension taxation regime were fairly low across the workforce, with dissatisfaction outweighing satisfaction in most staff groups.

Consultants expressed the highest levels of dissatisfaction, with 75% reporting some level of dissatisfaction, including 25% who selected "mostly dissatisfied" and 50% "very dissatisfied". Only 12% reported being satisfied. This indicates that pension taxation remains a particularly acute concern among senior doctors.

Among SAS doctors, dissatisfaction was also more common than satisfaction, though less pronounced than for consultants. Around half (49%) reported some level of dissatisfaction, including 25% "mostly dissatisfied" and 24% "very dissatisfied". This compared with 17% satisfied, while a third (33%) were unsure or felt the question was not applicable.

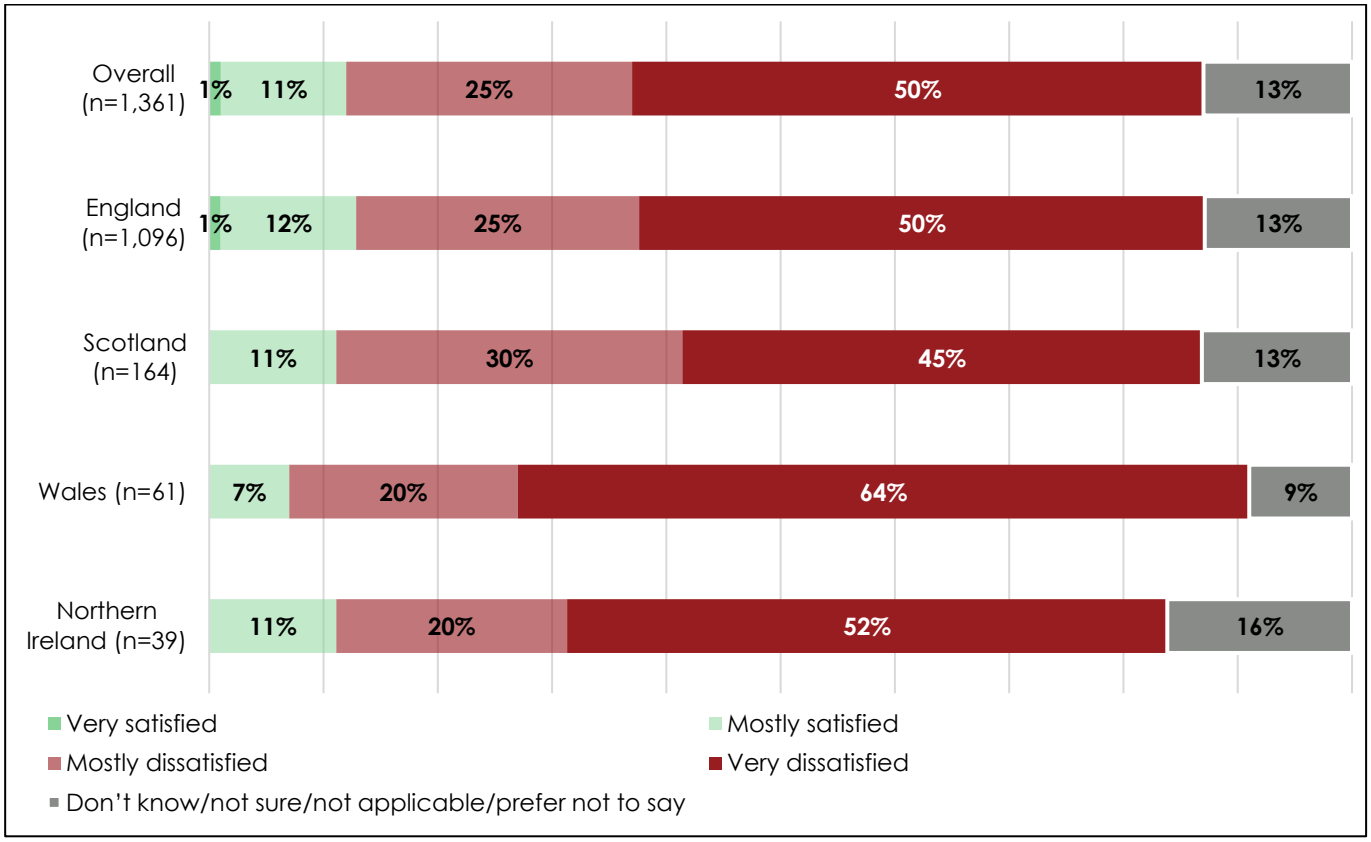
Figure 21 – Satisfaction with current pension taxation regime by staff group
Base: Shown in chart (Those working in the NHS, excluding student PAAs and Crown Dependency responses)



Among consultants, dissatisfaction with the current pension taxation regime was evident across all four nations, with "very dissatisfied" the most commonly selected response in each case.

In England, 75% expressed they were dissatisfied (25% "mostly" and 50% "very"). In Scotland this was also 75% (30% "mostly", 45% "very"). In Wales dissatisfaction was greatest of all, with 84% dissatisfied (20% "mostly", 64% "very"). In Northern Ireland, 72% were dissatisfied (20% "mostly", 52% "very"), though the base size here is relatively small, so these findings should be interpreted with caution.

Figure 22 – Consultant satisfaction with current pension taxation regime by UK nation
Base: Shown in chart (Consultants working in the NHS or private sector, excluding student PAAs and Crown Dependency responses)

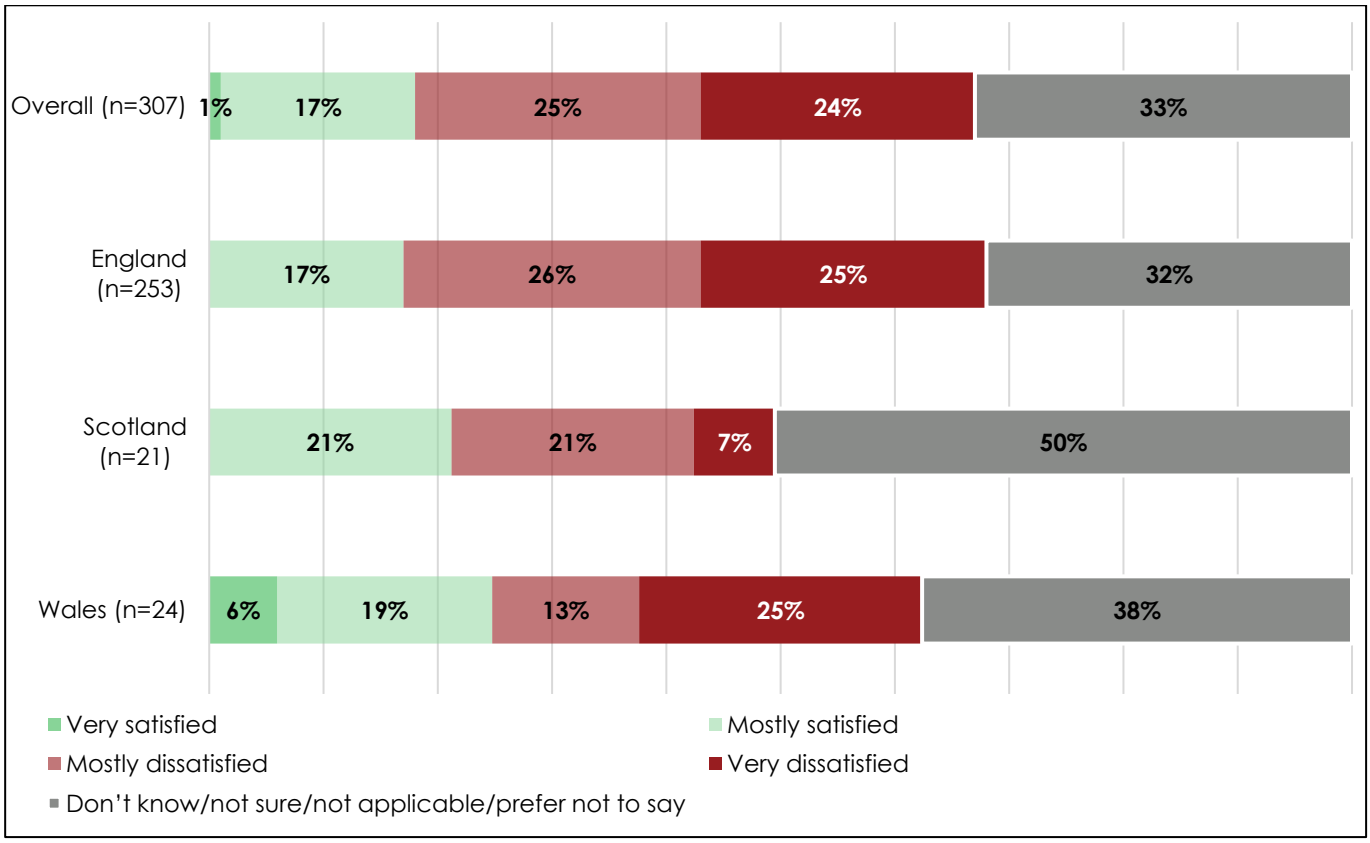


As mentioned earlier, across all nations SAS doctors' views on the current pension taxation regime were more mixed than among consultants, though dissatisfaction still outweighed satisfaction overall. Also, a substantial proportion also selected "don't know/not sure/not applicable" (33%).

In England, 51% reported being dissatisfied (26% "mostly" and 25% "very dissatisfied"). In Scotland, 28% were dissatisfied (21% "mostly" and 7% "very dissatisfied") and in Wales the figure was 38% (13% "mostly" and 25% "very dissatisfied"). In both cases, however, the base sizes were small and should be interpreted with caution.

Results from Northern Ireland have not been presented separately due to the even smaller base size (n=8), meaning percentages would not be robust.

Figure 23 – SAS doctor satisfaction with current pension taxation regime by UK nation
Base: Shown in chart (SAS doctors working in the NHS or private sector, excluding student PAAs and Crown Dependency responses)



Reduction in hours due to pension taxation

The current pension taxation regime is not only a source of dissatisfaction but also has potential implications for workforce capacity. To understand its practical impact, the Census asked respondents whether they were currently reducing their working hours as a result of the pension taxation regime.

Across all anaesthetists, 17% reported that they were currently working fewer hours due to pension taxation, which was highest amongst consultants (29%).

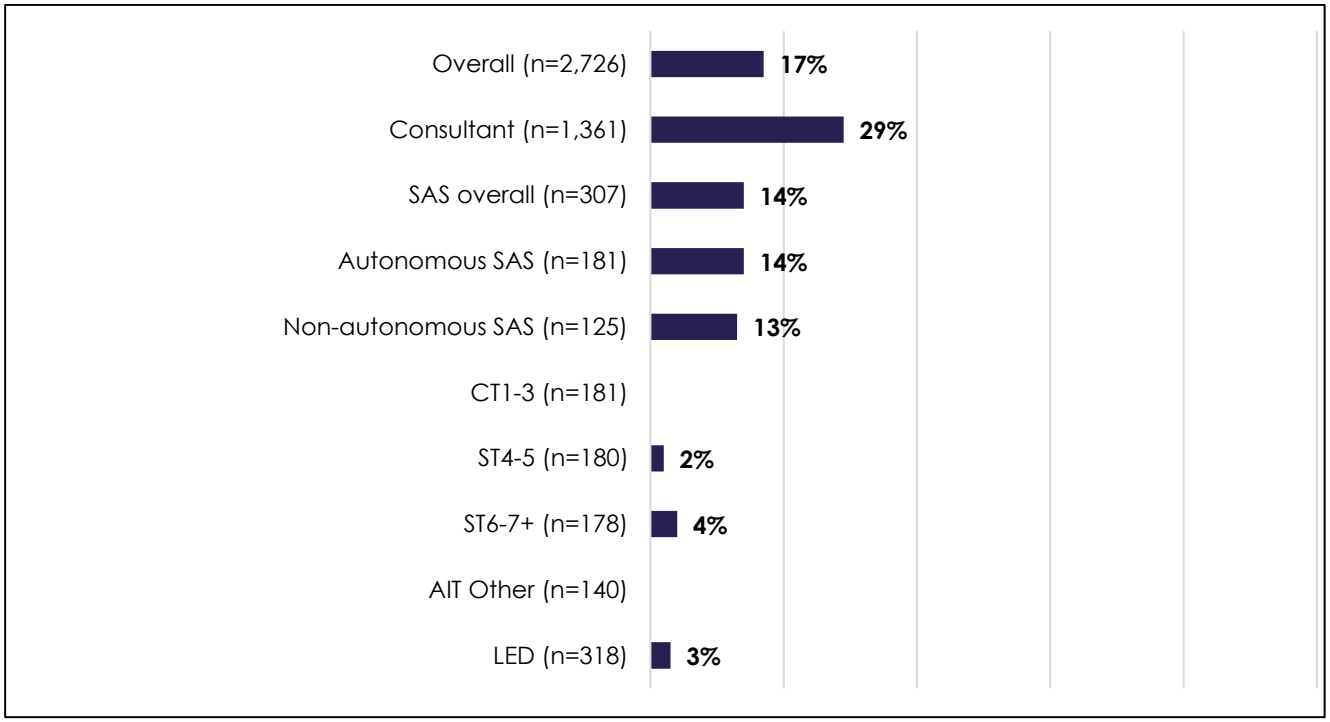
Among SAS doctors overall, around one in seven (14%) reported reducing their hours, with similar proportions among autonomous (14%) and non-autonomous SAS doctors (13%).

In contrast, relatively small proportions of AiTs reported reducing their hours. This includes no AiTs at CT1-3 level, 2% of those at ST4–5 level and 4% at ST6–7+ level.

Among LEDs, just 3% reported reducing their hours due to pension taxation.

Overall, the findings suggest that the impact of pension taxation on working hours is more concentrated among consultants and SAS doctors and is much less evident among other staff groups.

Figure 24 – Currently reducing hours by staff group
Base: Shown in chart (Those working in the NHS, excluding all PAAs and all Crown Dependency responses)



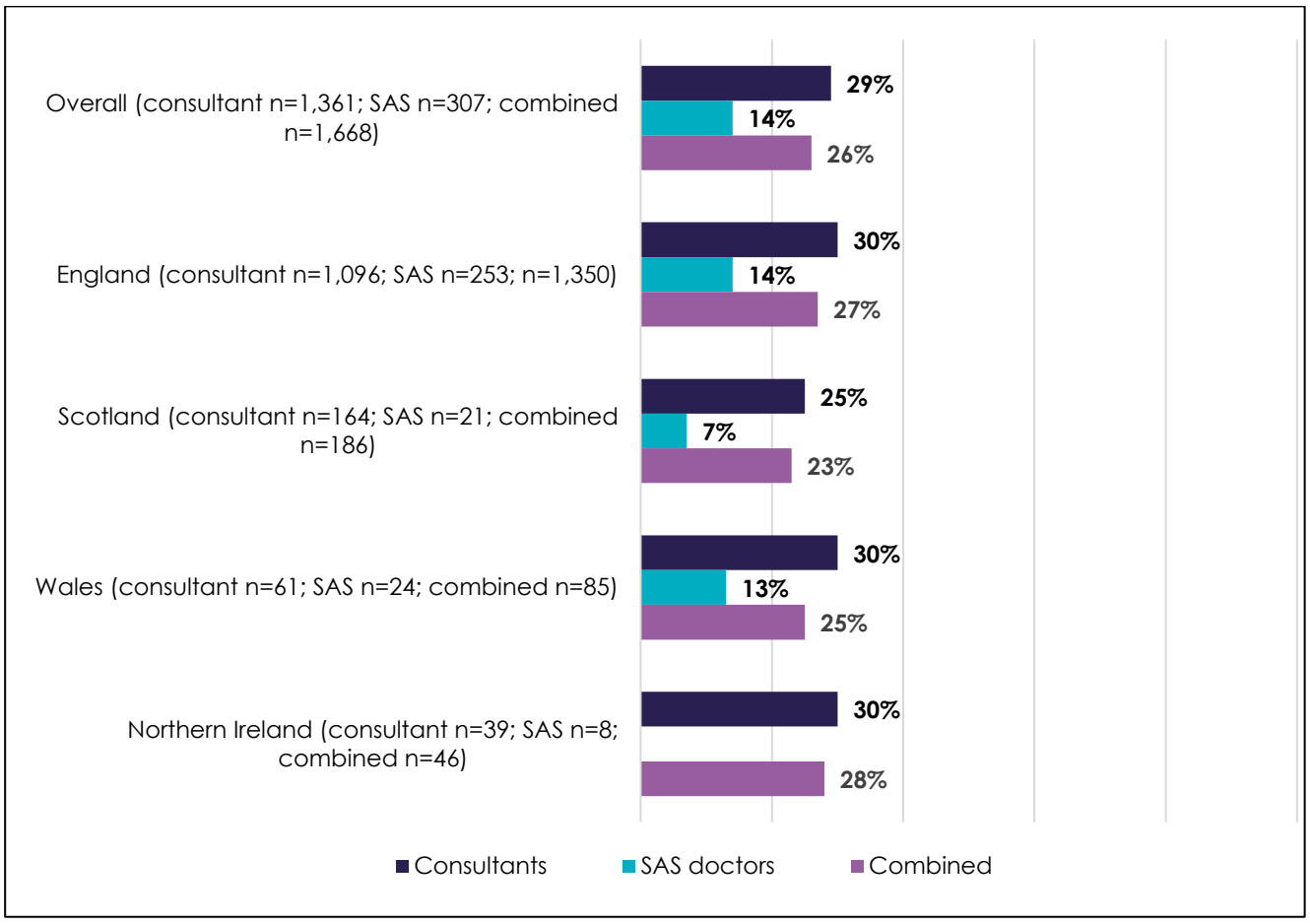
Grouping consultant and SAS anaesthetists together, 26% reported that they were currently working fewer hours due to pension taxation across the UK. This figure was broadly consistent between UK nations, with 27% working fewer hours in England, 23% in Scotland, 25% in Wales, and 28% in Northern Ireland.

Looking at consultants exclusively, 29% reported reducing their hours across the UK. Again, the pattern was relatively consistent across the different UK nations. In England, Wales, and Northern Ireland, this figure was 30%. However, it was slightly lower in Scotland, at 25%.

Among SAS doctors, the proportions were lower than for consultants in all nations. Overall, 14% of SAS doctors reported reducing their hours due to pension taxation. In England, the proportion was also 14%, mirroring the overall SAS figure. In Wales, 13% reported reducing hours, while in Scotland this fell to 7%.

The number of SAS respondents in Northern Ireland was very small (n=8), meaning the percentage is not reported separately.

Figure 25 – Consultants and SAS doctors currently reducing hours by UK nation
Base: Shown in chart (Consultants working in the NHS, excluding all PAAs and all Crown Dependency responses)



Quantifying hours lost due to pension taxation

Respondents who indicated that they were reducing their hours due to the current pension taxation regime were asked how much more they would work if pension taxation were no longer an issue. Responses were given in terms of programmed activities (PAs), the standard unit of NHS working time for consultants and SAS doctors. One PA equates to four hours of weekday working time, or three hours at weekends.

Only consultants and SAS doctors are shown in this analysis, as the base sizes for other staff groups who reported reducing their hours were too small to provide robust estimates.

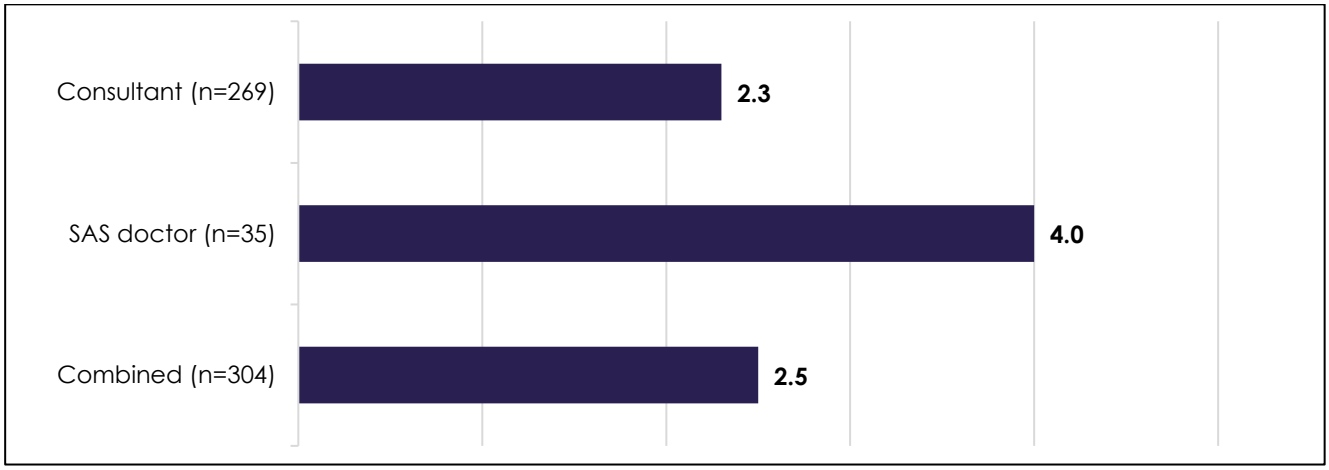
Among consultants, those reducing their hours reported that they would work an average of 2.3 additional PAs if pension taxation were not a factor. This equates to approximately 9 additional weekday hours per week (or just under 7 hours at weekend rates).

Among SAS doctors, the reported average was higher at 4.0 additional PAs, which is equivalent to around 16 additional weekday hours per week (or 12 hours at weekend rates). However, the smaller base size for SAS doctors should be noted when interpreting this figure.

Across a weighted average of consultants and SAS doctors, those reducing their hours reported that they would work an average of 2.5 additional PAs if pension taxation were not a factor. This equates to approximately 10 additional weekday hours per week (or just under 7.5 hours at weekend rates).

Figure 26 – Consultant and SAS doctor extra PAs worked per week if pension taxation were not an issue by staff group

Base: Shown in chart (Consultants and SAS doctors currently reducing their hours who gave an answer)

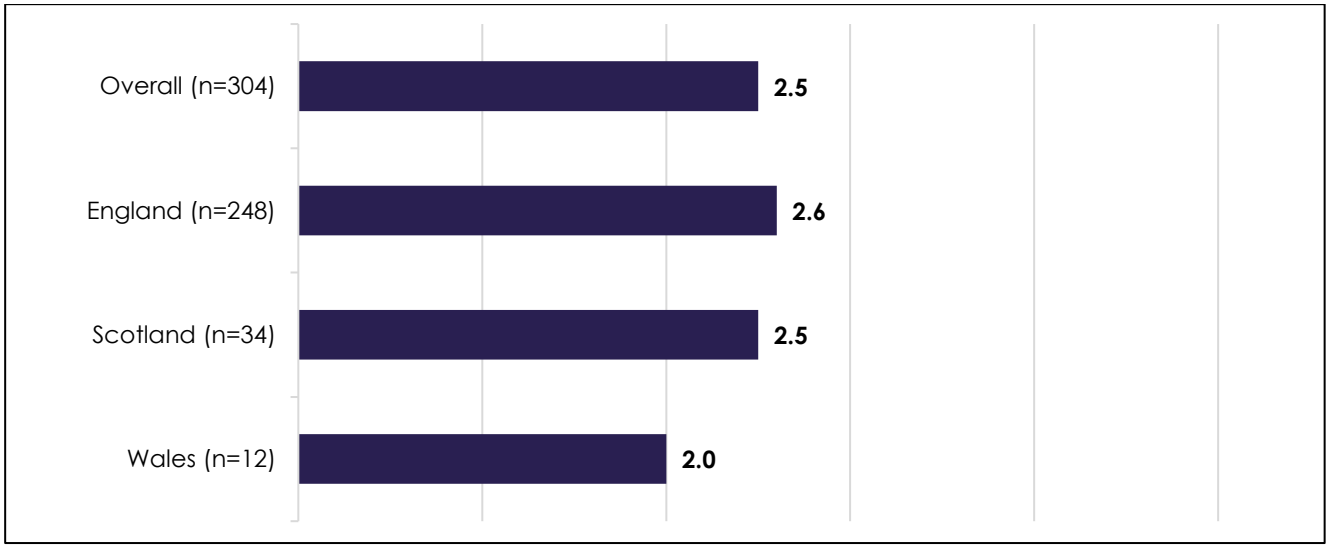


Breaking the figures down by UK nation requires combining consultants and SAS doctors into one group. This is due to small base sizes when analysed separately. However, even with this combination, the number of respondents remained too small in Northern Ireland to produce a figure reliable and hence is not included in the reporting.

Overall, the findings suggest a fairly consistent pattern across nations. In England, the average was slightly higher than the UK average (2.5) at 2.6 PAs. In Scotland, the figure was 2.5 PAs, also closely mirroring the overall result. In Wales, the reported average was lower at 2.0 PAs; however, the smaller base size in Wales should be taken into account when interpreting this figure.

Figure 27 – Consultant and SAS doctor extra worked per week if pension taxation were not an issue by UK nation

Base: Shown in chart (Consultants and SAS doctors currently reducing their hours who gave an answer)



Quantifying patient cases lost due to pension taxation

As shown in the previous sections, 26% of consultants and SAS doctors reported that they were reducing their hours due to pension taxation. Among those affected, the number of extra PAs they would work if pension taxation were not an issue was 2.5 per week.

In the Census survey completed by clinical leaders, headcounts of 9,858 consultants and 2,182 SAS were recorded across the UK. Combining all this data allows one to estimate the total potential of additional PAs that could be worked per week if pension taxation were not a limiting factor – a figure of almost 8,000 (specifically, 7,826).

Furthermore, additional data from the survey of the wider anaesthetic workforce shows the average number of PAs currently worked by a consultant or SAS anaesthetist per week is 11.2. This means, again on average, a total of 134,848 PAs are worked per week across the workforce. Increasing that figure by 7,826 would represent a 5.5% increase in total PAs.

The average number of patients that consultant and SAS doctors (combined) administer anaesthetic to per week is 14. This yields an average of 1.3 cases per PA. Combining all this additional data allows one to estimate the total potential additional cases that could be performed per week if pension taxation were not a limiting factor – a figure of almost 10,000 (specifically, 9,783).

These figures can be broken down by UK nation. In England, around 27% of respondents reported reducing their hours, with an average reduction of 2.6 PAs per week, equating to an estimated 7,181 PAs lost per week. This represents a potential 5.9% increase in available PAs, equivalent to around 9,122 additional cases per week.

In Scotland, 23% reported reducing their hours, with an average reduction of 2.5 PAs per week. This corresponds to around 518 PAs lost per week, or a potential 5.0% increase in PAs, equating to approximately 635 additional cases per week.

In Wales, 25% reported reducing their hours, though the average reduction was slightly lower at 2.0 PAs per week. This results in an estimated 307 PAs lost per week, representing a 3.9% potential increase in PAs, equivalent to around 319 additional cases per week.

Finally, in Northern Ireland, 28% reported reducing their hours, with an average reduction of 1.8 PAs per week. This equates to approximately 150 PAs lost per week, representing a potential 4.1% increase in PAs and around 193 additional cases per week.

Figure 28 – Estimate of PAs and cases lost to the NHS per week amongst consultants and SAS doctors

Nation	% currently reducing hours	Average PAs reduced per week	Estimated total PAs lost per week	Estimated % increase in PAs per week*	Total extra cases across workforce per week^
England	27%	2.6	7,181	5.9%	9,122
Scotland	23%	2.5	518	5.0%	635
Wales	25%	2.0	307	3.9%	319
Northern Ireland	28%	1.8	150	4.1%	193
Overall	26%	2.5	7,826	5.5%	9,783

* Based on the average number of PAs worked per week: 11.1 in England, 11.0 in Scotland, 12.4 in Wales, 11.7 in Northern Ireland, and 11.2 across the UK.

^Based on the average number of weekly cases for consultants and autonomous SAS doctors only: 14.1 in England, 13.5 in Scotland, 12.9 in Wales, 15.0 in Northern Ireland, and 14.0 across the UK.

The weekly estimates of lost programmed activities (PAs) can also been scaled to an annual level by factoring in the average number of weeks worked per year by consultants and SAS doctors, taking into account annual leave*.

This means, on average, for each consultant and SAS anaesthetist, the potential extra annual working time is 115.4 PAs. Summing this across the workforce yields a figure of around 360,000 (361,248 specifically) PAs that potentially could be gained per year if pension taxation were not an issue.

Based on the average number of patients treated by consultants and autonomous SAS doctors, restoring this capacity could enable just over 450,000 (specifically 451,560) additional cases per year.

As with the weekly estimates, these figures can be broken down by UK nation. In England, just over 330,000 (specifically 332,756) extra PAs could potentially be gained per year if those hours were restored, equivalent to around 420,000 (specifically 422,690) cases.

In Scotland, almost 25,000 (23,846) extra PAs could potentially be gained per year, equating to almost 30,000 (29,266) additional cases. In Wales, the figures come to just over 14,000 (14,124) extra PAs, equivalent to almost 15,000 (14,693) additional cases. Finally, in Northern Ireland, the figures come to just under 7,000 (6,942) PAs, which could translate to just under 9,000 (8,900) additional cases.

Figure 29 – Estimate of PAs and cases lost to the NHS per year amongst consultants and SAS doctors

Nation	% currently reducing hours	Average PAs reduced per year	Estimated total PAs lost per year*	Estimated % increase in PAs per year	Total extra cases across workforce per year^
England	27%	120.5	332,756	5.9%	422,690
Scotland	23%	115.2	23,846	5.0%	29,266
Wales	25%	92.2	14,124	3.9%	14,693
Northern Ireland	28%	83.2	6,942	4.1%	8,900
Overall	26%	115.4	361,248	5.5%	451,560

*Based on the average number of weeks worked per year: 46.34 in England, 46.08 in Scotland, 46.08 in Wales, 46.22 in Northern Ireland and 46.16 across the UK.

^Based on average number of annual cases for consultants and autonomous SAS doctors only.

Behaviour and pension tax bills

Respondents were asked whether they had actually received a pension tax bill in specified preceding years.

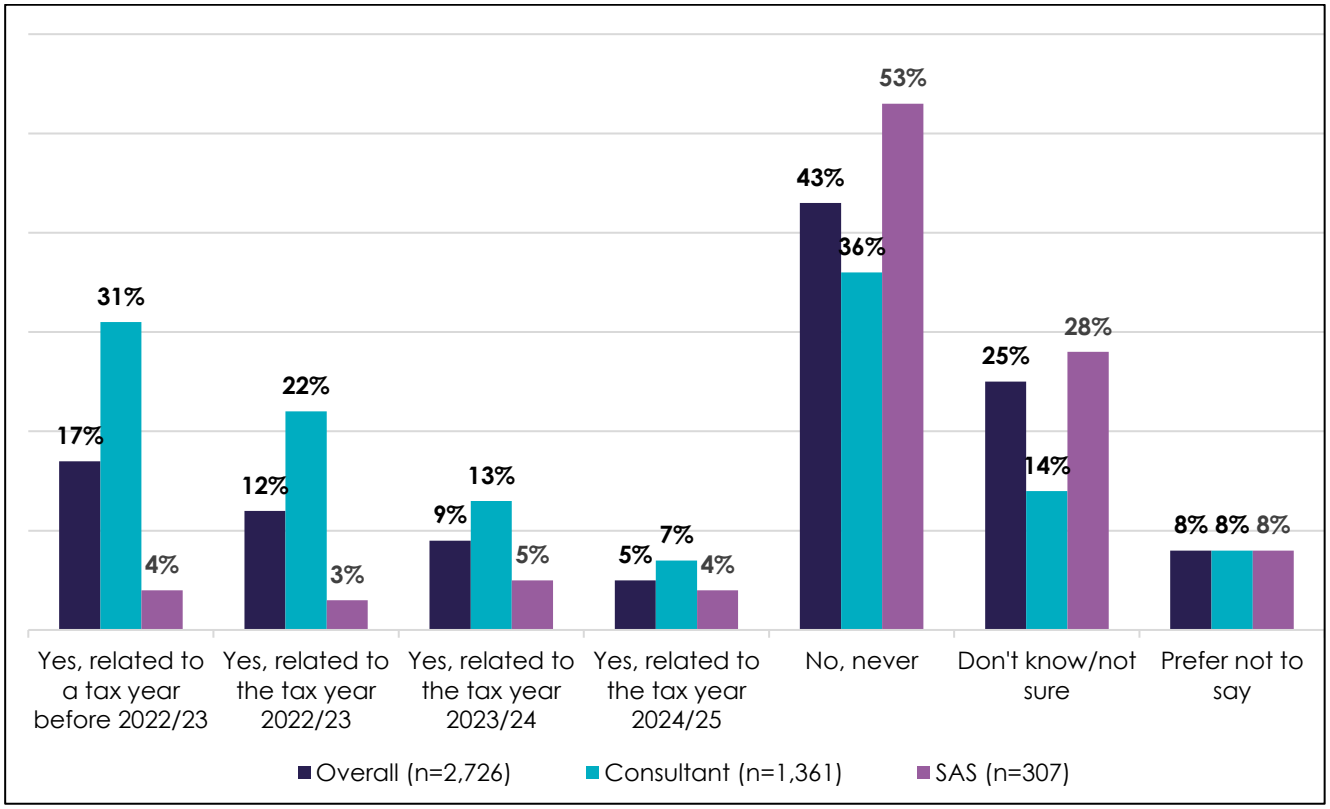
Overall, 17% reported receiving a pension tax bill relating to a tax year before 2022/23. Twelve per cent reported receiving a bill relating to the 2022/23 tax year, 9% for 2023/24, and 5% for 2024/25 – although, in that last case, that tax year had only just ended at the time of the survey. In contrast, 43% said they had never received a pension tax bill. A further 25% were unsure, and 8% preferred not to say.

Consultants were substantially more likely than other groups to report having received a pension tax bill. Around three in ten (31%) said they had received a bill relating to a tax year before 2022/23, 22% for 2022/23, 13% for 2023/24, and 7% for 2024/25. Just over a third (36%) reported never having received a tax bill, and 14% were unsure.

SAS doctors were less likely to report receiving pension tax bills. 4% said they had received a bill relating to a tax year before 2022/23, 3% for 2022/23, 5% for 2023/24, and 4% for 2024/25. Over half (53%) reported never having received a pension tax bill, while 28% were unsure.

The pattern suggests that the proportion of anaesthetists reporting pension tax bills has decreased in more recent tax years. This may reflect the changes made in the 2023 Budget, which were intended to reduce the number of doctors affected by pension tax charges. However, it is also possible that behavioural change has contributed to this trend, with some anaesthetists reducing their working hours in order to avoid triggering pension tax liabilities.

Figure 30 – Receipt of taxation bills by year
Base: Shown in chart (Those working in the NHS, excluding all PAAs and all Crown Dependency responses)



That latter factor was explored by asking respondents whether they had limited, or were currently limiting, their hours in order to prevent themselves from being hit by a pension tax bill.

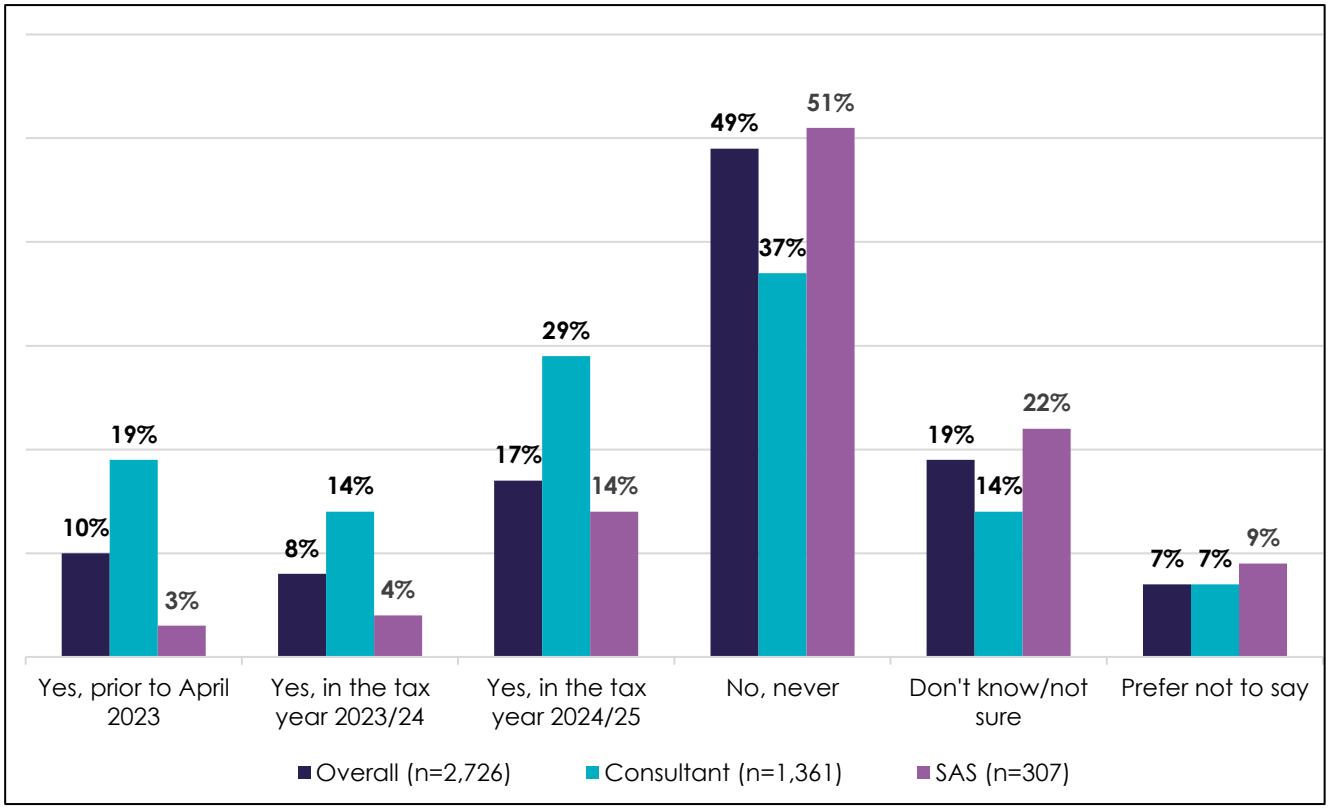
The figures do indeed indicate behavioural change over time. 10% of anaesthetic staff said they had limited their hours prior to April 2023 due to pension taxation, 8% in 2023/4, rising to 17% in 2024/25. Around half (49%) reported that they had never done this. A further 19% were unsure and 7% preferred not to say.

Consultants were the most likely to report limiting their hours – 19% had done so prior to April 2023, 14% during the 2023/24 tax year, and nearly three in ten (29%) said they were currently limiting their hours in the tax year 2024/25. Just over a third (37%) stated that they had never limited their hours in response to pension taxation.

SAS doctors were less likely to report having reduced their hours for this reason – 3% had done so prior to April 2023, 4% during the 2023/24 tax year, and 14% said they were currently limiting their hours in the tax year 2024/25. A slim majority (51%) reported never limiting their hours due to pension taxation, although 22% were unsure.

Figure 31 – Reducing hours by year

Base: Shown in chart (Those working in the NHS, excluding all PAAs and all Crown Dependency responses)



Pension taxation and retention

As per the Census Wellbeing report, 19% of all anaesthetic staff indicated that they did not expect to be working in the NHS in five years' time, and a further 22% were unsure.

That group was then asked whether certain changes would make them want to stay working in the NHS. One of the options presented was pension taxation.

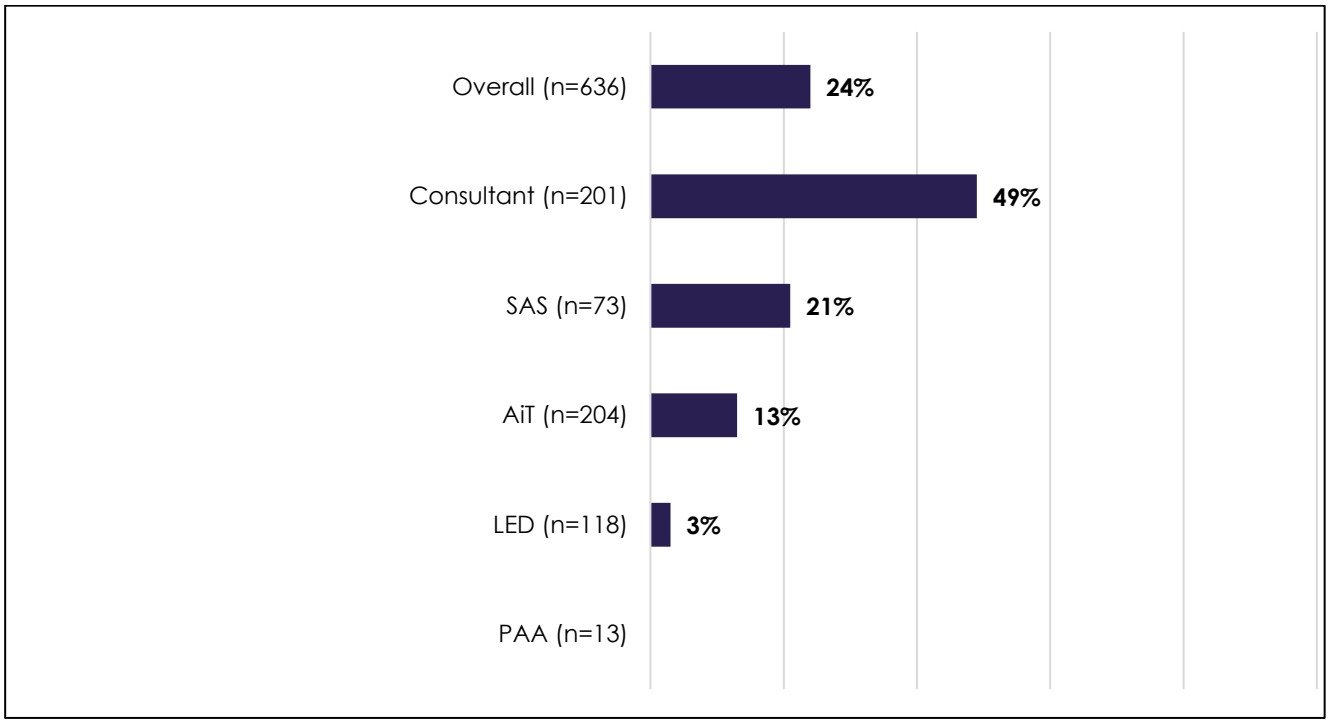
Overall, almost a quarter (24%) of the group said that changes to pension taxation would make them more likely to remain in the NHS. The impact was particularly pronounced among consultants: nearly half (49%) of consultants who were expected to leave, or were unsure, said that reform of the pension taxation regime would influence them to stay.

Among relevant SAS doctors, 21% said that pension taxation changes would make them more likely to remain. The proportion was lower among AiTs (13%) and LEDs (3%).

These findings suggest that, while pension taxation does not account for all intentions to leave NHS employment, it represents a potentially significant lever for improving retention, particularly among consultants.

Figure 32 – Changes to the pension taxation regime would contribute to wanting to stay working in the NHS by staff group

Base: Shown in chart (Those who were not intending to still be working in the NHS in five years or were unsure, excluding retirement as a reason for leaving)



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Report authors

Andrew Cameron
Research Director
Enventure Research

Peter Kunzmann
Head of Policy and Public Affairs
Royal College of Anaesthetists