

# Anaesthetic Workforce Census 2025

## Anaesthetists' Working Lives



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# 1 Executive summary

## Background

The contribution anaesthetists make to the NHS is huge. 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. However, the working lives of anaesthetists remain under-studied – which is what this report aims to correct.

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 one component of this, respondents were asked about their backgrounds, the sectors they work in, their working hours, their supervision arrangements, and a great deal more.

## 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 relevant 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

### Doctors' backgrounds

- The proportion of doctors who gained their primary medical qualification (PMQ) in the UK varies considerably by anaesthetic staff group. 93% of AiTs gained their PMQ in the UK, 80% of consultants, 56% of LEDs, and 41% of SAS doctors.
- Within SAS doctor grades, 60% of specialist doctors gained their PMQ in the UK, compared to 39% of specialty doctors and 24% of associate specialist doctors.

### Sectors where anaesthetic staff work

- Across all anaesthetic staff, 99.0% work at least some of the time in the NHS and 79.6% work in the NHS exclusively.
- 17.8% do at least some of their work in the independent sector, but only 0.7% do it exclusively – indicating a tiny purely independent sector workforce.
- 1.4% do at least some of their work in the military, including 0.2% exclusively.
- Consultants are the group most likely to do some work in the independent sector (33.1%), but only 1.3% do it exclusively. The majority, 98.3% do at least some work in the NHS and 64.4% do it exclusively.

## NHS contracts

- The anaesthetic workforce is mostly permanently employed, particularly consultants (93.7%) and SAS doctors (88.0%), with limited numbers on fixed-term or external/agency locum contracts.
- In contrast, LEDs are predominantly employed on fixed-term contracts (81%), with only a small minority holding permanent roles (15%).

## Additional areas of work

- 60% of consultants, SAS doctors and LEDs worked in anaesthesia exclusively.
- 33% worked in both anaesthesia and intensive care medicine, whilst 5% worked in anaesthesia and pain medicine.
- Across the UK it is estimated that 6,703 consultants work exclusively in anaesthesia, 2,366 work in both anaesthesia and intensive care medicine, and 591 work in both anaesthesia and pain medicine.

## NHS Programmed Activities (PAs)

- Most consultants (98%) and SAS doctors (96%) had job plans organised according to Programmed Activities (PAs) – however, this was true for only small numbers of LEDs (7%) and AiTs (1%).
- By staff group, autonomous SAS doctors had the highest average weekly PA total (11.9), followed by non-autonomous SAS (11.3) and consultants (11.0).
- Across the UK, consultant PAs broke down as an average of 8.0 Direct Clinical Care (DCC), 2.6 Supporting Professional Activities (SPA), 0.6 additional NHS activities, and 0.2 agreed external duties.
- Consultants in England worked an average of 11.0 PAs per week, breaking down as 7.9 DCC, 2.6 SPA, 0.6 additional contracted NHS activities, and 0.2 agreed external duties.
- Consultants in Scotland worked an average of 11.0 PAs per week, breaking down as 8 DCC, 2.6 SPA, 0.6 additional contracted NHS activities, and 0.2 agreed external duties.
- Consultants in Wales worked an average of 11.7 PAs per week, breaking down as 8.1 DCC, 2.8 SPA, 0.7 additional contracted NHS activities, and 0.1 agreed external duties.
- Consultants in Northern Ireland worked an average of 11.7 PAs per week, breaking down as 8.1 DCC, 2.4 SPA, 1.2 additional contracted NHS activities, and 0.3 agreed external duties.
- Among autonomous SAS doctors, PAs broke down as an average of 9.6 DCC, 1.7 SPA, 0.6 additional NHS activities, and 0.1 agreed external duties.
- Among non-autonomous SAS doctors, PAs broke down as an average of 9.3 DCC, 1.5 SPA, 0.5 additional NHS activities, and <0.1 agreed external duties.
- There were variations by age. For example, among consultants, the average number of PAs worked peaked in the 40-49 age group (11.4 per week). It fell to an average of 9.3 among those aged 60+.
- A majority of respondents worked more than the standard 10 PAs, including 61% of consultants and 68% of SAS doctors.

## NHS hours for AiTs, LEDs and PAAs

- Not all staff groups have job plans organised according to PAs (including the vast majority of AiTs, LEDs, and PAAs); these respondents were asked to report the hours they worked.
- On average, CT1-3 AiTs worked 46.5 hours on average per week, ST4-5 44.3 hours, ST6-7+ 43.8 hours, other AiTs 44.2 hours, LEDs 44.1 hours, and PAAs 34.6 hours.
- The vast majority of working time was devoted to DCC. For example, among CT1-3s, 44.1 hours (94.8%) were devoted to DCC, out of their total of 46.5 hours.
- At an overall level (male and female combined), over half of all AiT groups and LEDs worked over 43 hours or more per week.

- The group most likely to work more than 43 hours per week were CT1-3s, with 70% working such hours (43% working >43-48 hours, and 27% working >48 hours).
- The group most likely to work 35 hours or under were ST6-7+s, with 18% working such hours – including 35% of female ST6-7+s.

### Detailed NHS time use

- Consultant and autonomous SAS doctors spent 54.8% of their total NHS time undertaking solo clinical work, and 18.2% of their time supervising other staff.
- Consultants spent a larger proportion of their total NHS working time providing supervision than autonomous doctors (19.0% compared with 14.7%).
- Broken down by task, the single biggest chunk of consultants' and SAS doctors' NHS working time was devoted to solo working in elective surgery, accounting for 29.4%.
- This was also true for supervised staff, who spent 31.7% of their NHS working time in elective surgery.
- Consultants and SAS doctors spent 8.5% of all NHS working time providing educational supervision.

### Out of hours work

- Overall, 87% of anaesthetic staff reported doing at least some out of hours work.
- The groups most likely to do out of hours work were ST4-5s and ST6-7+s, with 97% of each of these groups engaged in this type of work. The group least likely to do out of hours work were PAAs (11%).
- Younger consultants and SAS doctors were more likely to work out of hours than older colleagues. For example, among consultants, 92% of those aged 30-39 and 93% of those aged 40-49 did at least some out of hours work, compared to 51% of those aged 60+.
- Resident out of hours work was predominantly done by non-autonomous SAS doctors, LEDs, and AiTs. For example, regarding *weekday night* resident work, 89% of ST6-7+s reported doing this kind of work at least some of the time.
- Regarding non-resident on-call work, this was predominantly done by consultants. For example, regarding *weekday night* non-resident work, 63% of consultants reported doing this kind of work at least some of the time.

### Supervision

- Among supervised staff, CT1-3 AiTs were most likely to receive 1:1 supervision (79%).
- LEDs received lower levels of 1:1 supervision (46%).
- Non-autonomous SAS doctors were least likely of all to receive 1:1 supervision (25%) and most likely to be supervised in ratios above 3:1 (30%).
- Across all groups, consultants supervised the majority of cases as opposed to autonomous SAS doctors. The proportion of supervision by consultants was highest for PAAs (96%), ST6-7+s (96%) and ST4-5s (94%).
- Non-autonomous SAS doctors had the highest proportion of cases supervised by autonomous SAS doctors (24%).

### Aspirations of anaesthetists in training

- 95% of AiTs' end goal is to become a consultant; the next most common response was 'don't know/not sure' at 4%. Only 0.4% mentioned an end goal as an SAS doctor and 0.1% as an LED.
- Becoming a consultant was overwhelmingly stated as the end goal across all grades of AiT. This included 93% of those at CT1-3 level, 97% at ST4-5 level, 99% at ST6-7+ level and 90% of other AiTs.
- It was also overwhelmingly stated as the end goal by nation, cited by 95% of AiTs in England, 99% in Scotland, 97% in Wales, and 100% in Northern Ireland.

## Annual leave

- Overall, anaesthetic staff were entitled to an average of 30.7 days of annual leave but took 28.5, leaving around two days untaken on average.
- Consultants and PAAs had the highest entitlement (32.0 and 32.1 days) and also took the most leave (29.8 and 31.4 days respectively).
- SAS doctors had the largest gap between what they were entitled to (30.2) and what they took (26.8).

## Case complexity

- Across all staff groups, 45% of cases on average were classed as low complexity (ASA 1–2) and 55% as high complexity (ASA 3+).
- PAAs had the highest proportion of low complexity cases, with 61% of their caseload falling into this category.
- Consultants had the highest proportion of high complexity cases, at 59%, followed by autonomous SAS doctors at 54%.

## College tutor role

- On average, college tutors were allocated 1.0 PAs in their job plans for college tutor work. However, on average, college tutors actually devoted 1.6 PAs to this work, with this pattern consistent by nation.

## Independent sector work

- Among the subset of consultants who undertake at least some independent sector work, the average number of hours devoted to this is 9.0 per week.
- Among the very small subset of consultants who work exclusively in the independent sector (n=16), the average numbers of hours worked was 32.1 per week.
- On average, male consultants worked more hours per week in the independent sector than female consultants (9.5 vs 7.2).
- On average, consultants aged 60+ worked the most hours in the independent sector (11.9 per week).

## Earnings

- Consultants had the highest total annual income, averaging £145,696 before tax.
- Among other doctors, LEDs had the lowest total income per year (£63,308).
- Among all anaesthetic staff, PAAs had the lowest total income per year (£55,474).

## Operating theatres

- There are an estimated 4,445 operating theatres across the UK: 3,724 in England, 384 in Scotland, 208 in Wales and 129 in Northern Ireland.

## 2 Introduction

Anaesthetists are vital to UK health services. Without anaesthetists, women would go without epidurals, 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, 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.

As such, it is vital to understand anaesthetists' working lives, which is what this report aims to achieve. This report presents the detailed findings related to factors such as: the sectors where anaesthetists work; their working hours; the time they devote to different tasks; and the supervision provided to and for staff groups such as A&Ts.

The evidence in this report will inform RCoA's advocacy and campaigning work related to the anaesthetic workforce.

# 3 Methodology

## Census background

In 2025, the Royal College of Anaesthetists (RCoA) working with Enventure Research, undertook its Workforce Census. This included surveys of anaesthetists and physician assistants in anaesthesia (PAAs) working in the UK, and clinical leaders and college tutors from NHS hospitals. This is part of the RCoA's ongoing cycle of data collection, including a full census every five years, interspersed with shorter workforce surveys.

## Questionnaire design

The questionnaires for the Workforce Census 2025 were developed collaboratively by the Royal College of Anaesthetists (RCoA) and Enventure Research.

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

## Administration and promotion

### College tutors' and clinical leaders' surveys

Headcount, demographic and shortfall-related data were collected through the RCoA Census 2025 surveys completed by clinical leaders and college tutors across NHS hospitals in the UK.

- The college tutors' survey gathered information on numbers of anaesthetists in training (AiTs) and LEDs, training capacity and related educational roles.
- The clinical leaders' survey collected headcounts for consultants, SAS doctors, LEDs and PAAs, alongside information on funded vacancies and workforce shortfalls.

Both surveys were administered online via personalised email invitations, with weekly reminders issued to encourage completion. The college tutors' survey received responses from 100% of relevant hospitals, the clinical leaders' survey received a 97% response rate by NHS Trust/Board.

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

### 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.

## 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. 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 five.

### 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.

### 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 data from the survey of the wider anaesthetic workforce

The RCoA Census received 2,797 valid responses, including 202 SAS doctors and 105 LEDs. Although the survey was voluntary and not a random probability sample, the response volume provides substantial insight into the UK anaesthetic workforce.

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  $\pm 1.7\%$  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, anaesthetists in training (AItTs), physician associates in anaesthesia (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.
- Statistically significant differences were tested and reported appropriately.
- 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.

### **Estimates based on clinical leaders' survey data**

Two versions of the clinical leaders' survey were used: a full version collecting detailed demographic data and a shorter version collecting headline counts. The latter survey was used if no response had been provided to the full version after repeated chasing. 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.

# 4 Doctors' backgrounds

## Introduction

In order to better understand the anaesthetic workforce, it is useful to know whether they gained their primary medical qualification (PMQ) in the UK or abroad.

## Key findings

- The proportion of doctors who gained their PMQ in the UK varies considerably by anaesthetic staff group. 93% of A&Ts gained their PMQ in the UK, 80% of consultants, 56% of LEDs, and 41% of SAS doctors.
- Within SAS doctor grades, 60% of specialist doctors gained their PMQ in the UK, compared to 39% of specialty doctors and 24% of associate specialist doctors.

## Location of primary medical qualification (PMQ)

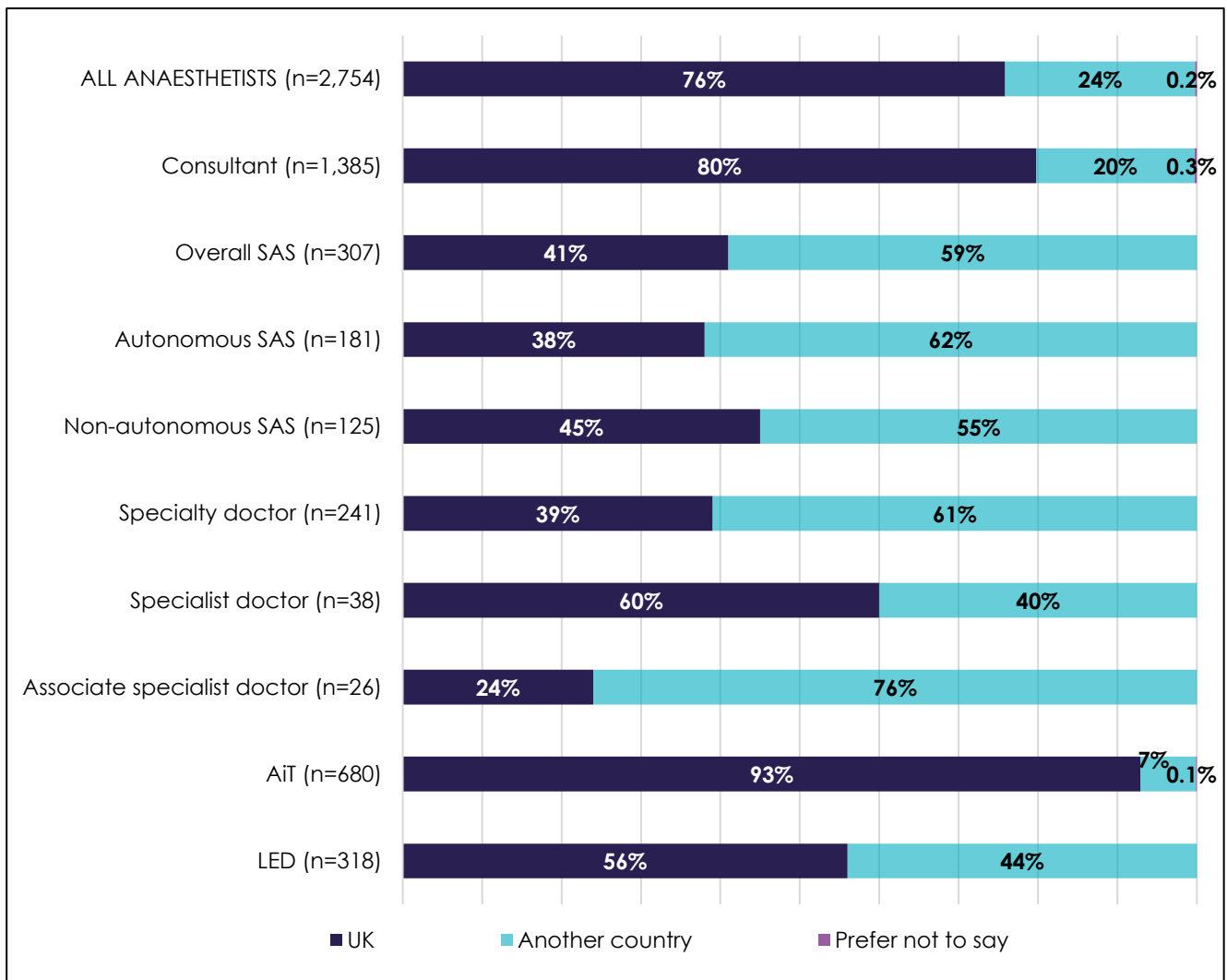
In the survey of the wider anaesthetic workforce, respondents were asked whether their PMQ was gained in the UK or in another country.

AiTs and consultants were the most likely to have trained in the UK, with the vast majority of AiTs (93%) and four in five consultants (80%) having gained their PMQ domestically.

In contrast, only 56% of LEDs and 41% of SAS doctors gained their PMQ in the UK. Within SAS doctor grades, 60% of specialist doctors gained their PMQ in the UK, compared to 39% of specialty doctors and 24% of associate specialist doctors. Comparing by level of autonomy, 38% of autonomous SAS doctors gained their PMQ in the UK compared to 45% of non-autonomous SAS doctors.

**Figure 1 – Location of primary medical qualification (PMQ) by staff group**

Base: Shown in chart (All anaesthetists in the survey of the wider anaesthetic workforce excluding Crown Dependency responses)



# 5 Sectors where anaesthetic staff work

## Introduction

Anaesthetic staff are employed across a range of healthcare settings. While the majority work within the NHS, others are based in the independent sector, the military, or academia. To build a fuller picture of the workforce, the Census examined the distribution of anaesthetists and PAAs across these different sectors.

## Key findings

- Across all anaesthetic staff, 99.0% work at least some of the time in the NHS and 79.6% work in the NHS exclusively.
- 17.8% do at least some of their work in the independent sector, but only 0.7% do it exclusively – suggesting a tiny purely independent sector workforce.
- 1.4% do at least some of their work in the military, including 0.2% exclusively.
- Consultants are the group most likely to do some work in the independent sector (33.1%), but only 1.3% do it exclusively. The majority, 98.3% do at least some work in the NHS and 64.4% do it exclusively.

## Sectors worked by staff group

Overall, across all anaesthetic staff, 99.0% work at least some of their time in the NHS, and 79.6% work in the NHS exclusively. 17.8% do at least some of their work in the independent sector, but only 0.7% do it exclusively. This suggests the independent sector workforce that exists entirely beyond the NHS is extremely small.

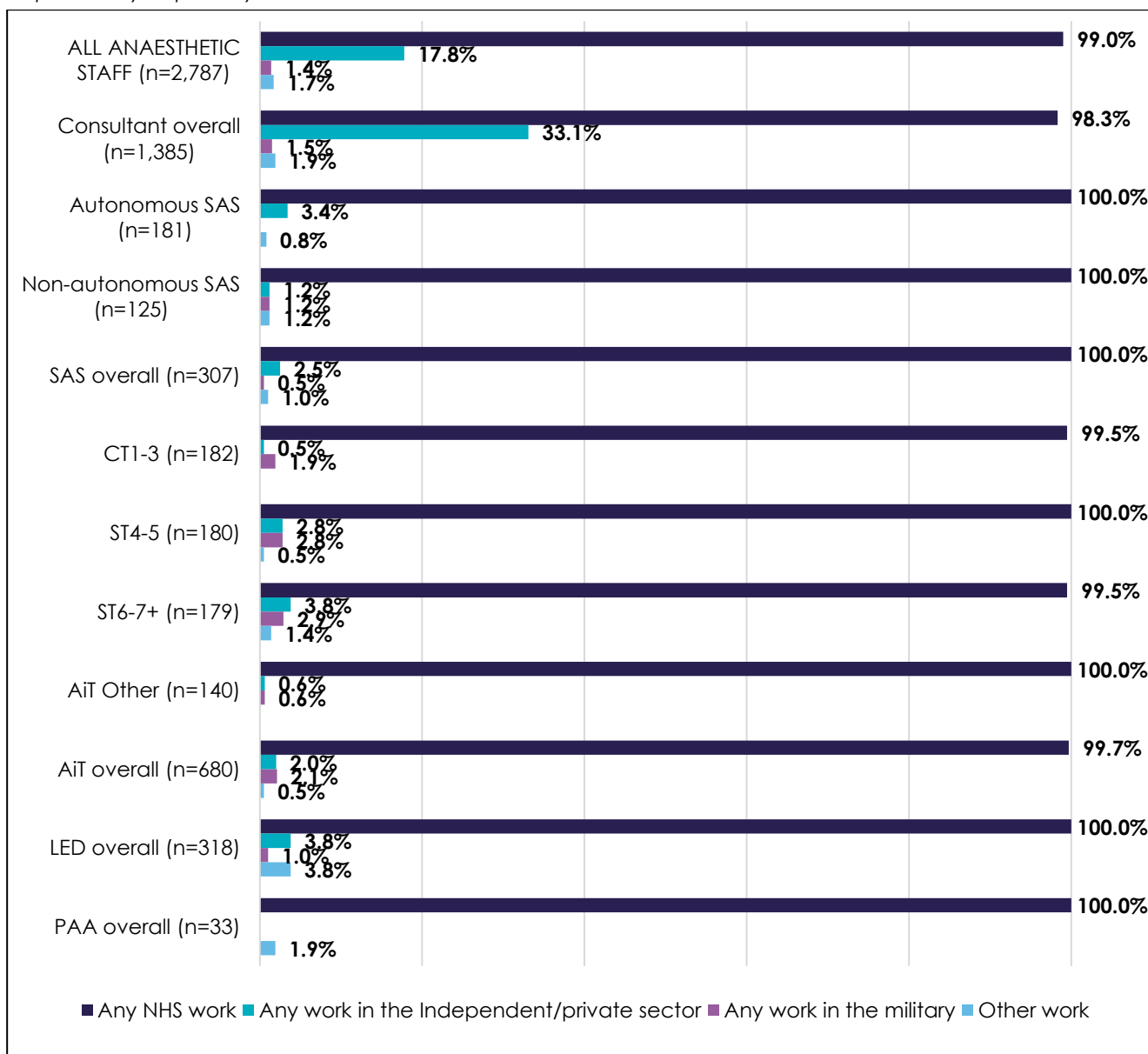
Some anaesthetists work in the military – 1.4% do at least some of their work in that setting, including 0.2% exclusively. There are also anaesthetic staff working in “other” sectors – which might include academia, for example. Overall, 1.7% do some “other” work, including 0.1% who do it exclusively.

Results vary by staff group. Consultants are by far the most likely to do some work in the independent sector – with 33.1% doing this. However, only 1.3% do independent sector work exclusively. The majority (98.3%) do at least some work in the NHS and 64.4% work in the NHS exclusively.

Other groups were far more likely to work in the NHS exclusively, including 95.8% of autonomous SAS doctors, 96.3% of non-autonomous SAS doctors, 92.4% of LEDss, and 98.1% of PAAs. Amongst AiTs, 97.7% of CT1-3s, 93.8% of ST4-5s, 91.9% of ST6-7+s, and 98.8% of other AiTs worked exclusively in the NHS.

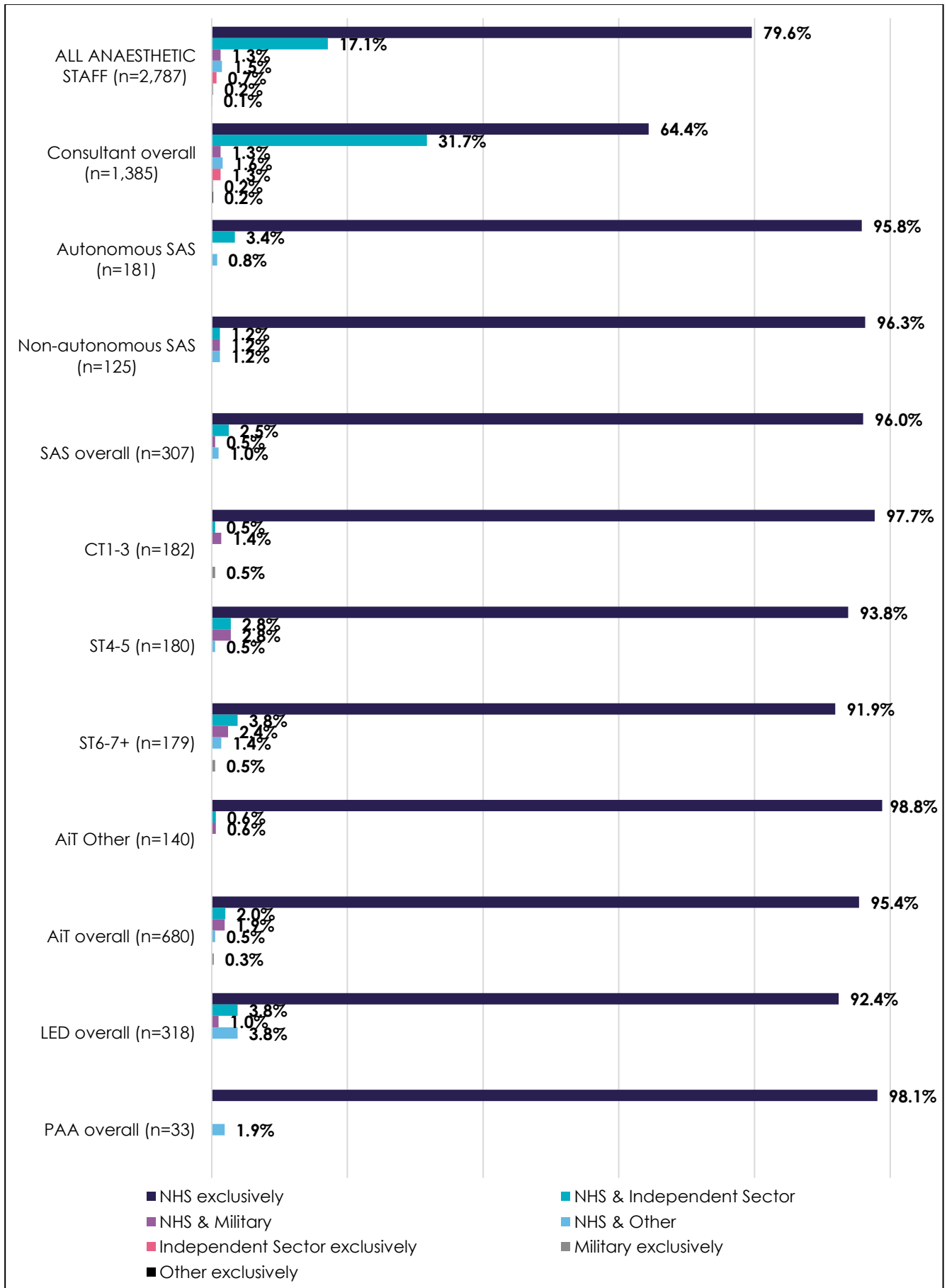
**Figure 2 – Sectors worked in by staff group**

Base: Shown in chart (All anaesthetic staff in the survey of the wider anaesthetic workforce excluding Crown Dependency responses)



**Figure 3 – Cross sector working by staff group**

Base: Shown in chart (All anaesthetic staff in the survey of the wider anaesthetic workforce excluding Crown Dependency responses)



# 6 NHS contracts

## Introduction

In the NHS, anaesthetic staff are employed on a wide range of contracts. This chapter provides a breakdown of the various contracts and how long staff have been working on them.

## Key findings

- The anaesthetic workforce is mostly permanently employed, particularly consultants (93.7%) and SAS doctors (88.0%), with limited numbers on fixed-term or external/agency locum contracts.
- In contrast, LEDs are predominantly employed on fixed-term contracts (81%), with only a small minority holding permanent roles (15%).

## Overview of contracts

Anaesthetic staff may be employed on permanent, fixed-term, or external/agency locum contracts. The full clinical leaders' survey collected information on these contract types for consultants, SAS doctors, and PAAs. However, the shorter version of the survey did not capture numbers of staff on external or agency locum contracts, nor the split between permanent and fixed-term posts. As a result, the figures presented here are based on scaled-up estimates derived from sites that completed the full version of the survey and should be interpreted with this in mind.

Across almost all staff groups, except for LEDs, a large majority of staff were reported to be employed on permanent contracts, with relatively small numbers working on fixed-term or external/agency locum arrangements. Among consultants, 9,588 (93.7%) worked on permanent contracts, with only 494 (4.8%) working on fixed-term contracts, and 154 (1.5%) working on external/agency locum contracts. A similar pattern was seen among SAS doctors: 1,984 were employed on permanent contracts (88.0%), compared with 231 (10.2%) on fixed-term contracts and just 40 (1.8%) working on external/agency locum contracts.

Within the SAS grades, 353 (97.5%) specialist doctors were employed on permanent contracts, with very small numbers on fixed-term (6, or 1.7%) or locum arrangements (3, or 0.8%). Specialty doctors had the largest number of non-permanent posts within the SAS group, though still overwhelmingly permanent (1,435, or 84.6%). Associate specialist doctors appear to be employed exclusively on permanent contracts, with no reported fixed-term or locum posts in this group.

PAAs also showed high levels of permanent contracts, with 245 permanent posts (98.0%) and very few fixed-term positions (5, or 2.0%) and no reported locum contracts.

**Figure 4 – Numbers by contract type**

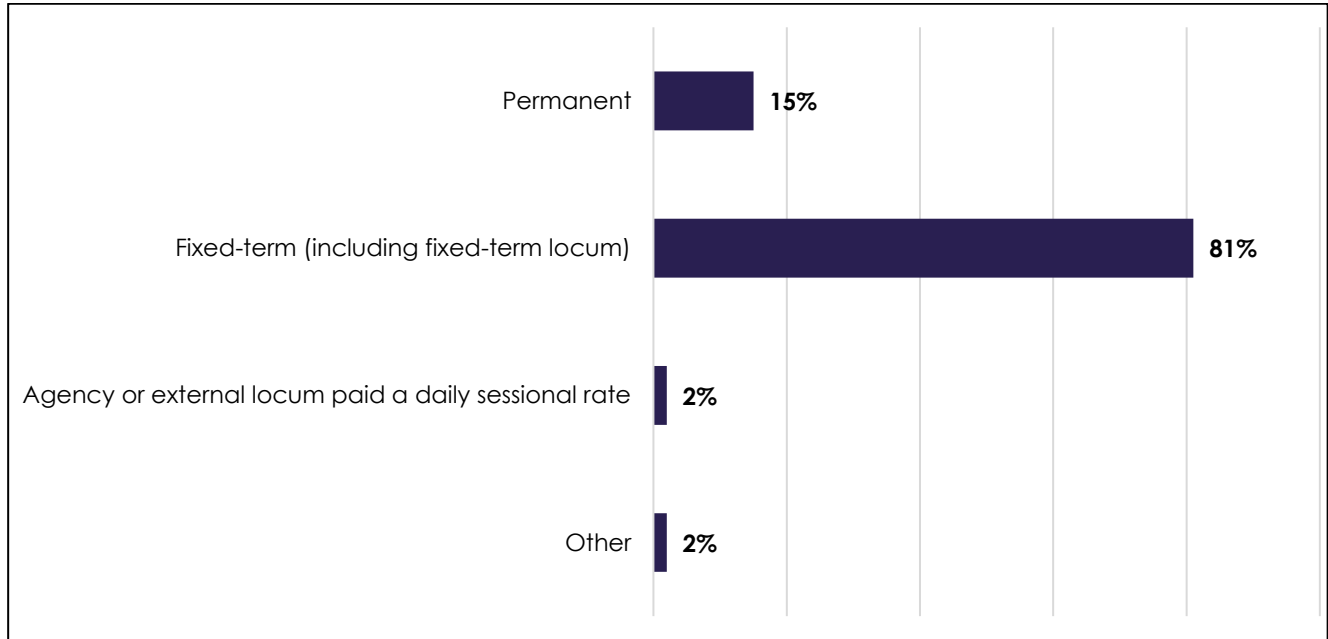
Group	Permanent contract	Fixed-term contract	External/agency locum contract	Total
Consultants	9,588 93.7%	494 4.8%	154 1.5%	10,236
Specialty doctors	1,435 84.6%	225 13.3%	37 2.2%	1,697
Specialist doctors	353 97.5%	6 1.7%	3 0.8%	362
Associate specialist doctors	196 100%	0	0	196
SAS doctors overall	1,984 88.0%	231 10.2%	40 1.8%	2,255
PAAs	245 98.0%	5 2.0%	0	250

Clinical leaders and college tutors were not asked to provide a breakdown of LEDs by the permanence of their contract. However, in the survey of the wider anaesthetic workforce, LEDs were asked whether their current contract was permanent, fixed-term, or agency/external locum and could select more than one response.

The vast majority of LEDs (81%) reported that they were on fixed-term contracts. Only a small minority are employed on permanent contracts (15%), and an even smaller proportion work as agency or external locums (2%).

**Figure 5 – LEDs: Is your current contract permanent, fixed-term, or agency/external locum?**

Base: 318 (LEDs in the anaesthetic workforce survey)



# 7 Additional areas of work

## Introduction

Although most anaesthetists work only in anaesthesia, some also work in other areas such as intensive care medicine (ICM), pain medicine, or Pre-Hospital Emergency Medicine (PHEM), a medical subspecialty focused on providing critical care to patients before they reach a hospital. The Census sought to quantify this.

## Key findings

- 60% of consultants, SAS doctors and LEDs worked in anaesthesia exclusively.
- 33% worked in both anaesthesia and intensive care medicine, whilst 5% worked in anaesthesia and pain medicine.
- Across the UK it is estimated that 6,703 consultants work exclusively in anaesthesia, 2,366 work in both anaesthesia and intensive care medicine, and 591 work in both anaesthesia and pain medicine.

## Additional areas of work

Respondents in the survey of the wider anaesthetic workforce were asked if they worked exclusively in anaesthesia, or in some other area. Across the workforce, the most common response from 60% was anaesthesia exclusively. This was followed by anaesthesia and intensive care medicine (33%), anaesthesia and pain medicine (5%), and anaesthesia and PHEM (1%).

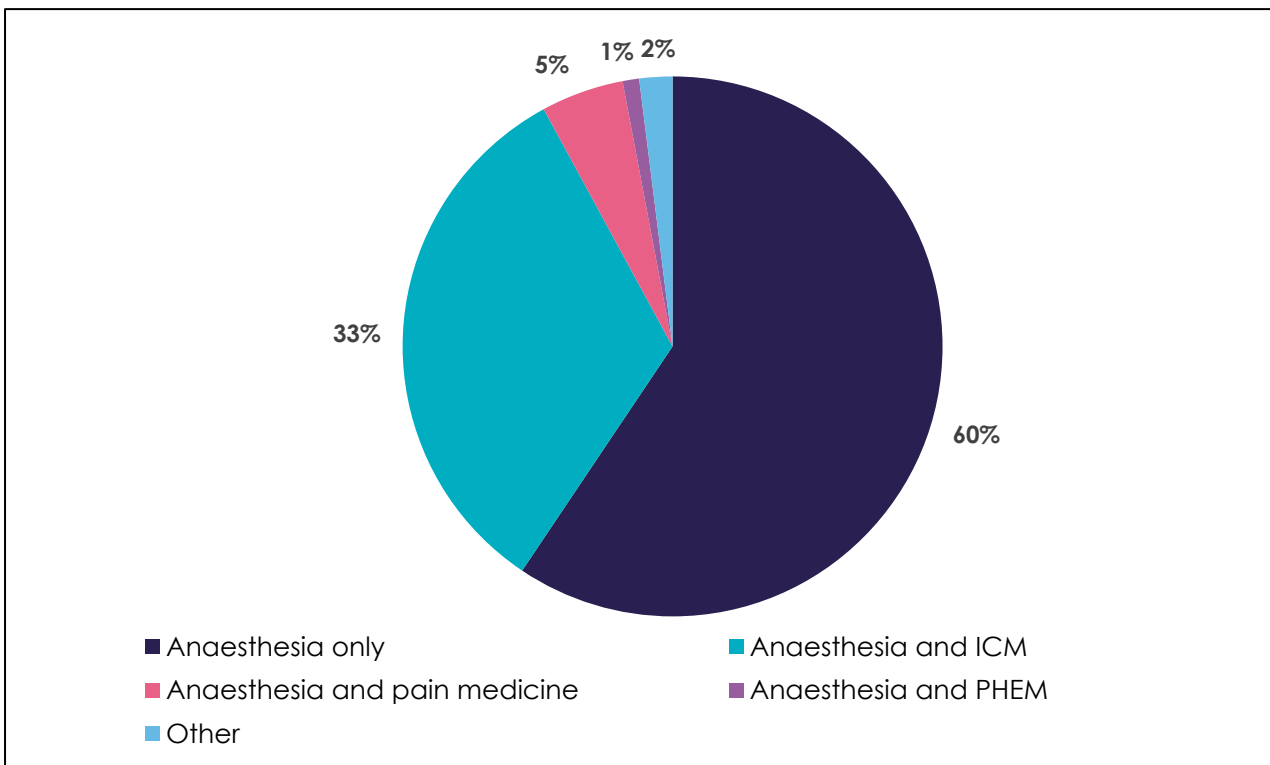
Some respondents indicated that they worked in anaesthesia and some other area of medicine in the free text boxes. These included areas such as “transfer medicine,” “major trauma,” and “obstetrics” – however, none of these had more than five responses each. Overall, the percentage of ‘other’ responses was 2%.

A small number of responses indicated that they did not practise anaesthesia (e.g. specifying they were practicing ICM only) and they have been excluded from this analysis.

It must be noted that the sample of this survey was self-selecting, meaning that the numbers are indicative and may not perfectly reflect actual numbers working in the NHS.

### Figure 6 – Additional areas of work

Base: 2,041 (Consultants, SAS doctors and LEDs who practised anaesthesia excluding Crown Dependency responses)



Looking at consultants - 68% worked in anaesthesia exclusively and 24% worked in both anaesthesia and intensive care medicine. Applying these percentages to the total number of consultants in the UK (9,858) suggests there are 6,703 consultants working in anaesthesia only, 2,366 working in both anaesthesia and intensive care medicine, and 591 working in anaesthesia and pain medicine.

**Figure 7 – Additional areas of work amongst consultants**

Area(s)	%	Number*
Anaesthesia only	68%	6,703
Anaesthesia and ICM	24%	2,366
Anaesthesia and pain medicine	6%	591
Anaesthesia and PHEM	1%	99
Other	2%	197

*\*Some totals may not add up due to rounding*

# 8 NHS Programmed Activities (PAs)

## Introduction

In the NHS, many doctors' job plans are structured around 'Programmed Activities' (PAs) – units of work typically equivalent to four hours on a weekday or three hours at the weekend.

PAs are divided into several categories. 'Direct Clinical Care' (DCC) covers the delivery of patient care or supervising others in doing so. 'Supporting Professional Activities' (SPA) includes work such as teaching, management, and professional development. 'Additional contracted NHS activities' refer to responsibilities beyond regular SPA work, for example, serving as a clinical or medical director. Finally, 'agreed regular external duties' can include roles such as examining for AiTs or undertaking work for medical Royal Colleges, trade unions, or other NHS bodies.

A standard full time consultant contract consists of 10 PAs, although many anaesthetists work more or less than this.

## Key findings

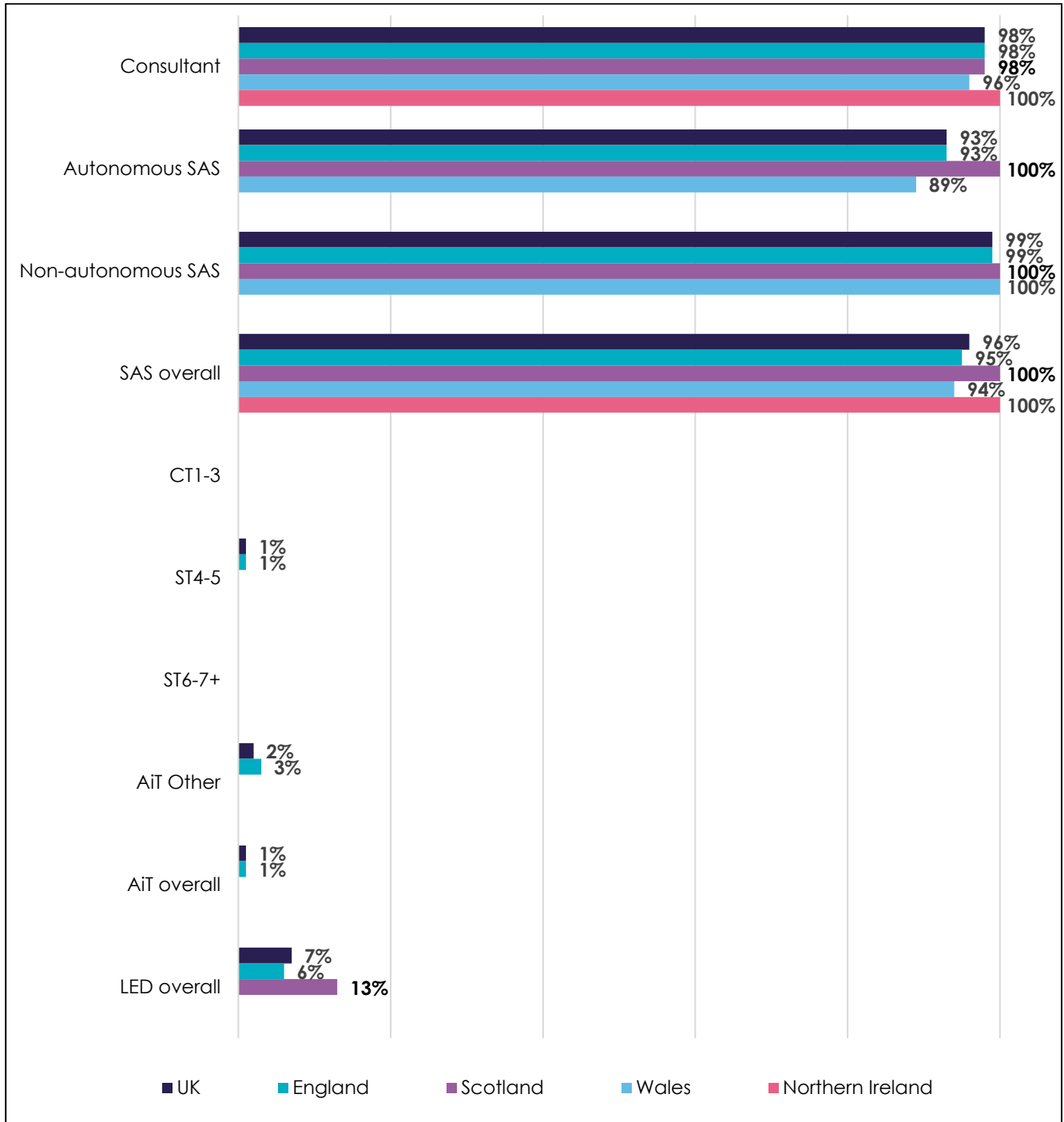
- Most consultants (98%) and SAS doctors (96%) had job plans organised according to Programmed Activities (PAs) – however, this was true for only small numbers of LEDs (7%) and AiTs (1%).
- By staff group, autonomous SAS doctors had the highest average weekly PA total (11.9), followed by non-autonomous SAS (11.3) and consultants (11.0).
- Across the UK, consultant PAs broke down as an average of 8.0 Direct Clinical Care (DCC), 2.6 Supporting Professional Activities (SPA), 0.6 additional NHS activities, and 0.2 agreed external duties.
- Consultants in England worked an average of 11 PAs per week, breaking down as 7.9 DCC, 2.6 SPA, 0.6 additional contracted NHS activities, and 0.2 agreed external duties.
- Consultants in Scotland worked an average of 11 PAs per week, breaking down as 8 DCC, 2.6 SPA, 0.6 additional contracted NHS activities, and 0.2 agreed external duties.
- Consultants in Wales worked an average of 11.7 PAs per week, breaking down as 8.1 DCC, 2.8 SPA, 0.7 additional contracted NHS activities, and 0.1 agreed external duties.
- Consultants in Northern Ireland worked an average of 11.7 PAs per week, breaking down as 8.1 DCC, 2.4 SPA, 1.2 additional contracted NHS activities, and 0.3 agreed external duties.
- Among autonomous SAS doctors, PAs broke down as an average of 9.6 DCC, 1.7 SPA, 0.6 additional NHS activities, and 0.1 agreed external duties.
- Among non-autonomous SAS doctors, PAs broke down as an average of 9.3 DCC, 1.5 SPA, 0.5 additional NHS activities, and <0.1 agreed external duties.
- There were variations by age. For example, among consultants, the average number of PAs worked peaked in the 40-49 age group (11.4 per week). It fell to an average of 9.3 among those aged 60+.
- A majority of respondents worked more than the standard 10 PAs, including 61% of consultants and 68% of SAS doctors.

## Use of PAs in job plans

At an overall UK level, the vast majority of consultants (98%) and SAS doctors (96%) had their job plans organised in PAs, but very few in other staff groups did. This pattern was seen for each devolved nation.

**Figure 8 – Job plans organised in PAs by staff group and nation**

Base: 2,726 (Consultants, SAS doctors, A&Ts, LEDs working in NHS)



## Number of PAs worked per week

Respondents were asked how many PAs they worked in four domains: DCC, SPA, additional contracted NHS activities, and agreed regular external duties. These are standard categories used by the NHS, so would likely be familiar to most respondents. However, it is possible there would be some variation in how respondents categorised certain activities, such as educational supervision.

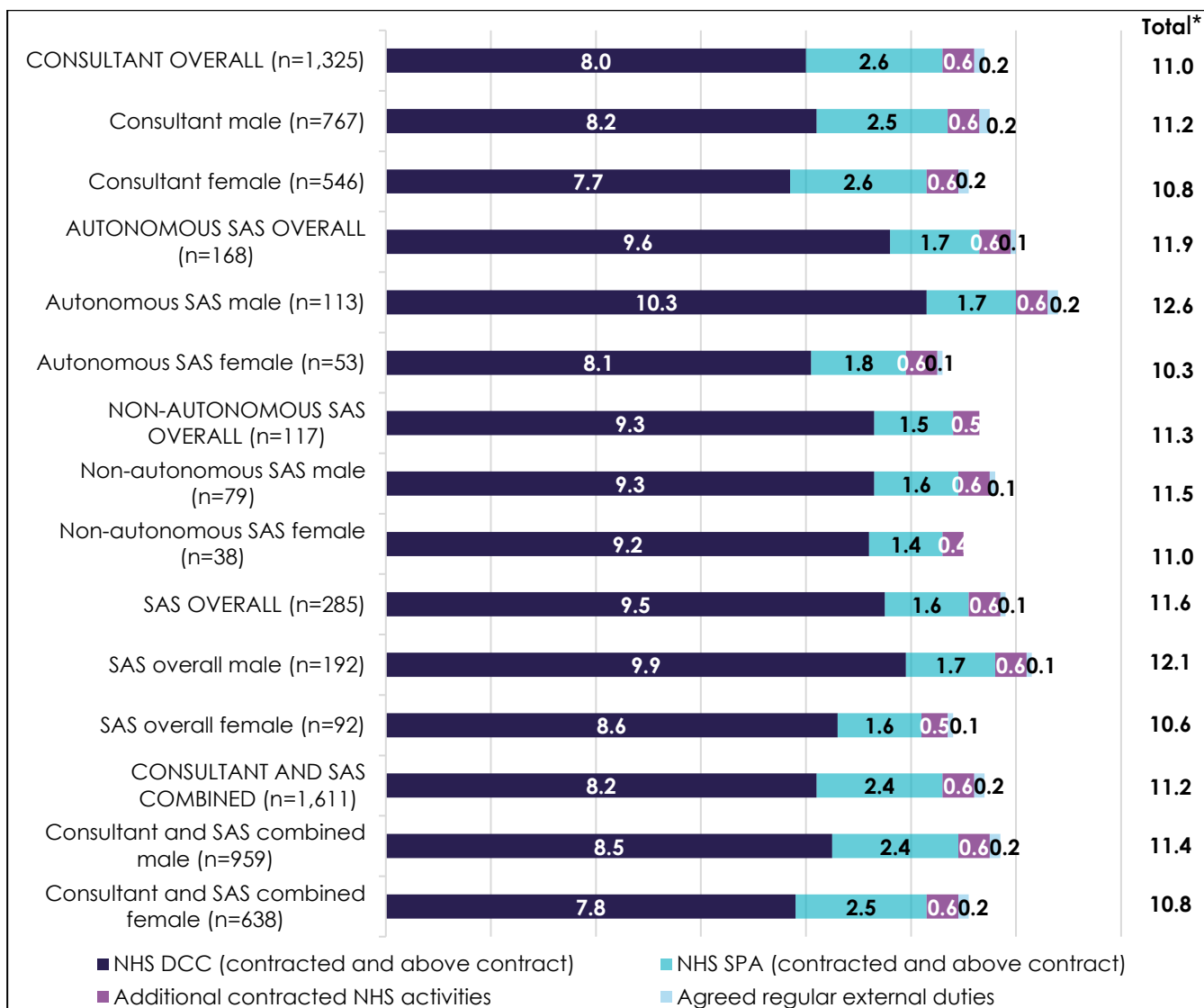
Overall, consultants worked an average of 11.0 PAs per week. SAS doctors worked slightly more (11.6), with autonomous SAS doctors working an average of 11.9 and non-autonomous doctors working an average of 11.3.

Most PAs were devoted to DCC. Consultants did an average of 8.0 PAs of DCC per week, autonomous SAS doctors 9.6 and non-autonomous SAS doctors 9.3. The next most common category was SPA. Consultants did an average of 2.6 PAs of SPA per week, autonomous SAS doctors 1.7 and non-autonomous SAS doctors 1.5. Additional contracted NHS activities and agreed regular external duties played relatively minor roles in job plans.

By gender, male anaesthetists tended to work slightly more PAs than female anaesthetists. For example, male consultants worked an average of 11.2 PAs per week compared to 10.8 for female consultants.

**Figure 9 – Mean number of PAs worked per week by staff group and gender**

Base: Shown in chart (Consultants and SAS doctors with job plans organised in PAs that gave an answer)



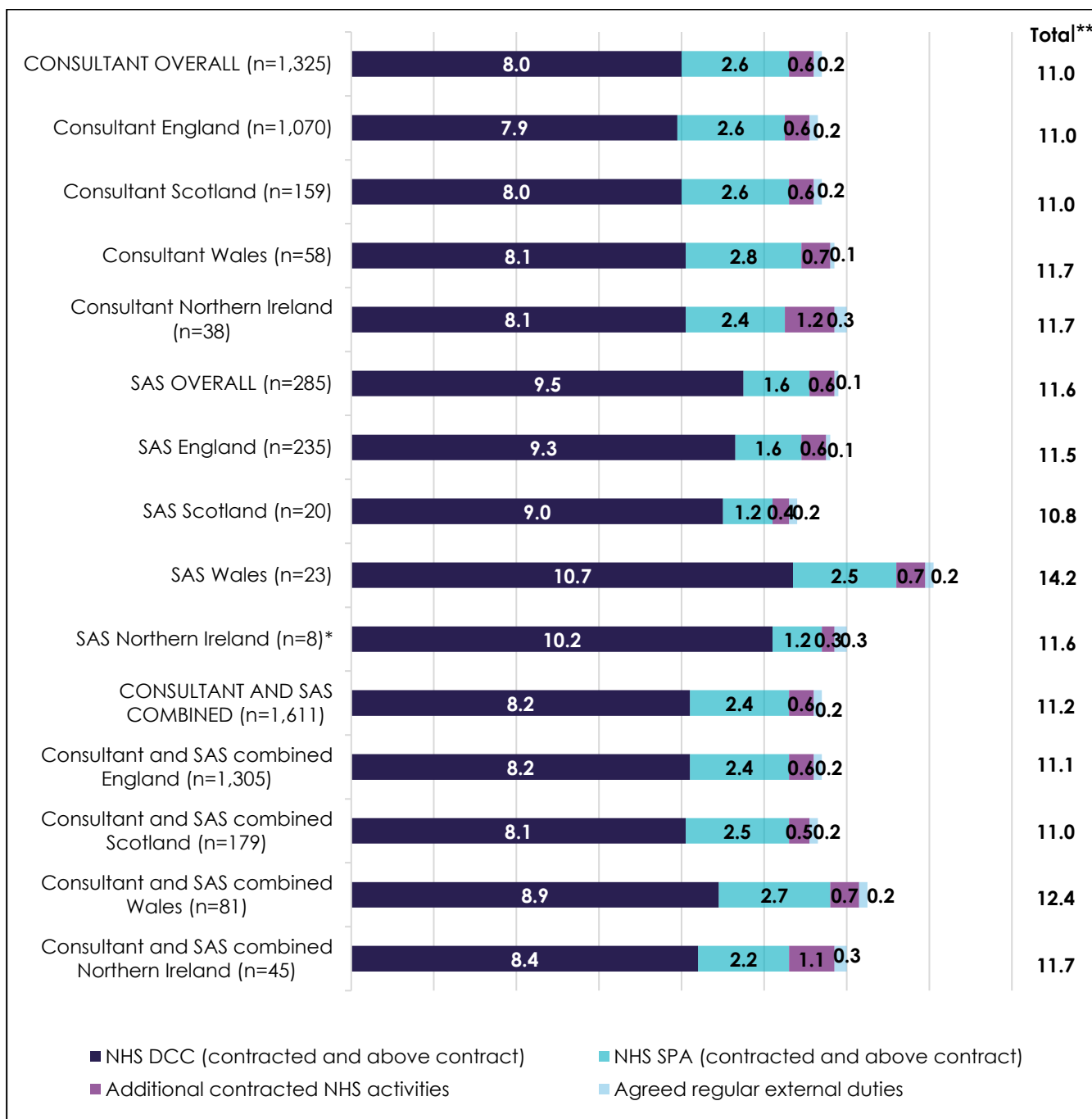
\*Figures are shown in the chart to one decimal place; as a result, the breakdowns may not add exactly to the reported totals due to rounding

By nation, there are similarities and differences in the number of PAs worked, and how those PAs are allocated. Consultants in England, for example, worked an average of 11.0 PAs per week, breaking down as 7.9 DCC, 2.6 SPA, 0.6 additional contracted NHS activities, and 0.2 agreed external duties. Consultants in Scotland had similar working patterns, also working an average of 11.0 PAs per week, breaking down as 8.0 DCC, 2.6 SPA, 0.6 additional contracted NHS activities, and 0.2 agreed external duties.

However, slightly more differences emerge in Wales and Northern Ireland. Consultants in Wales worked more PAs – an average of 11.7 per week, breaking down as 8.1 DCC, 2.8 SPA, 0.7 additional contracted NHS activities, and 0.1 agreed external duties. Consultants in Northern Ireland also worked an average of 11.7 PAs per week, breaking down as 8.1 DCC, 2.4 SPA, 1.2 additional contracted NHS activities, and 0.3 agreed external duties.

**Figure 10 – Mean number of PAs worked per week by staff group and nation**

Base: Shown in chart (Consultants and SAS doctors with job plans organised in PAs that gave an answer)



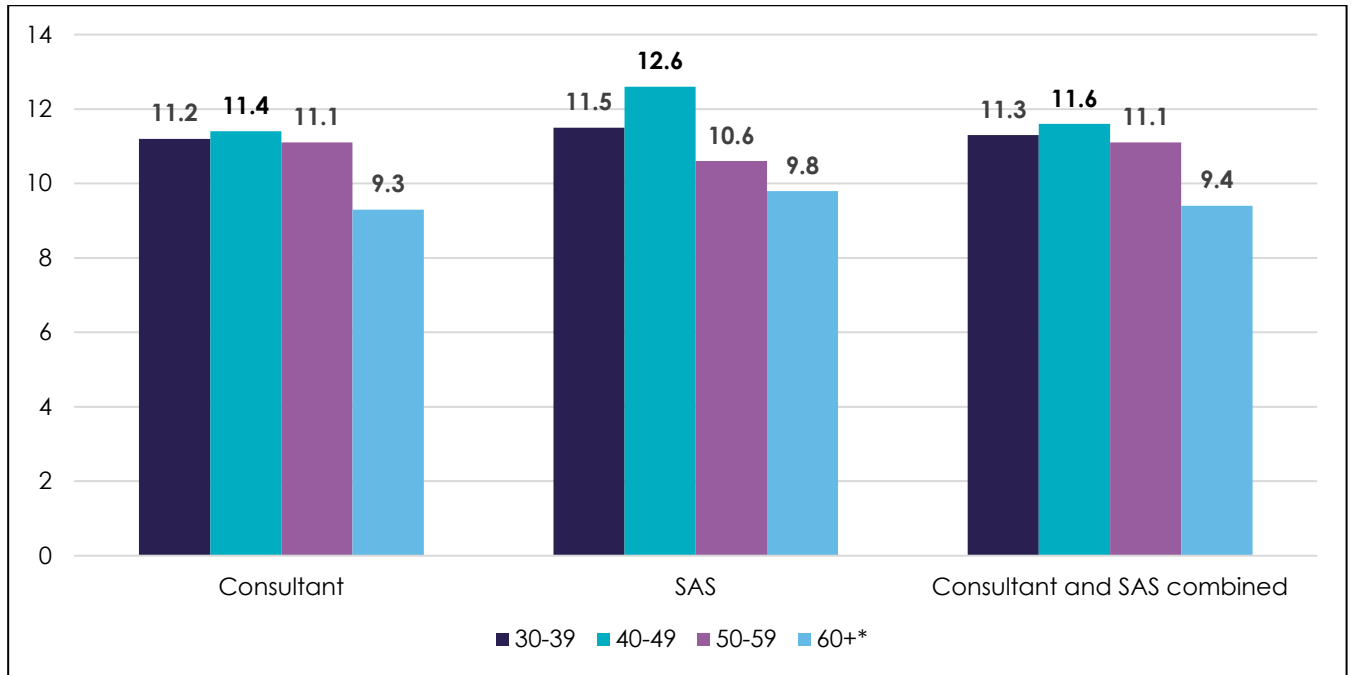
\*Small base size – results based on very small numbers may not be reliable

\*\*Figures are shown in the chart to one decimal place; as a result, the breakdowns may not add exactly to the reported totals due to rounding

There were also variations by age. For example, the average number of PAs worked peaked in the 40-49 age group for both consultants and SAS doctors (11.4 and 12.6 per week). It fell to 9.3 and 9.8 in the 60+ category.

**Figure 11 – Mean number of PAs worked per week by staff group and age**

Base: 1,611 (Consultants and SAS doctors with job plans organised in PAs that gave an answer)



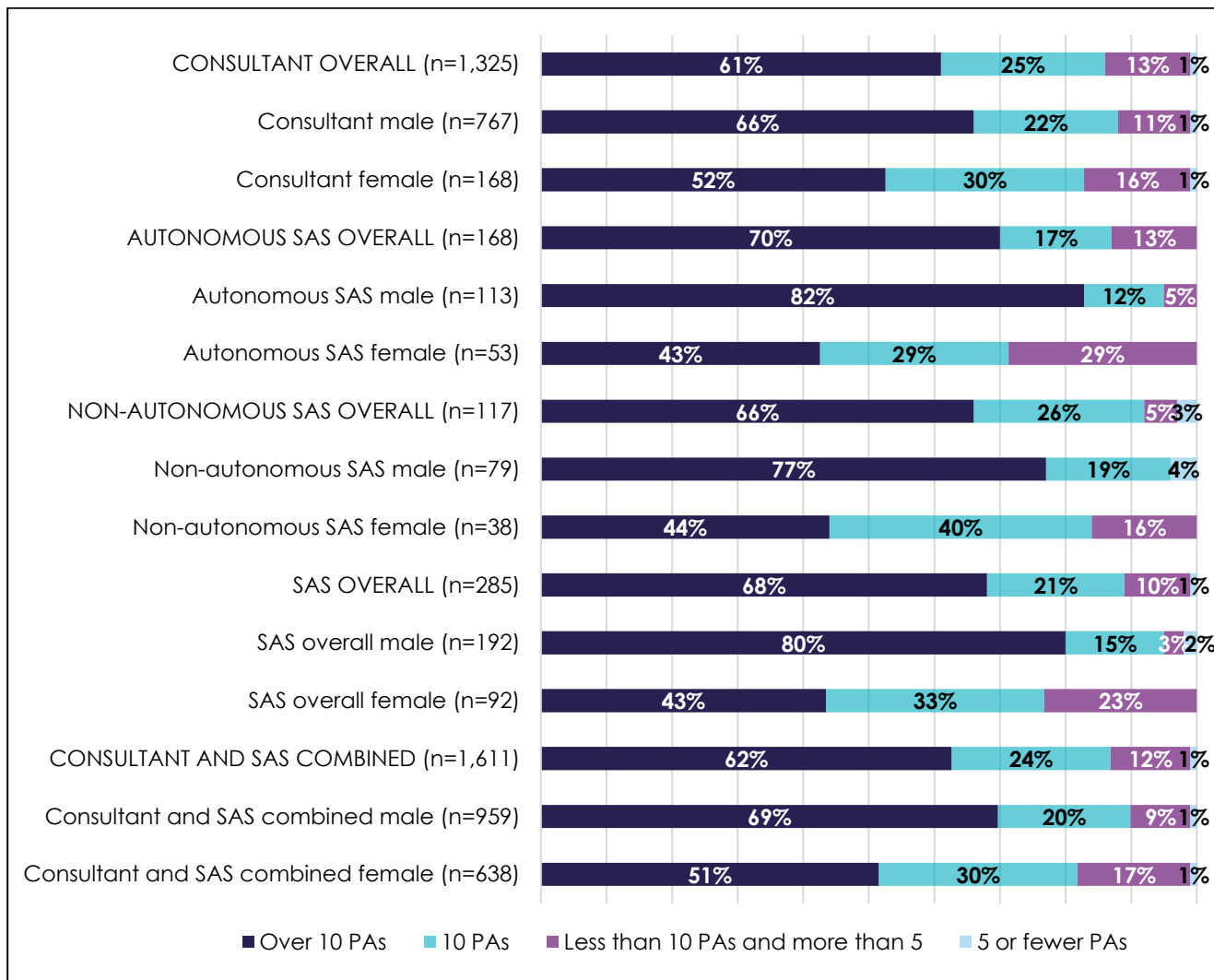
\*Small base size – results based on very small numbers may not be reliable

## Full and less than full time working based on PAs

The majority of consultant and SAS anaesthetists worked over and above the standard 10 PAs per week. For example, 61% of consultants worked more than 10 PAs per week, 25% worked exactly 10 PAs, and 14% worked fewer than 10 PAs, whilst 68% of SAS doctors worked more than 10 PAs.

**Figure 12 – Full time and less than full time working on PA basis by staff group and gender**

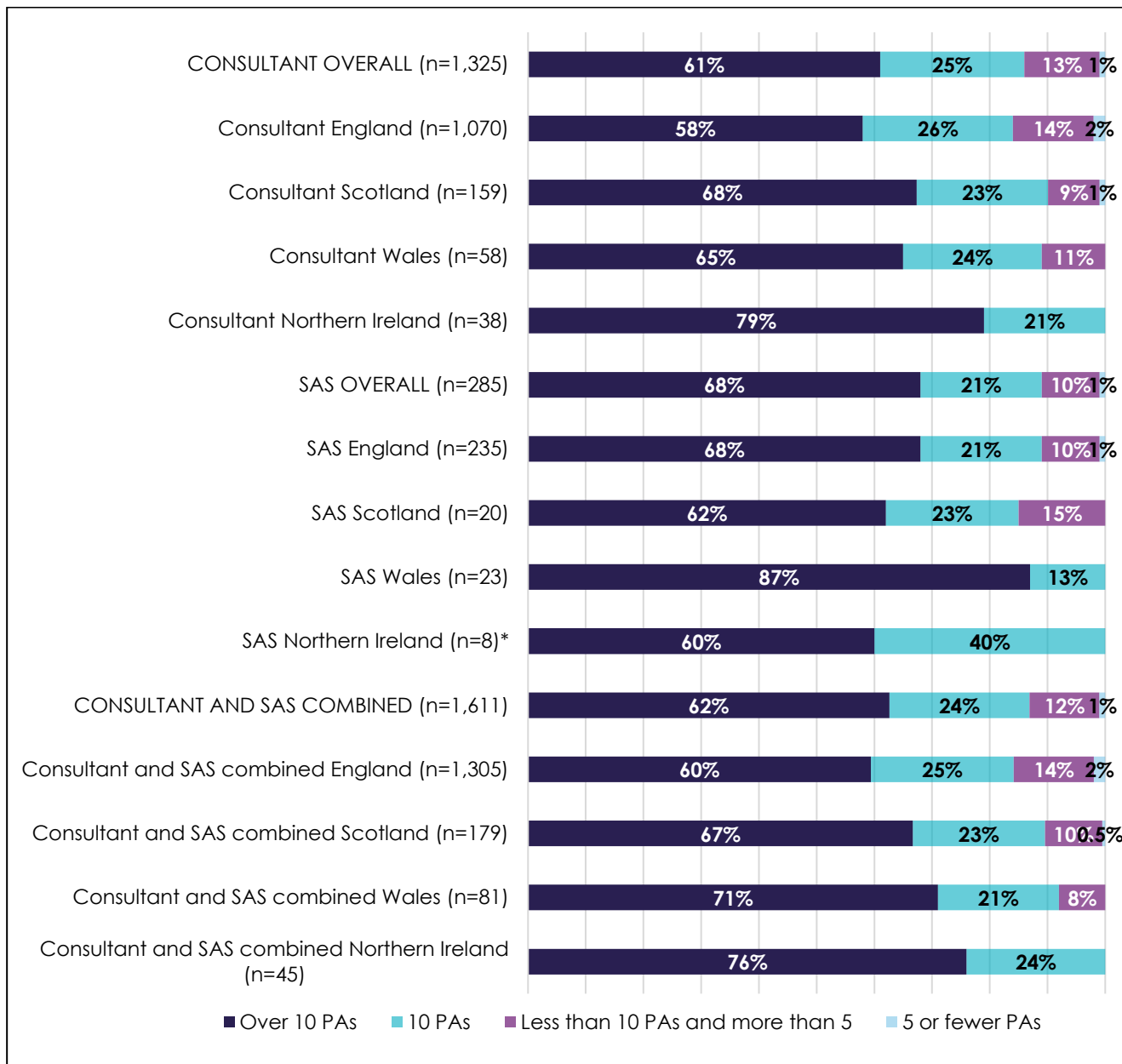
Base: Shown in chart (Consultants and SAS doctors with job plans organised in PAs that gave an answer)



There were variations by nation. For example, among consultants, 58% worked over 10 PAs per week in England, 68% in Scotland, 65% in Wales, and 79% in Northern Ireland.

**Figure 13 – Full time and less than full time working on PA basis by staff group and nation**

Base: Shown in chart (Consultants and SAS doctors with job plans organised in PAs that gave an answer)



\*Small base size – results based on very small numbers may not be reliable

# 9 NHS hours for AiTs, LEDs and PAAs

## Introduction

AiTs, LEDs and PAAs do not usually have their job plans organised in terms of PAs. The Census also enquired about the numbers of hours these groups worked.

## Key findings

- Not all staff groups have job plans organised according to PAs (including the vast majority of AiTs, LEDs, and PAAs); these respondents were asked to report the hours they worked.
- On average, CT1-3 AiTs worked 46.5 hours on average per week, ST4-5 44.3 hours, ST6-7+ 43.8 hours, other AiTs 44.2 hours, LEDs 44.1 hours, and PAAs 34.6 hours.
- The vast majority of working time was devoted to DCC. For example, among CT1-3s, 44.1 hours (94.8%) were devoted to DCC, out of their total of 46.5 hours.
- At an overall level (male and female combined), over half of all AiT groups and LEDs worked over 43 hours or more per week.
- The group most likely to work more 43 hours per week were CT1-3s, with 70% working such hours (43% working >43-48 hours, and 27% working >48 hours).
- The group most likely to work 35 hours or under were ST6-7+s, with 18% working such hours – including 35% of female ST6-7+s.

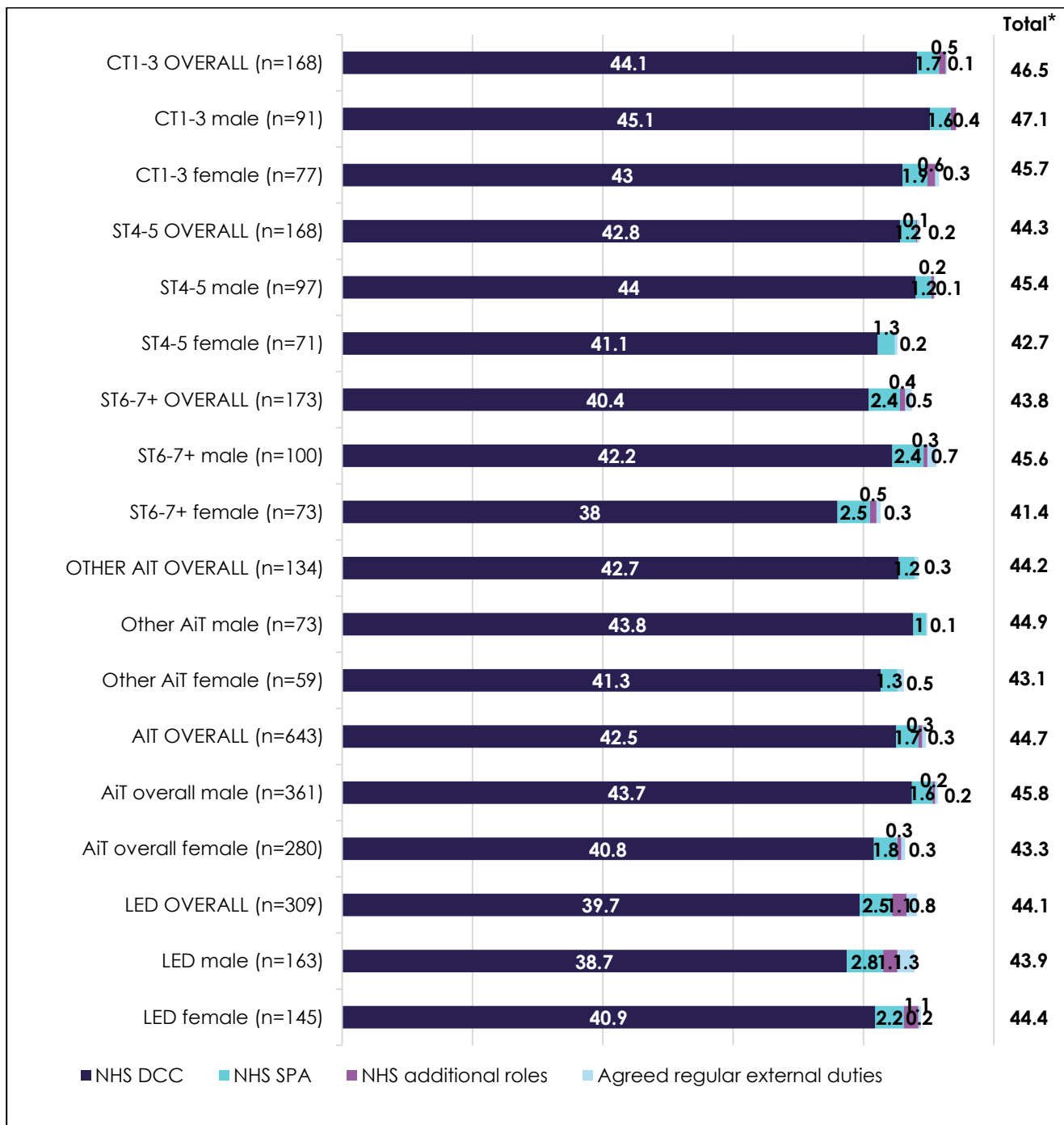
## Number of hours worked per week

On average, CT1-3 AITs worked 46.5 hours per week, ST4-5 44.3 hours, ST6-7+ 43.8 hours, 44.2 hours for other AITs, and LEDs 44.1 hours. The vast majority of working time was devoted to DCC. For example, among CT1-3s, 44.1 hours (94.8%) out of their total of 46.5 hours, were devoted to DCC.

Looking at the average number of hours worked per week by gender, male AITs worked more hours on average than female AITs across all groups – however, on average female LEDs worked more hours than male LEDs (44.4 compared with 43.9).

**Figure 14 – Mean NHS hours worked per week by staff group and gender**

Base: Shown in chart (AITs and LEDs working in the NHS who gave an answer)

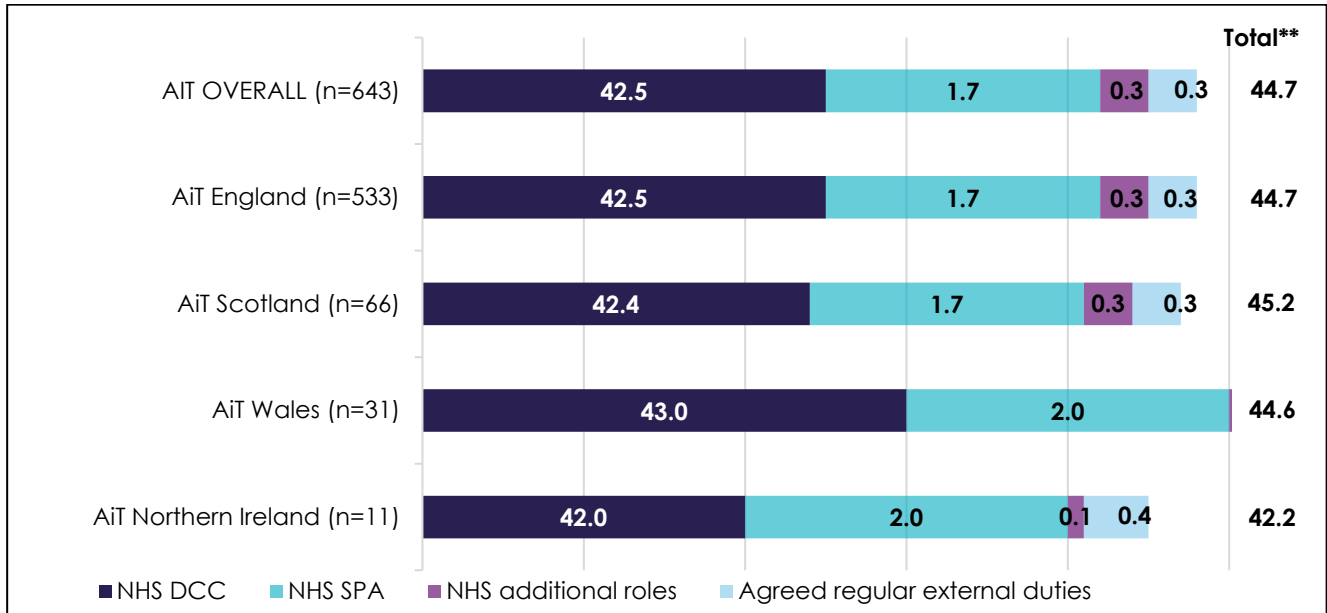


\*Figures are shown in the chart to one decimal place; as a result, the breakdowns may not add exactly to the reported totals due to rounding

There is some variation in working hours by nation amongst AiTs, with those in Wales working more DCC hours per week (43.0) than in other parts of the UK, whilst those in Northern Ireland worked fewer hours in total (42.2) than those in other nations, but the small base size should be noted. Due to small base sizes for nations other than England, all AiT groups have been combined for this analysis. Small base sizes also preclude analysis by nation for LEDs and PAAs.

**Figure 15 – AiT mean NHS hours worked per week by nation\***

Base: Shown in chart (AiTs working in the NHS who gave an answer)



\*Small base size – results based on very small numbers may not be reliable

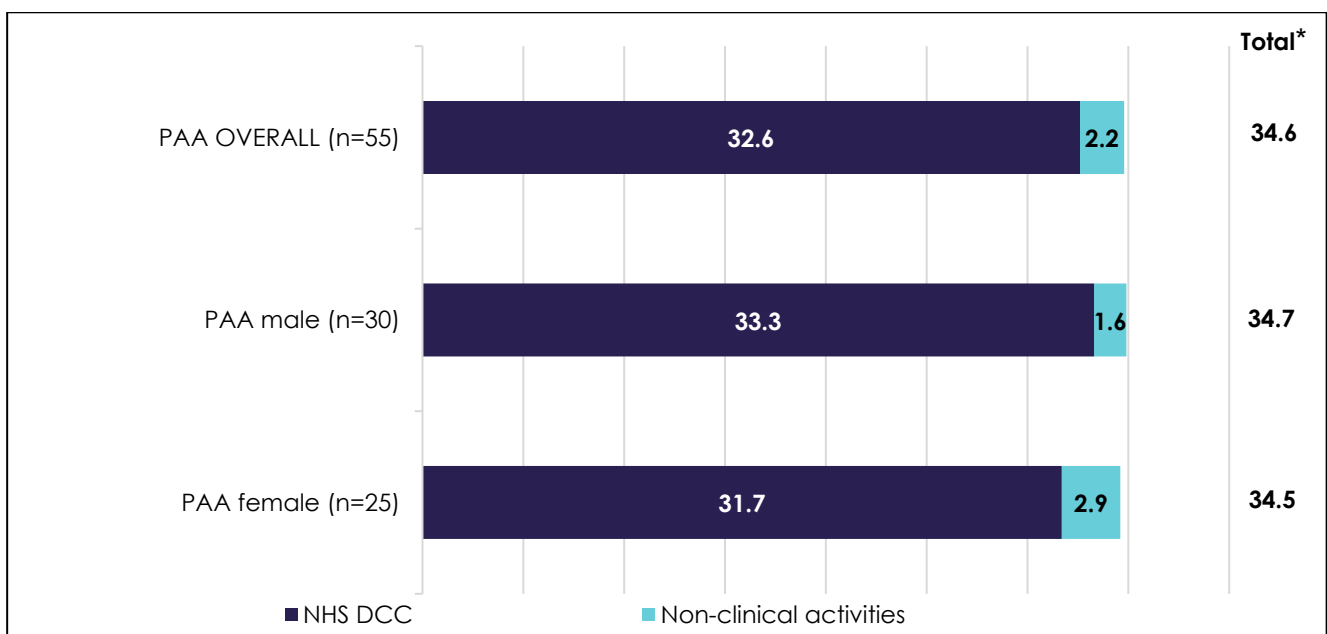
\*\*Figures are shown in the chart to one decimal place; as a result, the breakdowns may not add exactly to the reported totals due to rounding

PAAs are employed under the NHS Agenda for Change (AfC) framework. Standard full time hours for those working on Agenda for Change contracts are 37.5 hours per week – however, not all employees work full time.

Among PAAs the overall average working hours was 34.6 per week, with little difference between male and female respondents.

**Figure 16 – Average NHS hours worked per week by PAAs by gender**

Base: Shown in chart (PAAs working in NHS who gave an answer)



## Full and less than full time working based on hours

The Census explored what proportions of supervised staff worked in different ranges of hours. The ranges used were:

- >48 hours: (Above the European Working Time Directive limit, EWTD\*)
- >43 to ≤48 hours
- >35 to ≤43 hours
- >28 to ≤35 hours
- 22 to ≤28 hours
- ≤22 hours

At an overall level (male and female combined), over half of each AiT and LED group worked over 43 hours per week.

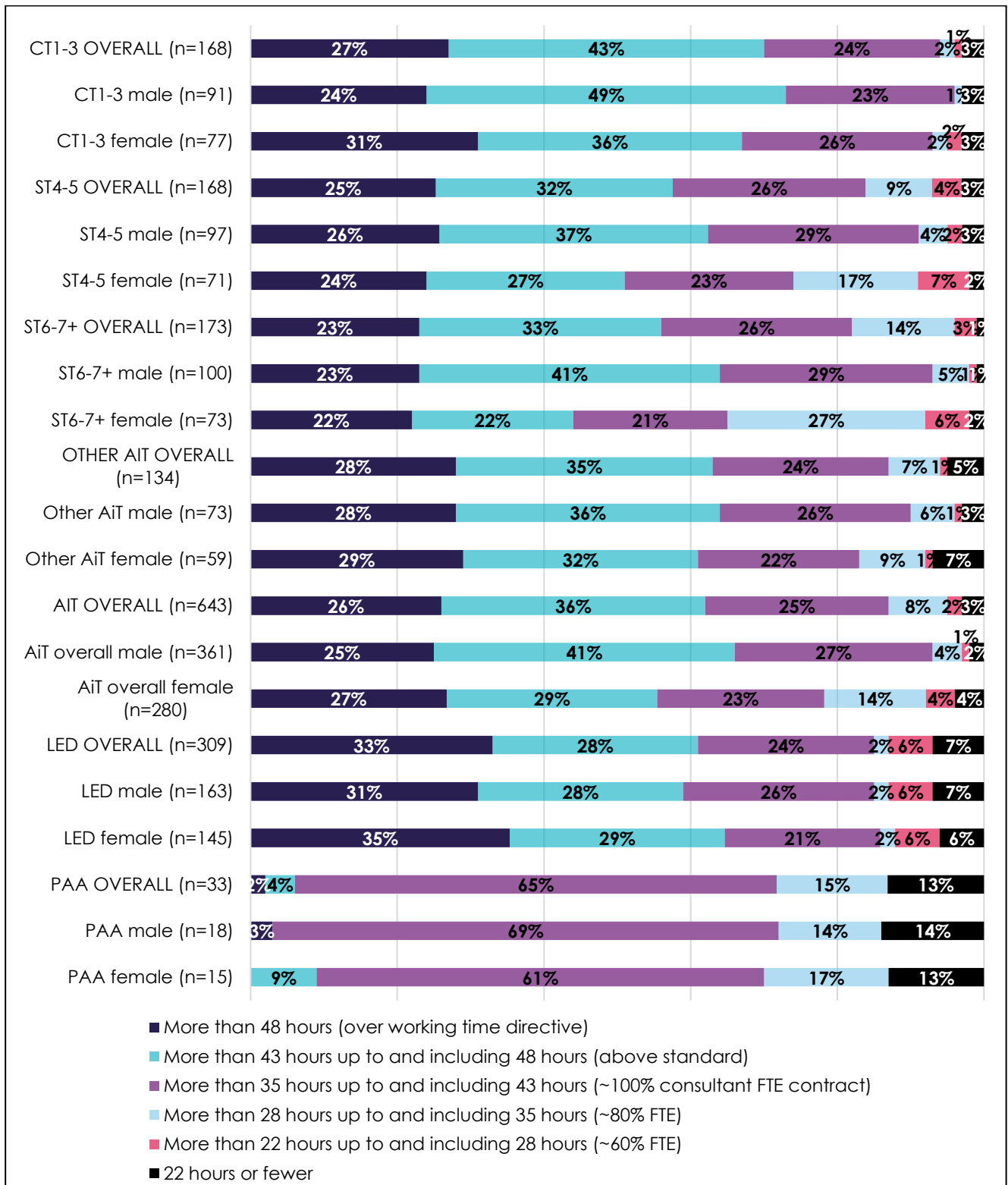
The group most likely to work over 43 hours per week were CT1-3s, with 70% working such hours (43% working >43-48 hours, and 27% working >48 hours).

Among ST6-7+ 56% worked over 43 hours – however, they were also the group with the greatest percentage working 35 hours or under (18%). This broke down as including 14% working >28-35 hours, 3% >22-28 hours, and 1% 22 hours or fewer. The percentage working under 35 hours was particularly large among female ST6-7+s, at 35%.

\*Those working in anaesthesia, like many working in the NHS, can opt out of the maximum 48-hour average weekly working limit set by the EWTD.

**Figure 17 – Full time and less than full time working on hours basis by staff group and gender**

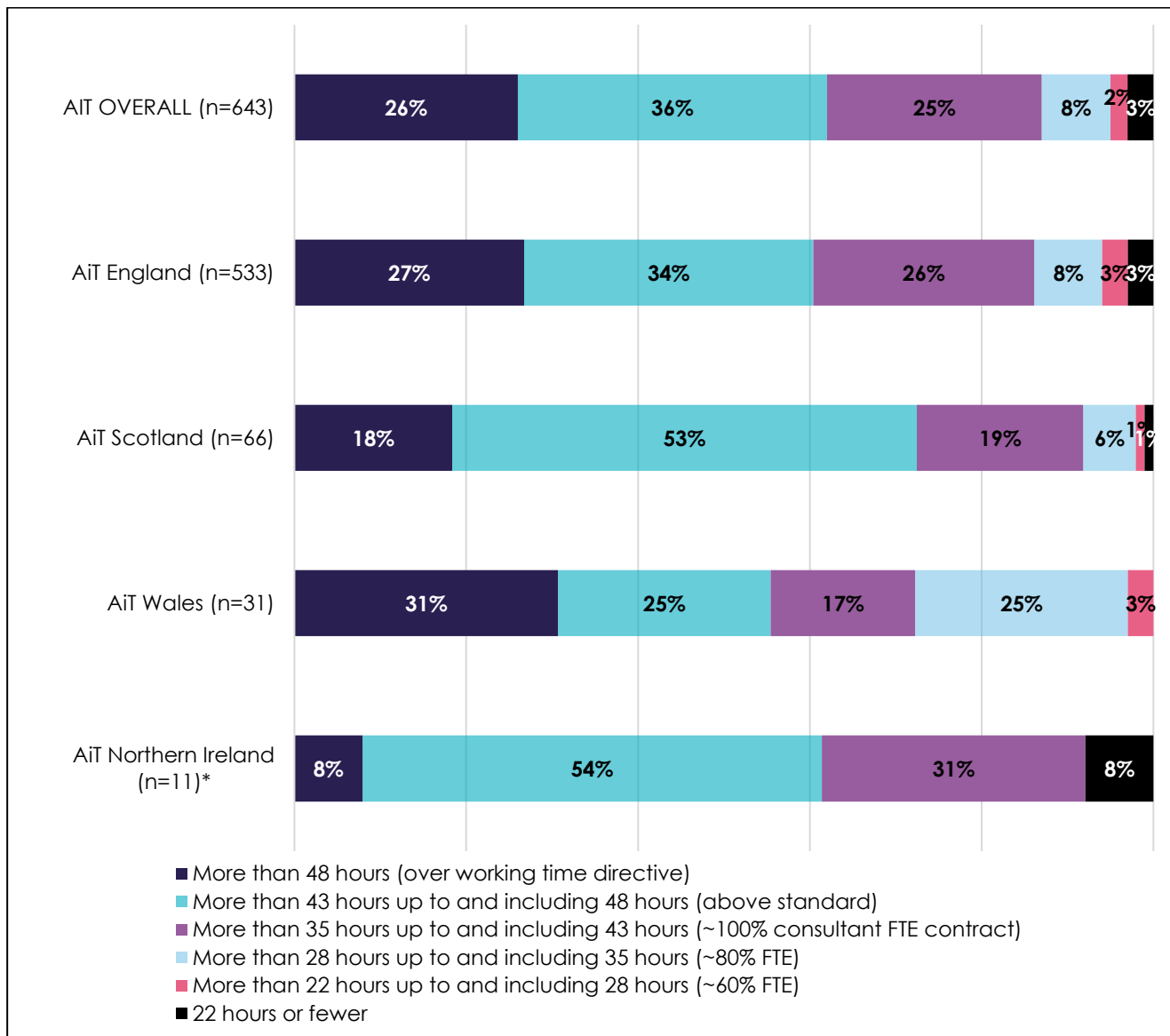
Base: Shown in chart (AitTs, LEDs and PAAs working in the NHS who gave an answer)



Amongst AITs, there were variations by nation – 71% in Scotland worked more than full time hours, compared with 61% in England, 56% in Wales and 62% in Northern Ireland.

**Figure 18 – Full time and less than full time working on hours basis by AIT group and nation**

Base: Shown in chart (AITs who gave an answer)



\*Small base size – results based on very small numbers may not be reliable

# 10 Detailed NHS time use

## Introduction

Anaesthetists' clinical time is divided across a wide range of services, including elective surgery, maternity care and more. For consultants and autonomously practising SAS doctors, this time is also split between solo working (providing anaesthesia directly to patients themselves) and supervising more junior colleagues.

Supervision can take different forms, from being physically present in theatre throughout a case to being on call from home and available to provide advice by telephone if required. The appropriate level depends on both the supervisee's experience and the complexity of the case.

In addition to clinical duties, consultants and autonomous SAS doctors also contribute to research, management, governance, education, appraisal and Royal College responsibilities. The Census explored all these different areas of work in detail.

Supervised anaesthetic staff – including non-autonomous SAS doctors, AiTs, LEDs and PAAs – also deliver direct patient care across a wide range of clinical services. The Census set out to capture, codify and quantify this activity.

## Key findings

- Consultant and autonomous SAS doctors spent 54.8% of their total NHS time undertaking solo clinical work, and 18.2% of their time supervising other staff.
- Consultants spent a larger proportion of their total NHS working time providing supervision than autonomous doctors (19.0% compared with 14.7%).
- Broken down by task, the single biggest chunk of consultants and SAS doctors' NHS working time was devoted to solo working in elective surgery, accounting for 29.4%.
- This was also true for supervised staff, who spent 31.7% of their NHS working time in elective surgery.
- Consultants and SAS doctors spent 8.5% of all NHS working time providing educational supervision.

## Consultants' and autonomous SAS doctors' DCC time

Most of anaesthetists' NHS working time is dedicated to DCC. This can be broadly subdivided into time devoted to solo working (i.e. the solo provision of care to patients) and time devoted to the supervision of others.

Overall, consultant and autonomous SAS doctors spent 54.8% of their NHS working time solo working, and 18.2% supervising others. Consultants tended to spend more of their NHS working time supervising than autonomous SAS doctors (19.0% compared with 14.7%).

**Figure 19 – Time spent solo working and supervising by staff group and gender**

Base: Shown in table (Consultants and autonomous SAS doctors who gave an answer)

Type	Overall (n=1,501)	Consultant overall (n=1,324)	Consultant male (n=767)	Consultant female (n=547)	Autonomous SAS overall (n=177)	Autonomous SAS male (n=122)	Autonomous SAS female (n=53)
Solo working as % of all NHS working time	54.8%	53.8%	54.3%	52.4%	66.0%	68.1%	60.9%
Supervising as % of all NHS working time	18.2%	19.0%	18.9%	18.9%	14.7%	13.7%	17.7%

Among consultants, those in Northern Ireland spent the largest proportion of their NHS working time solo working (54.3%) and the least time supervising (15.0%).

**Figure 20 – DCC time spent solo working and supervising by staff group and nation**

Base: Shown in table (Consultants and autonomous SAS doctors who gave an answer)

Type	Consultant England (n=1,066)	Consultant Scotland (n=159)	Consultant Wales (n=61)	Consultant Northern Ireland (n=37)	Autonomous SAS England (n=145)	Autonomous SAS Scotland (n=15)*	Autonomous SAS Wales (n=14)*
Solo working as % of all NHS working time	53.4%	51.1%	50.1%	54.3%	65.0%	67.4%	73.7%
Supervising as % of all NHS working time	18.5%	21.6%	19.1%	15.0%	14.3%	15.9%	11.6%

\*Findings should be interpreted with caution due to the small number of responses – figures for autonomous SAS doctors in Northern Ireland have been omitted due to a very small base size

## Consultants' and autonomous SAS doctors' solo working DCC time

The most common solo DCC working activity was elective surgery – which accounted for 29.4% of autonomous staff's overall NHS time. This broke down as 29.5% for consultants and 33.0% for autonomous SAS doctors.

The next largest amount of time was devoted to ICU – 7.9% of all NHS time, breaking down as 9.2% for consultants and 13.5% for autonomous SAS doctors.

This was closely followed by urgent and emergency – 7.5% of NHS time, breaking down as 7.3% for consultants and 7.8% for autonomous SAS doctors.

**Figure 21 – Solo working activity type as percentage of all NHS working time by staff group and gender**

Base: Shown in table (Consultants and autonomous SAS doctors working in NHS who gave an answer)

Activity type	Overall (n=1,501)	Consultant overall (n=1,324)	Consultant male (n=767)	Consultant female (n=547)	Autonomous SAS overall (n=177)	Autonomous SAS male (n=122)	Autonomous SAS female (n=53)
Elective surgery	29.4%	29.5%	28.7%	33.3%	33.0%	34.1%	29.5%
Maternity	2.7%	2.0%	3.6%	9.8%	9.8%	10.2%	3.6%
Urgent and emergency	7.5%	7.3%	7.9%	7.8%	7.8%	8.3%	7.5%
ICU	7.9%	9.2%	5.7%	11.0%	13.5%	3.1%	8.1%
Pain management	2.1%	2.4%	1.3%	0.7%	0.9%	0.4%	1.8%
Pre-op and post op work	3.5%	2.8%	4.3%	3.4%	3.0%	4.4%	3.4%
All other clinical cases	0.8%	1.2%	0.4%	0.2%	0.2%	0.2%	0.8%

The proportion of NHS time spent on elective surgery was highest across each of the four UK nations. However, for consultants it was slightly higher in England (29.5%) and Northern Ireland (28.5%) than Scotland (26.6%) and Wales (26.0%). Amongst autonomous SAS doctors, the proportion of NHS time spent on solo elective surgery was highest in Scotland (39.4%), although the base size is small.

**Figure 22 – Solo working activity type as percentage of all NHS working time by staff group and nation**

Base: Shown in table (Consultants and autonomous SAS doctors who gave an answer)

Type	Consultant England (n=1,066)	Consultant Scotland (n=159)	Consultant Wales (n=61)	Consultant Northern Ireland (n=37)	Autonomous SAS England (n=145)	Autonomous SAS Scotland (n=15)*	Autonomous SAS Wales (n=14)*
Elective surgery	29.5%	26.6%	26.0%	28.5%	33.3%	39.4%	26.1%
Maternity	2.9%	1.2%	2.5%	2.9%	9.2%	3.6%	23.9%
Urgent and emergency	7.2%	9.5%	8.0%	5.3%	5.6%	20.9%	12.0%
ICU	7.6%	8.2%	7.6%	11.5%	12.3%	-	8.0%
Pain management	2.1%	2.1%	0.8%	1.2%	0.9%	-	-
Pre-op and post-op work	3.5%	3.1%	3.8%	4.1%	3.6%	2.7%	3.5%
All other clinical cases	0.8%	0.4%	1.5%	0.8%	0.2%	0.8%	-

\*Findings should be interpreted with caution due to the small number of responses – figures for autonomous SAS doctors in Northern Ireland have been omitted due to a very small base size

## Consultants' and autonomous SAS doctors' non-clinical time

Most of consultants' and autonomous SAS doctors' non-clinical NHS time is SPA time. However, it may also include additional NHS roles and potentially some regular external duties. This non-clinical time can be devoted to duties such as providing educational supervision or conducting governance duties.

Overall, on average, the most common type of non-clinical activity was educational supervision, accounting for 8.5% of all consultants' and autonomous SAS doctors' NHS time (8.6% for consultants and 7.5% for autonomous SAS doctors).

Governance was the next most common non-clinical activity, taking up 4.7% of NHS working time.

**Figure 23 – Non-clinical activity type as percentage of all NHS working time by staff group and gender**

Base: Shown in table (Consultants and autonomous SAS doctors working in NHS who gave an answer)

Activity type	Overall (n=1,501)	Consultant overall (n=1,324)	Consultant male (n=767)	Consultant female (n=547)	Autonomous SAS overall (n=177)	Autonomous SAS male (n=122)	Autonomous SAS female (n=53)
Providing educational supervision	8.5%	8.6%	8.0%	8.9%	7.5%	7.5%	8.5%
Governance (incl. quality assurance)	4.7%	5.1%	4.9%	4.9%	2.4%	2.6%	4.7%
Line management	2.3%	2.7%	2.6%	2.4%	1.0%	1.5%	2.3%
Patient administration	2.9%	2.7%	2.9%	2.8%	2.7%	3.1%	2.9%
Research	1.5%	1.5%	1.7%	1.2%	1.0%	1.0%	1.5%
Appraiser role	1.2%	1.2%	1.1%	1.5%	1.0%	1.3%	1.2%
RCoA duties	1.5%	1.8%	1.4%	1.8%	0.5%	-	1.5%
All other	7.0%	7.4%	6.9%	8.3%	3.9%	2.8%	7.0%

Consultants in Wales spent more of their non-clinical time on providing educational supervision, which constituted 10.0% of all their NHS working time, higher than consultants in other nations.

**Figure 24 – Non-clinical activity type as percentage of all NHS working time by staff group and nation**

Base: Shown in table (Consultants and autonomous SAS doctors who gave an answer)

Type	Consultant England (n=1,066)	Consultant Scotland (n=159)	Consultant Wales (n=61)	Consultant Northern Ireland (n=37)	Autonomous SAS England (n=145)	Autonomous SAS Scotland (n=15)*	Autonomous SAS Wales (n=14)*
Providing educational supervision	8.7%	8.0%	10.0%	9.1%	8.8%	5.9%	0.7%
Governance (incl. quality assurance)	4.8%	5.4%	5.5%	7.3%	2.7%	2.0%	1.5%
Line management	2.4%	2.9%	2.4%	3.8%	1.2%	-	-
Patient administration	2.7%	3.2%	2.4%	4.4%	2.2%	3.4%	8.3%
Research	1.5%	1.3%	1.1%	0.9%	0.7%	2.0%	3.4%
Appraiser role	1.2%	1.9%	1.1%	1.5%	1.2%	-	0.7%

Type	Consultant England (n=1,066)	Consultant Scotland (n=159)	Consultant Wales (n=61)	Consultant Northern Ireland (n=37)	Autonomous SAS England (n=145)	Autonomous SAS Scotland (n=15)*	Autonomous SAS Wales (n=14)*
RCoA duties	1.8%	1.9%	1.8%	1.2%	0.5%	-	-
All other	7.8%	6.4%	6.6%	5.3%	4.2%	3.4%	-

\*Findings for autonomous SAS doctors in Scotland and Wales should be interpreted with caution due to the small number of responses – figures for SAS doctors in Northern Ireland have been omitted due to a very small base size

## Supervised anaesthetic staff DCC time

As with consultants and autonomous SAS doctors, DCC time for supervised staff (AiTs, LEDs, and PAAs) was most commonly spent in elective surgery, which accounted for 31.7% of all NHS working time. This was highest amongst PAAs (65.5% of all NHS working time) and lowest amongst other AiTs (24.6% of all NHS time).

Working in ICU was the next most common, accounting for 19.3% of all NHS working time, followed by urgent and emergency (15.6%) and maternity (12.8% of all NHS working time).

**Figure 25 – DCC activity type as percentage of all NHS working time by staff group**

Base: Shown in table (Supervised staff who gave an answer)

Activity type	Overall (n=1,115)	Non-autonomous SAS (n=117)	CT1-3 (n=178)	ST4-5 (n=176)	ST6-7+ (n=174)	Other AiT (n=128)	LED (n=309)	PAA (n=33)
Elective surgery	31.7%	29.1%	32.3%	32.7%	36.4%	24.6%	29.4%	65.5%
Maternity	12.8%	20.6%	12.6%	15.7%	10.6%	13.4%	11.0%	-
Urgent and emergency	15.6%	10.8%	19.7%	15.7%	21.5%	19.3%	10.4%	14.8%
ICU	19.3%	21.3%	17.6%	17.6%	12.1%	21.8%	24.8%	-
Pain management	0.4%	-	0.2%	0.4%	1.4%	0.2%	-	0.8%
Pre-op and post-op work	2.0%	2.1%	1.7%	1.6%	1.4%	0.6%	2.8%	3.6%
All other clinical cases	1.2%	0.7%	0.7%	1.2%	1.4%	3.0%	0.6%	2.9%

# 11 Out of hours work

## Introduction

Many NHS staff, including those in anaesthetics, regularly work beyond 'normal' hours – defined in this report as before 7am and after 7pm, or at weekends. To build a clearer picture of the contribution anaesthetic staff make to the NHS, and the pressure this places on their lives, the Census examined the extent of out of hours working.

Out of hours work can be subdivided in several ways. Firstly, it can be divided into 'resident', where a doctor is present in the hospital, and 'non-resident', where a doctor is on-call remotely, usually at home.

It can be also divided into weekday nights, weekend nights, and weekend days – and by frequency. Frequency refers to how often this kind of work is done. This ranges from 'never' at one extreme to '1:7 or under', which means that this kind of work is done every 7 days or fewer.

## Key findings

- Overall, 87% of anaesthetic staff reported doing at least some out of hours work.
- The groups most likely to do out of hours work were ST4-5s and ST6-7+s, with 97% of each of these groups engaged in this type of work. The group least likely to do out of hours work was PAAs (11%).
- Younger consultants and SAS doctors were more likely to work out of hours than older colleagues. For example, among consultants, 92% of those aged 30-39 and 93% of those aged 40-49 did at least some out of hours work, compared to 51% of those aged 60+.
- Resident out of hours work was predominantly done by non-autonomous SAS doctors, LEDs, and AiTs. For example, regarding *weekday night* resident work, 89% of ST6-7+s reported doing this kind of work at least some of the time.
- Regarding non-resident on-call work, this was predominantly done by consultants. For example, regarding *weekday night* non-resident work, 63% of consultants reported doing this kind of work at least some of the time.

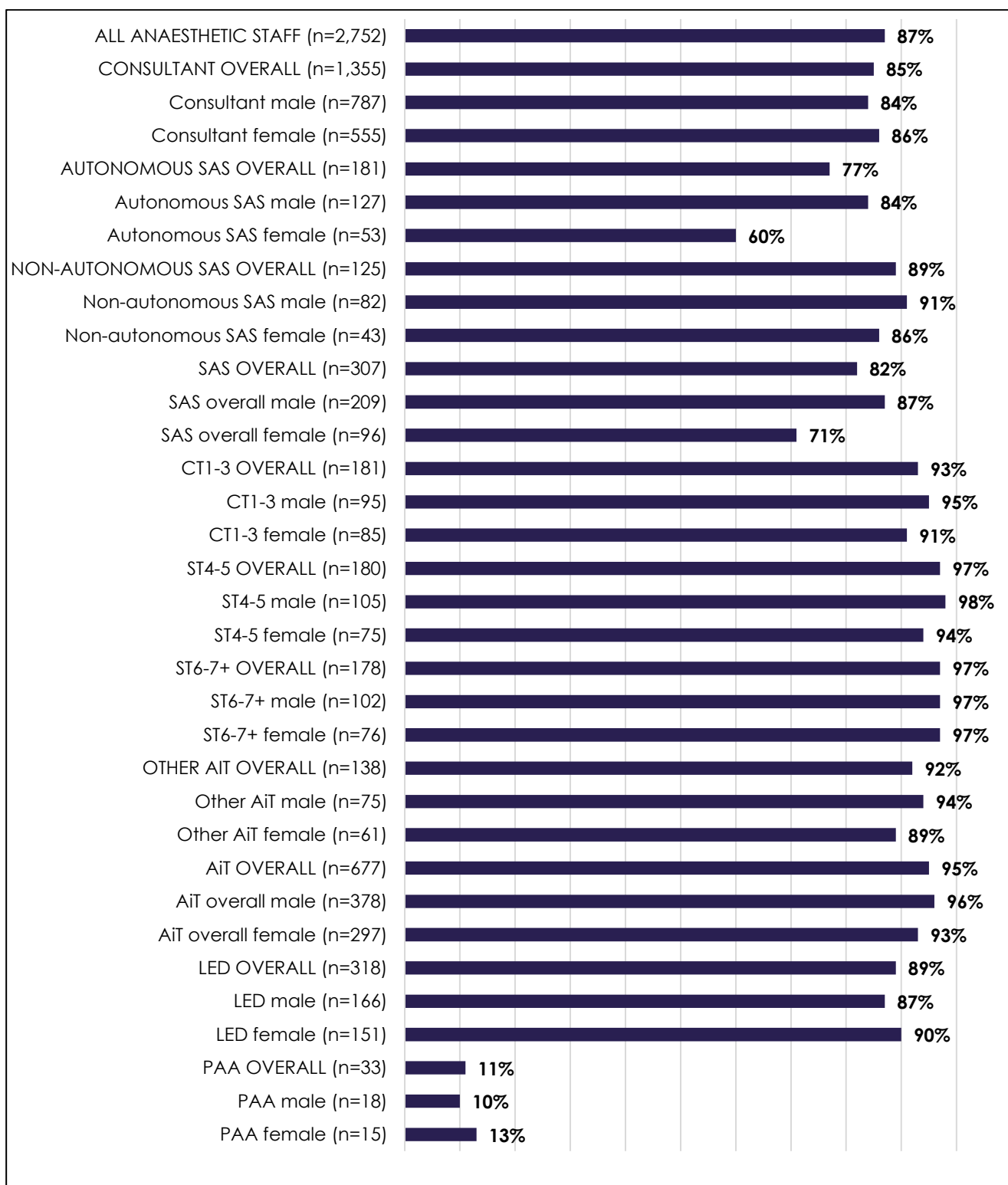
## Working out of hours

Overall, 87% of anaesthetic staff reported working out of hours at least some of the time. This varied substantially by staff group. For example, 97% of ST4-5s and ST6-7+ reported working out of hours compared with 11% of PAAs.

There were also some differences by gender. For example, 60% of female autonomous SAS doctors reported working out of hours compared to 84% of males.

**Figure 26 – Out of hours work by staff group and gender**

Base: Shown in chart (Those working in NHS who gave an answer)

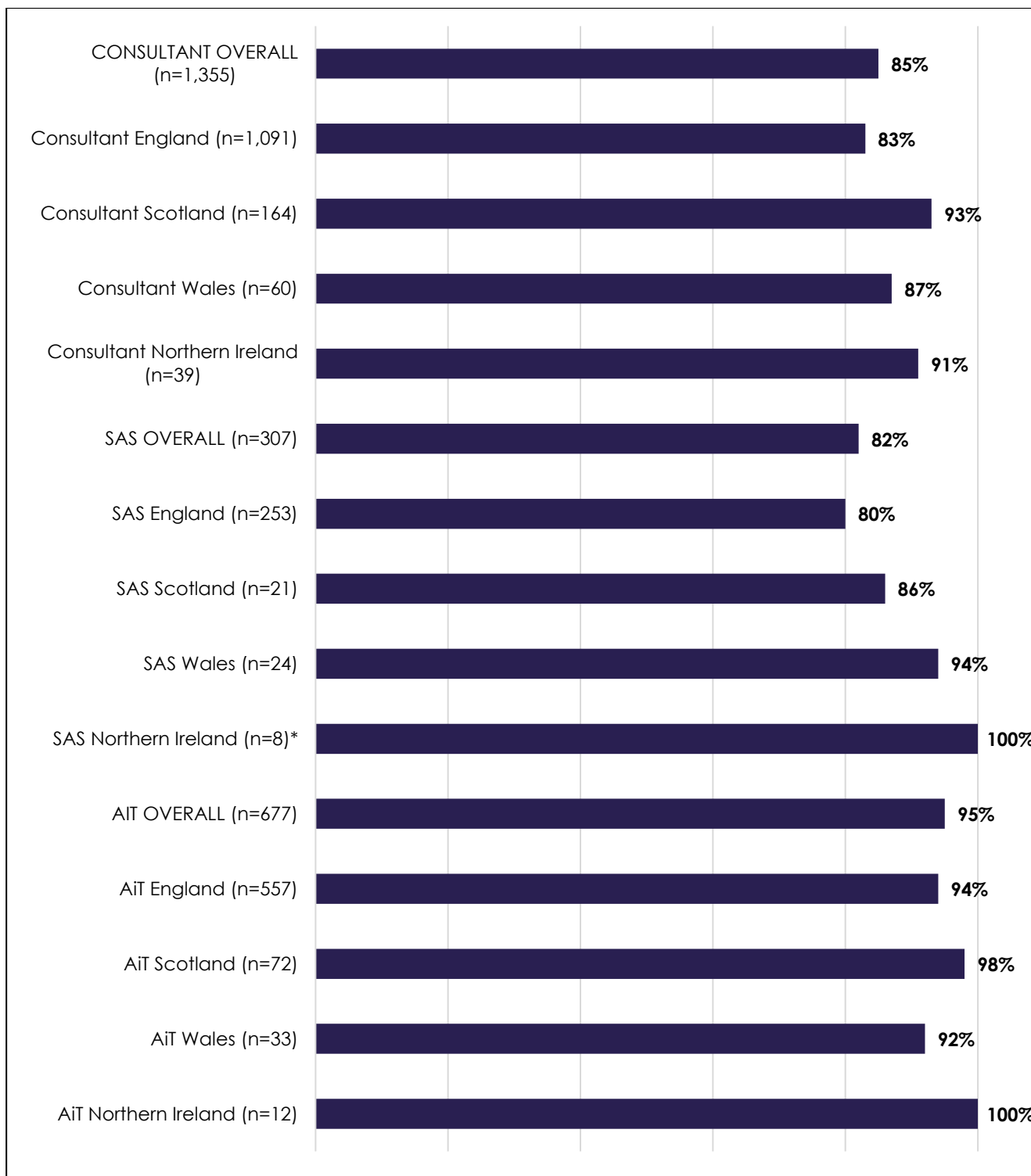


By nation, it was generally the case that those in Scotland worked out of hours the most and those in England the least. For example, 93% of consultants in Scotland, 86% of SAS doctors and 98% of AITs worked out of hours, compared with 83% of consultants, 80% of SAS doctors and 94% of AITs in England.

Comparisons for LEDs and PAAs are not shown due to insufficient numbers of responses by nation.

**Figure 27 – Out of hours work by staff group and nation**

Base: Shown in chart (Those working in NHS who gave an answer)

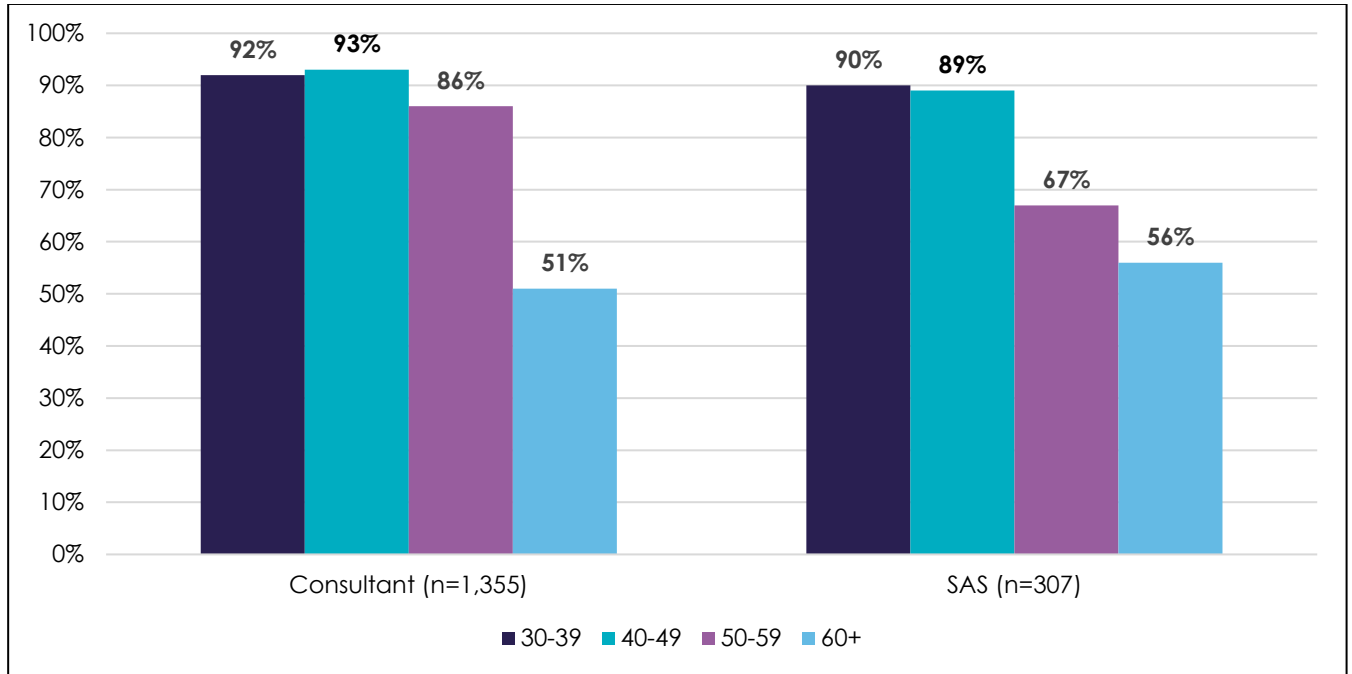


\*Small base size – results based on very small numbers may not be reliable

By age, younger consultants and SAS doctors were more likely to work out of hours than their older colleagues. Amongst consultants, 92% of those aged 30-39 and 93% of those aged 40-49 did at least some out of hours work, compared to 51% of those aged 60+. For SAS doctors, 90% of those aged 30-39 and 89% of those aged 40-49 worked out of hours, whilst only 56% of those aged 60+ did.

**Figure 28 – Out of hours work by staff group and age**

Base: Shown in chart (Consultants and SAS doctors working in NHS that gave an answer)



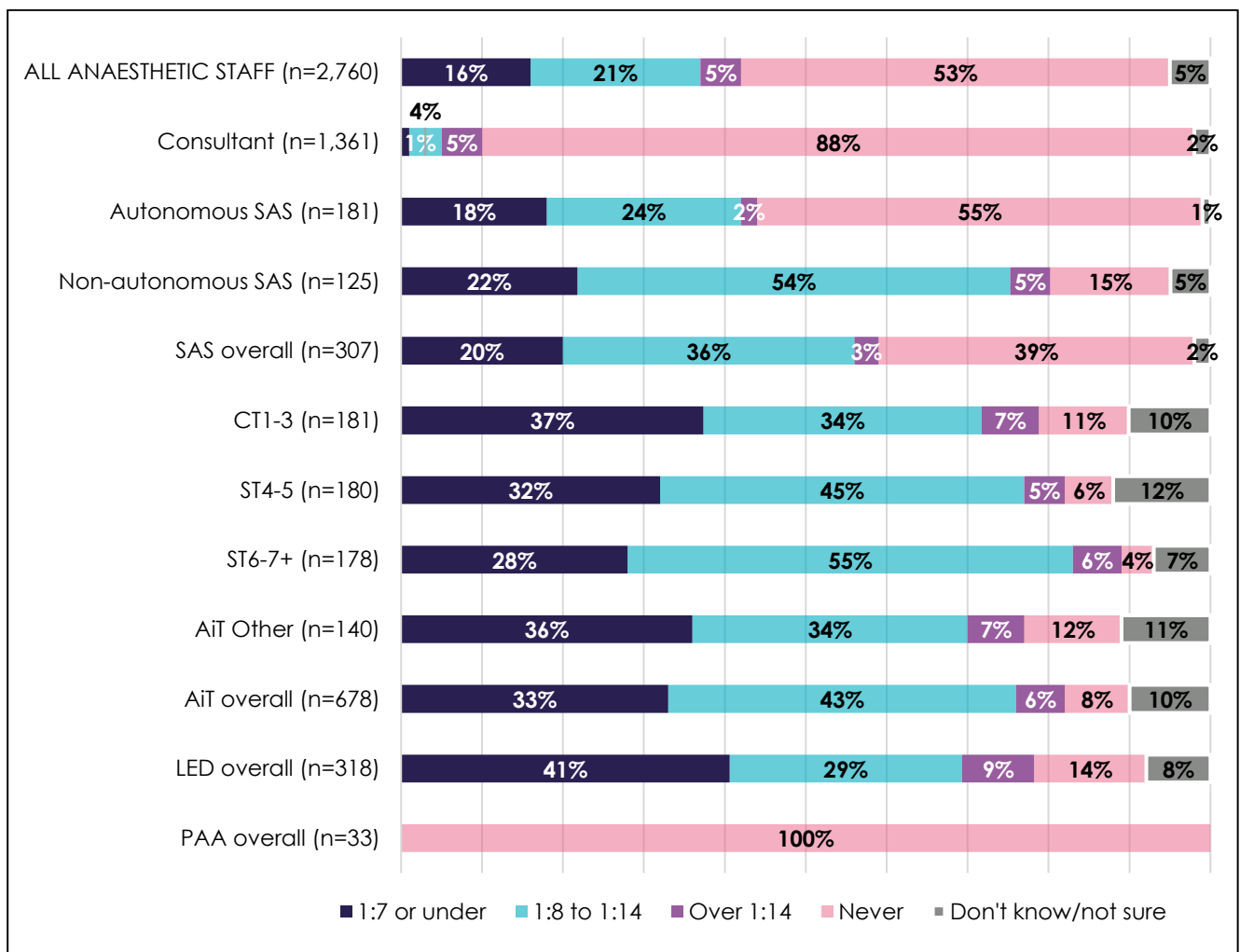
## Resident out of hours work

Regarding *weekday night* resident work, the groups most engaged were non-autonomous SAS doctors, LEDs, and AiTs. ST6-7+s reported doing the most of all, with 89% of this group reporting doing this work at least some of the time. This contrasts with PAAs, where none reported doing this kind of work. Consultants also did relatively little weekday night resident work, with only 10% reporting this.

Looking at ratios, the group most likely to do this kind of work 1:7 or under is LEDs (41%).

**Figure 29 – Out of hours ratios worked – Weekday night resident by staff group**

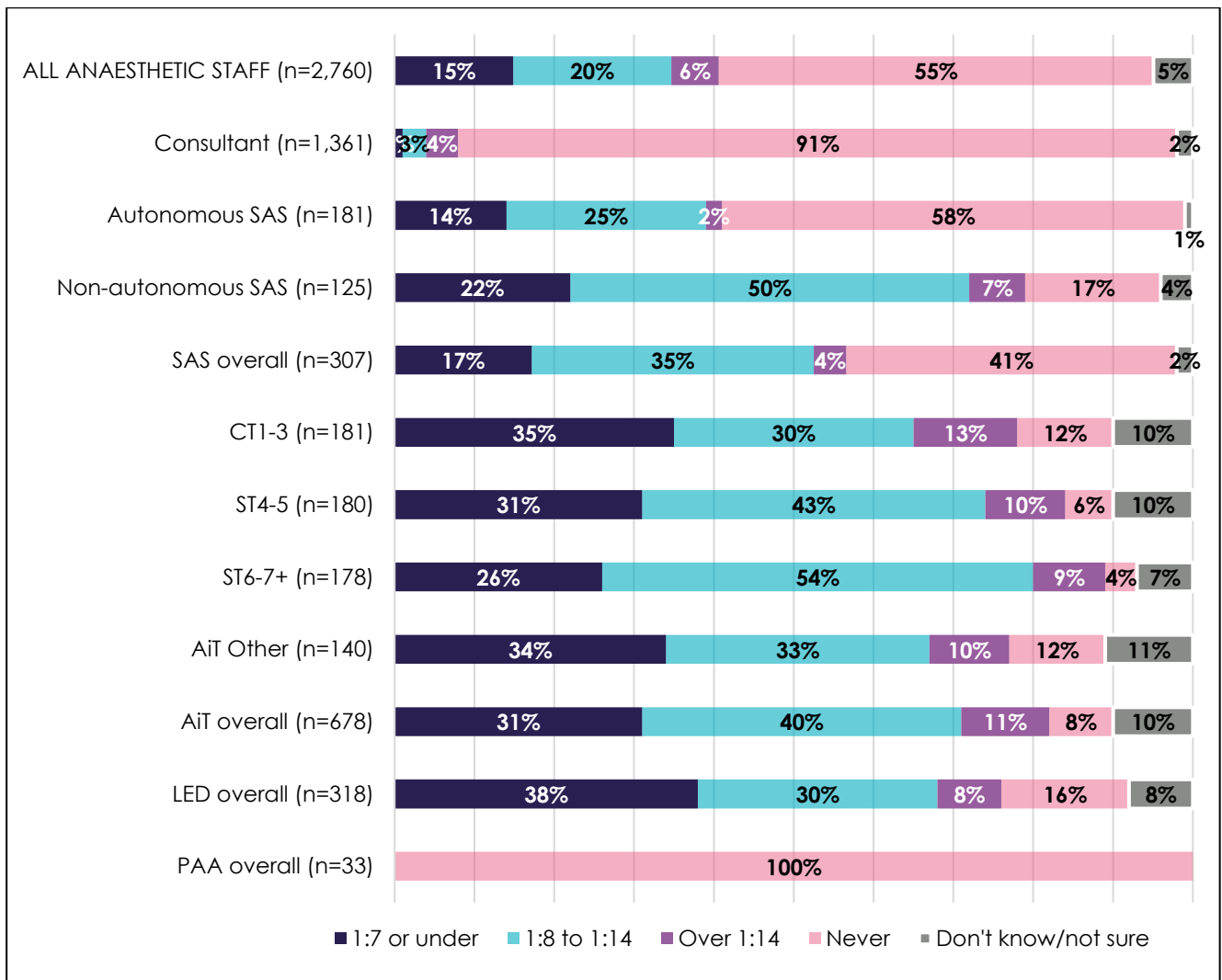
Base: Shown in chart (Those working in NHS who gave an answer)



Regarding weekend night resident work, a similar pattern emerged. This kind of work was most common among non-autonomous SAS doctors, LEDs, and AiTs. ST6-7+s were again the most likely to do any of this kind work, at 89% and LEDs were the most likely group to do this work 1:7 or under (38%).

**Figure 30 – Out of hours ratios worked – Weekend night resident by staff group**

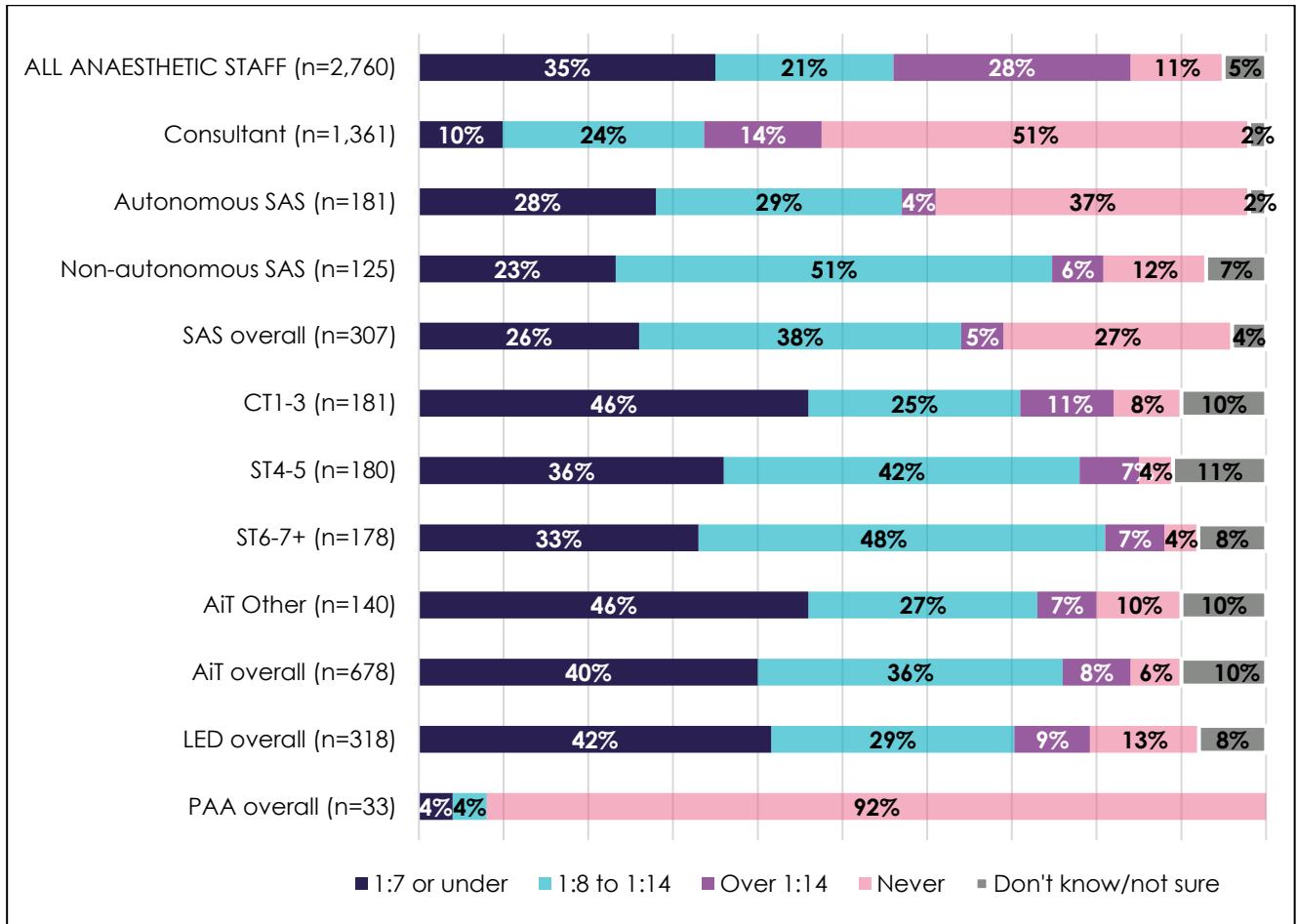
Base: Shown in chart (Those working in NHS who gave an answer)



Regarding weekend day resident work, yet again this was common among non-autonomous SAS doctors, LEDs, and AiTs. ST6-7+ were the most likely of all to do any of this work (88%). The groups most likely to do this work 1:7 or under were CT1-3s and 'other' AiTs (46% for both).

**Figure 31 – Out of hours ratios worked – Weekend day resident by staff group**

Base: Shown in chart (Those working in NHS who gave an answer)

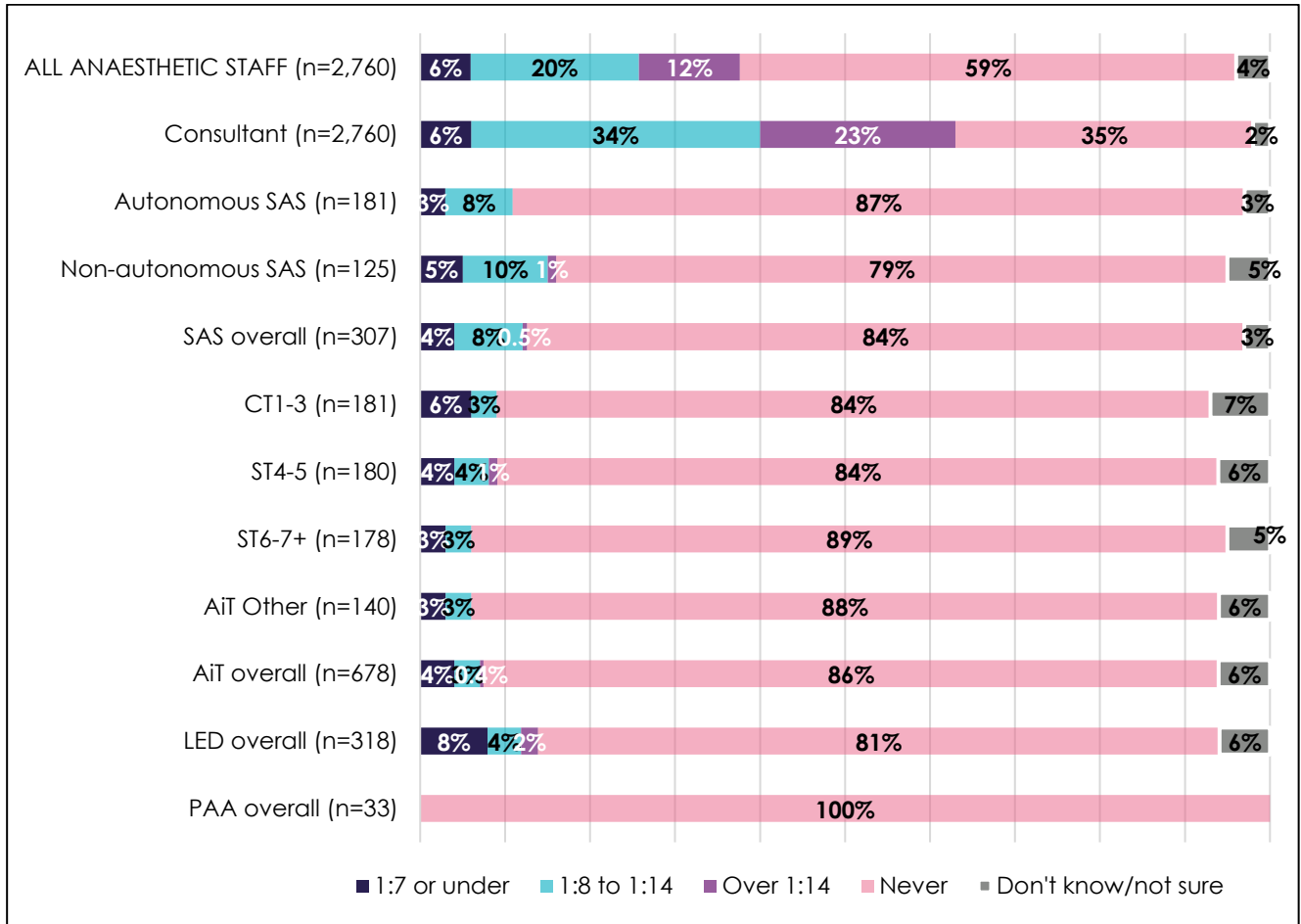


## Non-resident out of hours work

There is also non-resident out of hours work, which usually means the doctor is supervising remotely from home. Regarding weekday night non-resident work, consultants were the group who were most engaged, at 63%.

**Figure 32 – Out of hours ratios worked – Weekday night non-resident by staff group**

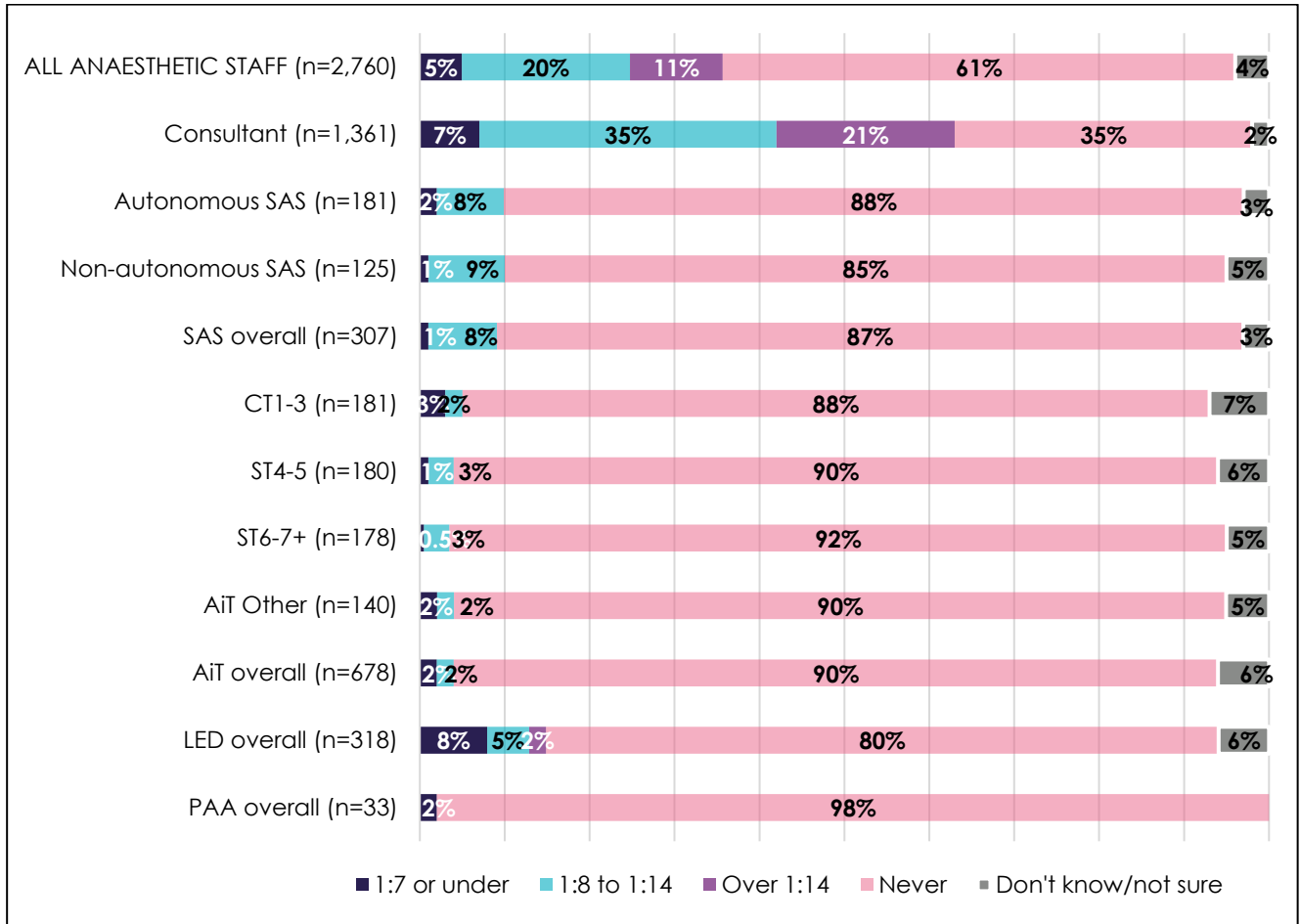
Base: Shown in chart (Those working in NHS who gave an answer)



Regarding weekend night non-resident on call, consultants were again the most likely group to do this kind of work, with 63% engaged.

**Figure 33 – Out of hours ratios worked – Weekend night non-resident by staff group**

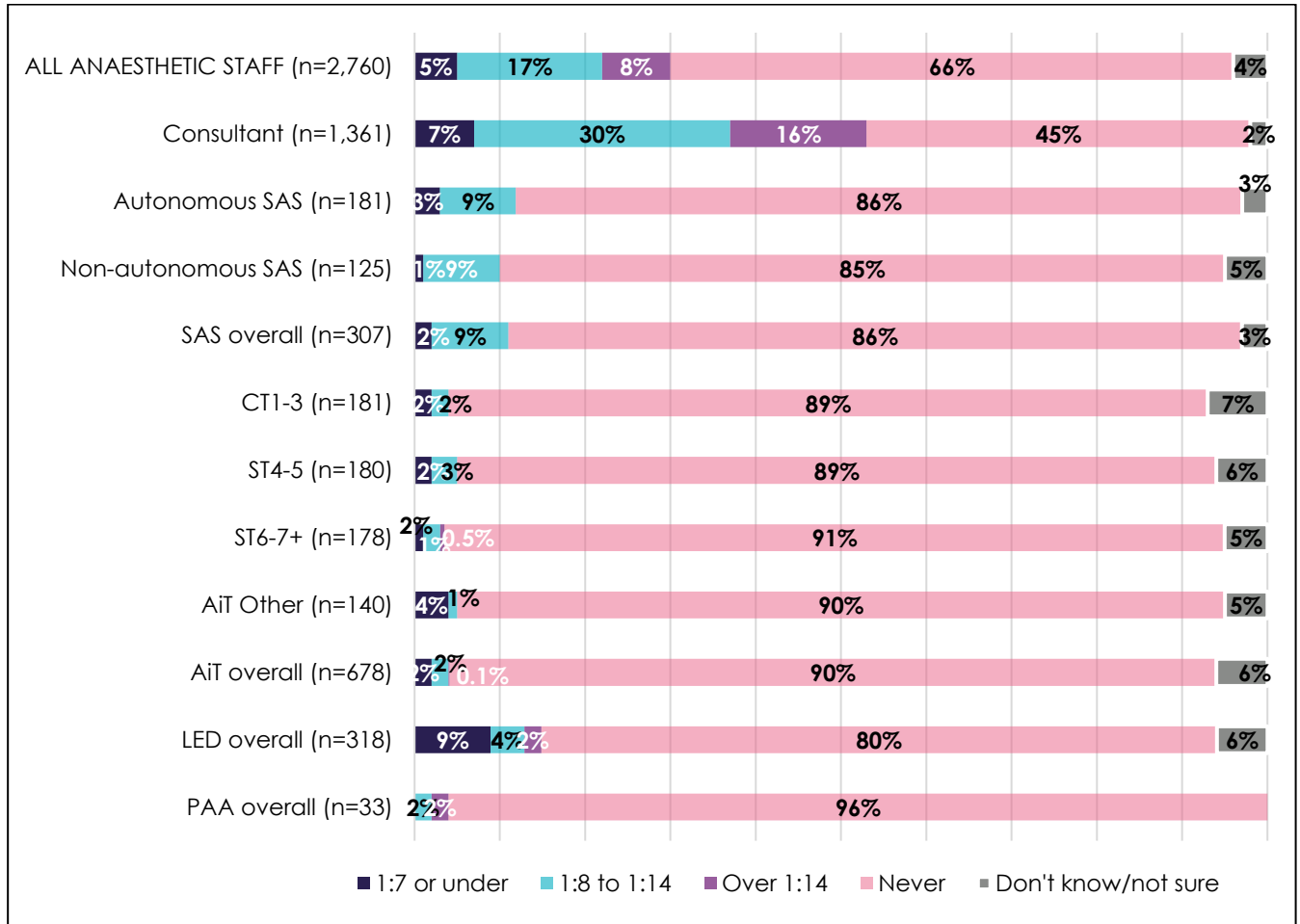
Base: Shown in chart (Those working in NHS who gave an answer)



As with other non-resident work, consultants were again the most likely to be engaged with weekend day non-resident work (53%).

**Figure 34 – Out of hours ratios worked – Weekend day non-resident by staff group**

Base: Shown in chart (Those working in NHS who gave an answer)



# 12 Supervision

## Introduction

Supervision can be provided by either consultants or autonomous SAS doctors. It can also be provided in different ratios. Sometimes it is provided 1:1, but other times a supervisor will supervise more than one member of staff. The Census sought to explore the relative prevalence of these different kinds of supervision.

## Key findings

- Among supervised staff, CT1–3 AITs were most likely to receive 1:1 supervision (79%).
- LEDs received lower levels of 1:1 supervision (46%).
- Non-autonomous SAS doctors were least likely of all to receive 1:1 supervision (25%) and most likely to be supervised in ratios above 3:1 (30%).
- Across all groups, consultants supervised the majority of cases as opposed to autonomous SAS doctors.
- Consultant supervision was highest for PAAs (96%), ST6–7+s (96%) and ST4–5s (94%).
- Non-autonomous SAS doctors had the highest proportion of cases supervised by autonomous SAS doctors (24%).

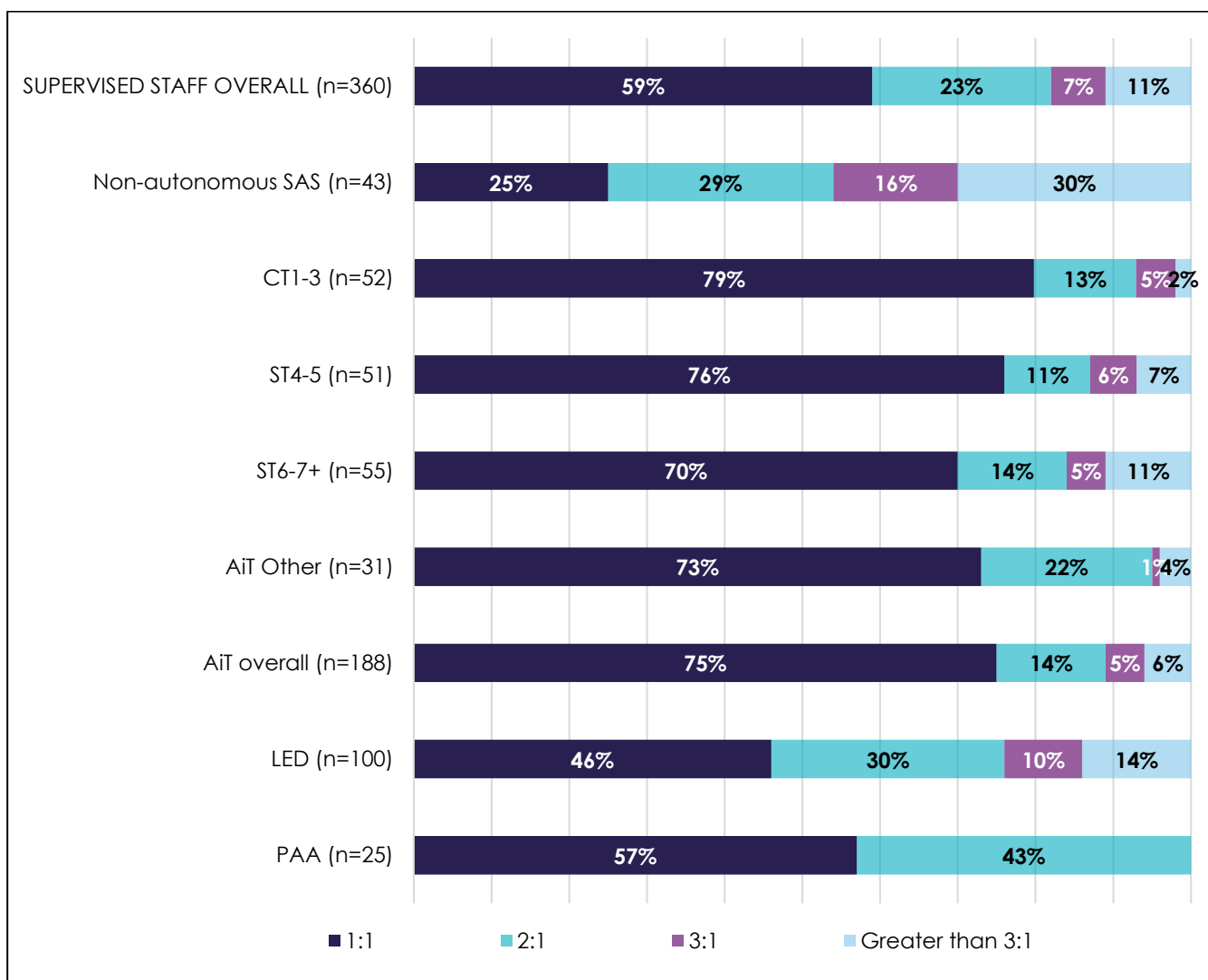
## Supervision ratios

AiTs were more likely to have 1:1 supervision than other groups (75%). Within this group, CT1-3 AiTs were most likely to have this level of supervision (79%). LEDs received lower levels of 1:1 supervision (46%). Non-autonomous SAS doctors were least likely to have 1:1 supervision and most likely to have a supervision ratio greater than 3:1 (30%).

It should be noted that this question was optional, and many respondents chose to skip it.

**Figure 35 – Percentage of cases under each level of supervision by staff group**

Base: Shown in chart (Supervised staff that gave an answer)



## Who provides supervision

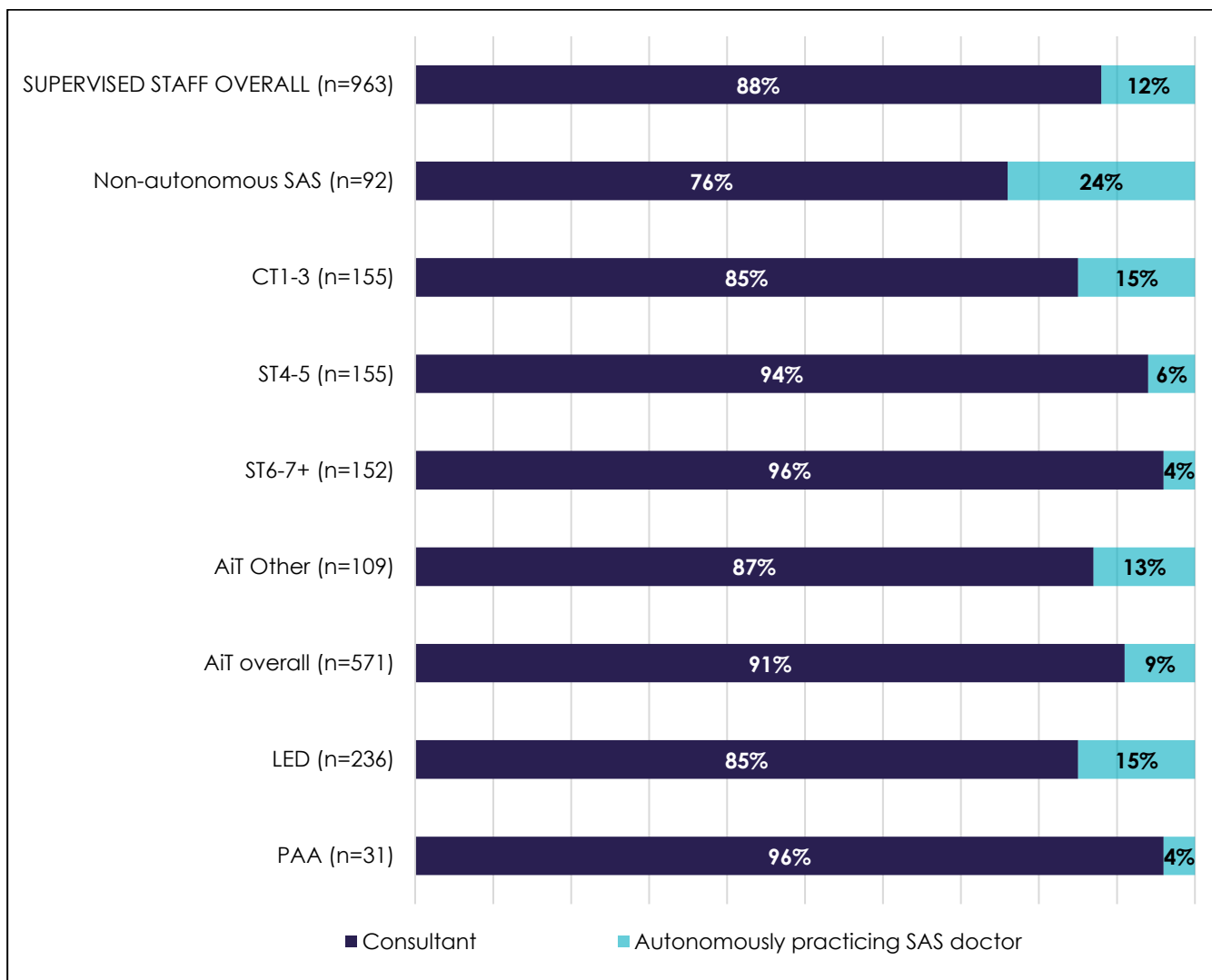
Every staff group on average had a higher percentage of cases supervised by a consultant than an autonomous SAS doctor – which likely reflects the greater number of consultants in post.

The percentage of staff who were supervised by consultants was highest for PAAs (96%), ST6-7+ AiTs (96%) and ST4-5 AiTs (94%). Non-autonomous SAS doctors had a higher proportion of cases supervised by autonomous SAS doctors (24%) than other groups.

Again, this question was voluntary, so some respondents chose to skip it.

**Figure 36 – Percentage of cases supervised by consultants and autonomous SAS doctors by staff group**

Base: Shown in chart (Supervised staff that gave an answer)



# 13 Aspirations of anaesthetists in training

## Introduction

At the heart of anaesthetic training is the AiTs themselves. In order to better understand what AiTs want from training, the Census sought to understand their end goal post-training.

## Key findings

- 95% of AiTs' end goal is to become a consultant; the next most common response was 'don't know/not sure' at 4%. Only 0.4% mentioned an end goal as an SAS doctor and 0.1% as an LED.
- Becoming a consultant was overwhelmingly stated as the end goal across all grades of AiT. This included 93% of those at CT1-3 level, 97% at ST4-5 level, 99% at ST6-7+ level and 90% of other AiTs.
- Becoming a consultant was also overwhelmingly stated as the end goal by nation, cited by 95% of AiTs in England, 99% in Scotland, 97% in Wales, and 100% in Northern Ireland.

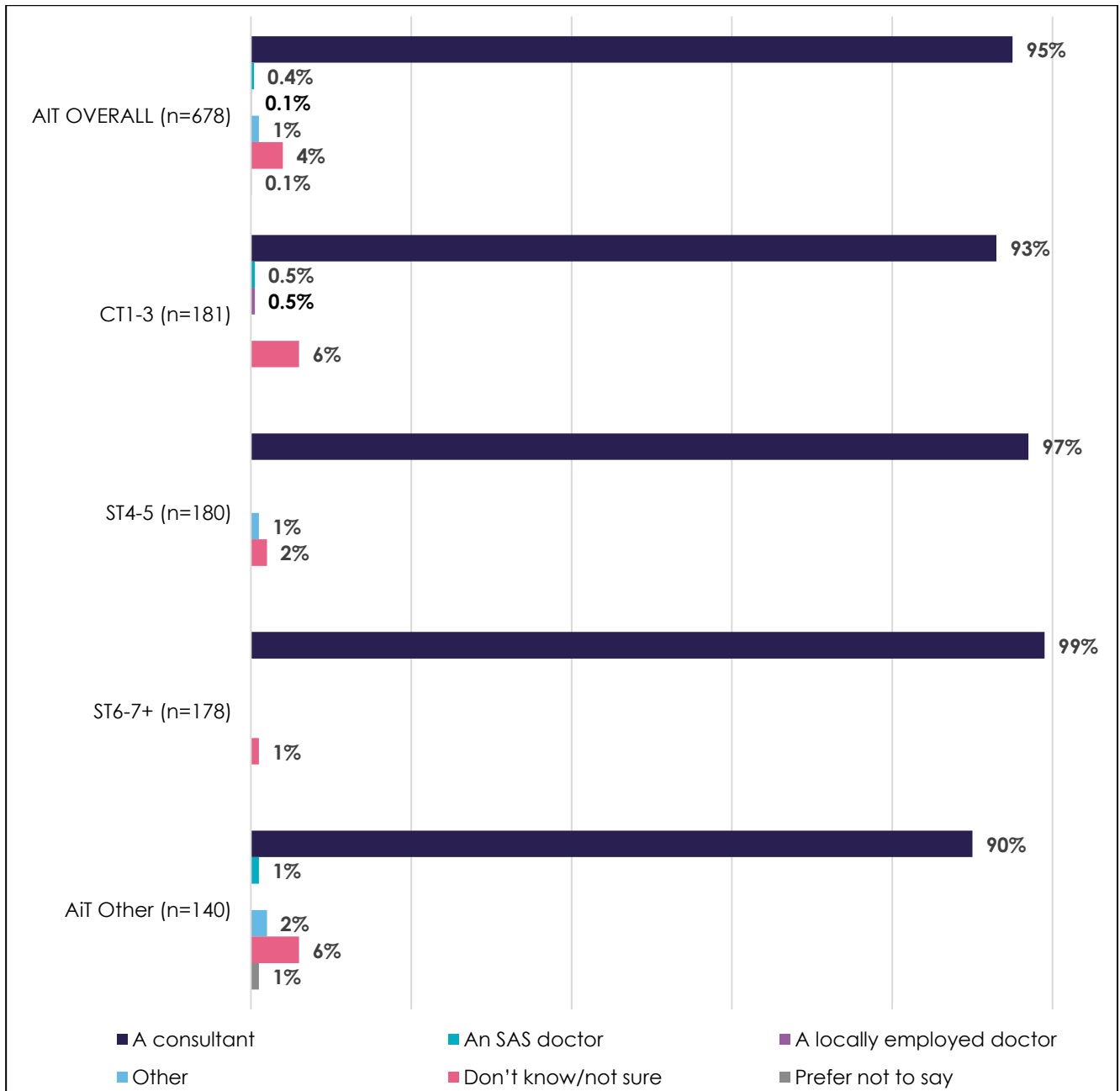
## AiT aspirations

In the Census AiTs were asked what their end goal of training was. The overwhelming answer was to become a consultant – cited by 95%. The next most common answer was 'don't know/not sure' (4%), followed by a tiny number saying SAS doctor (0.4%), and an almost negligible 0.1% saying LED. 1% said 'other', with responses suggesting they would leave the NHS or the country, change specialty, or were simply unable to complete training.

This pattern was consistent by type of training post. The end goal of becoming a consultant was cited by 93% of those at CT1-3 level, 97% at ST4-5 level, 99% at ST6-7+ level and 90% of other AiTs.

**Figure 37 – AiT end goals by type of training post**

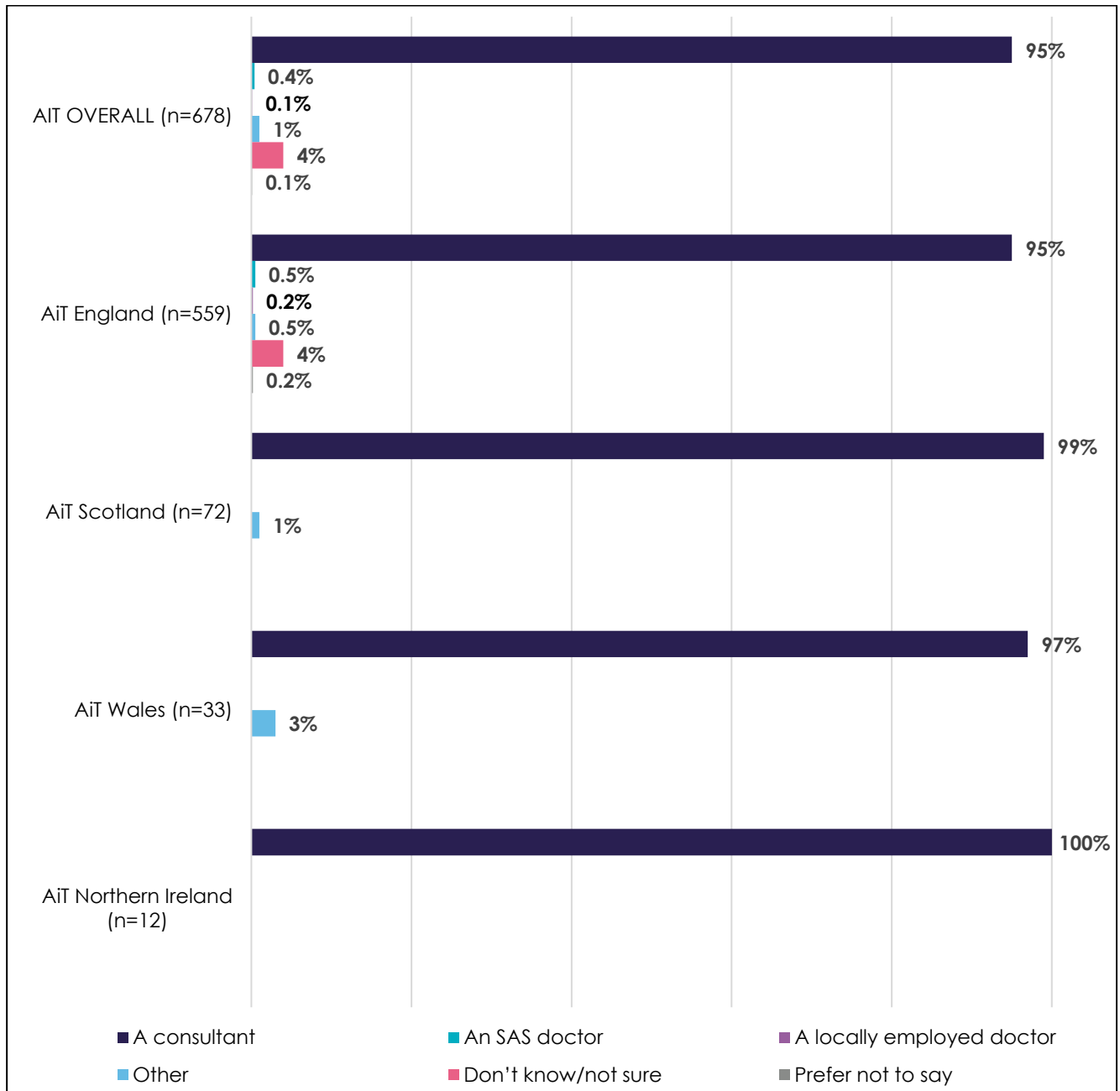
Base: Shown in chart (AiTs)



The pattern was also consistent by nation, with becoming a consultant the most common goal. This was highest in Northern Ireland, where all AiTs said this was their goal.

**Figure 38 – AiT end goals by nation**

Base: Shown in chart (AiTs)



# 14 Annual leave

## Introduction

Like all employees, anaesthetic staff are entitled to annual leave, which is vital for rest, wellbeing, and work–life balance. The Census explored how much leave staff are taking and whether they are able to take their full entitlement.

## Key findings

- Overall, anaesthetic staff were entitled to an average of 30.7 days of annual leave but took 28.5, leaving around two days untaken on average.
- Consultants and PAAs had the highest entitlement (32.0 and 32.1 days) and also took the most leave (29.8 and 31.4 days respectively).
- SAS doctors had the largest gap between what they were entitled to (30.2) and what they took (26.8).

## Leave entitlement and leave taken

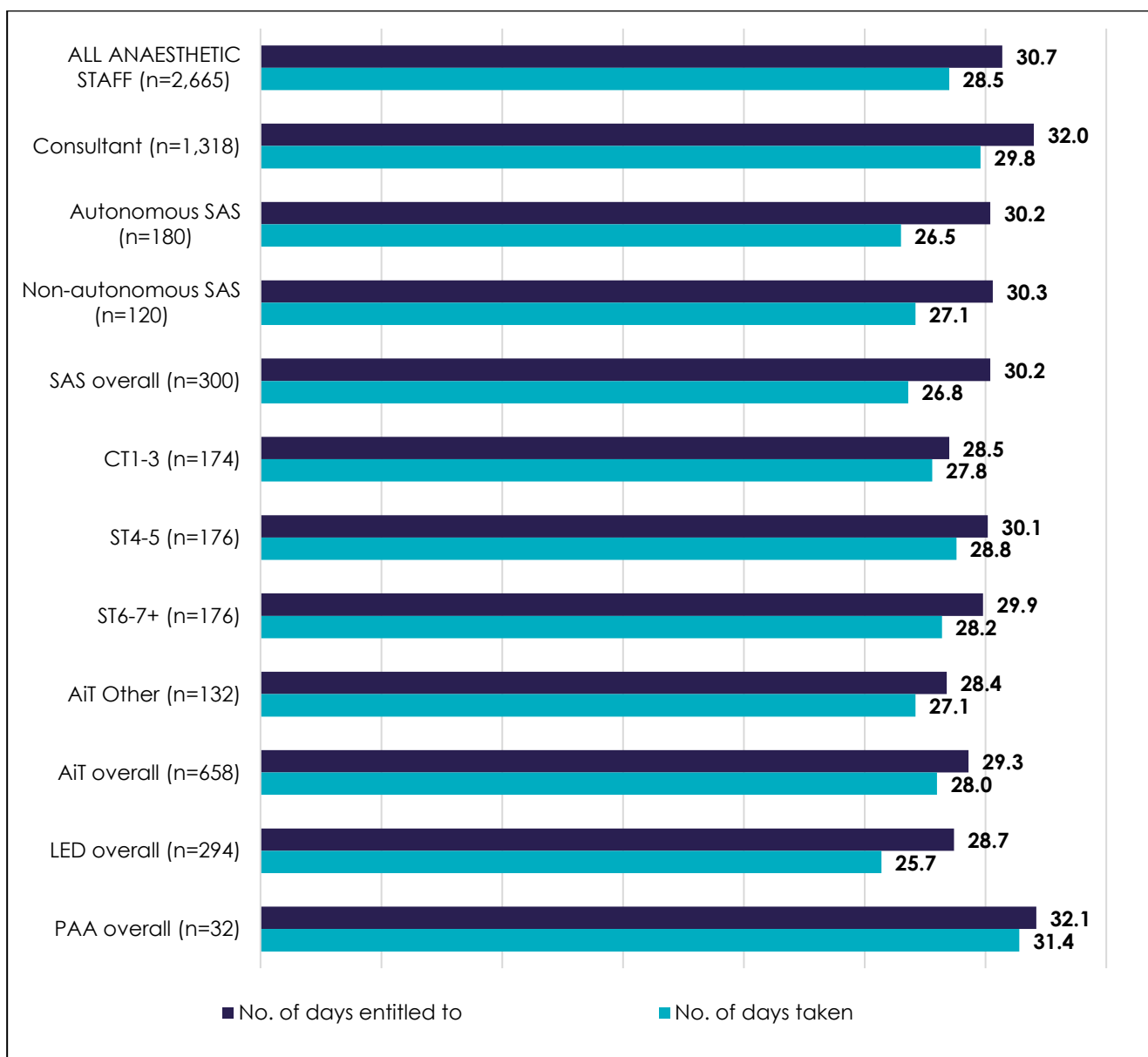
Combining all staff groups, the average (mean) annual leave entitlement was 30.7 days last year and the average number of days' leave taken was 28.5, indicating that across the workforce there are on average two days of annual leave not taken.

Consultants and PAAs were entitled to the most annual leave on average (32.0 and 32.1 days) and also took the most leave (consultants 29.8 and PAAs 31.4 days).

SAS doctors reported the largest difference between the number of days they were entitled to (30.2) and that they took (26.8). This was particularly true for autonomous SAS doctors, with an entitlement of 30.2 days but with only 26.5 taken.

**Figure 39 – Mean number of days of annual leave entitlement and days taken in past year by staff group**

Base: Shown in chart (Those who gave an answer)



# 15 Case complexity

## Introduction

The complexity of administering anaesthesia can vary greatly between patients. A common way of categorising this complexity is through the American Society of Anaesthesiologists (ASA) physical status classification system, which ranges from:

- ASA 1 – a normal, healthy patient with no significant medical history
- ASA 2 – a patient with mild systemic disease
- ASA 3 – a patient with severe systemic disease
- ASA 4 – a patient with severe systemic disease that is a constant threat to life
- ASA 5 – a moribund patient not expected to survive without the operation
- ASA 6 – a declared brain-dead patient whose organs are being removed for donation

To better understand the nature of anaesthetic caseloads, the Census explored the extent to which different anaesthetic staff groups are involved in administering anaesthesia to patients across these levels of complexity.

## Key findings

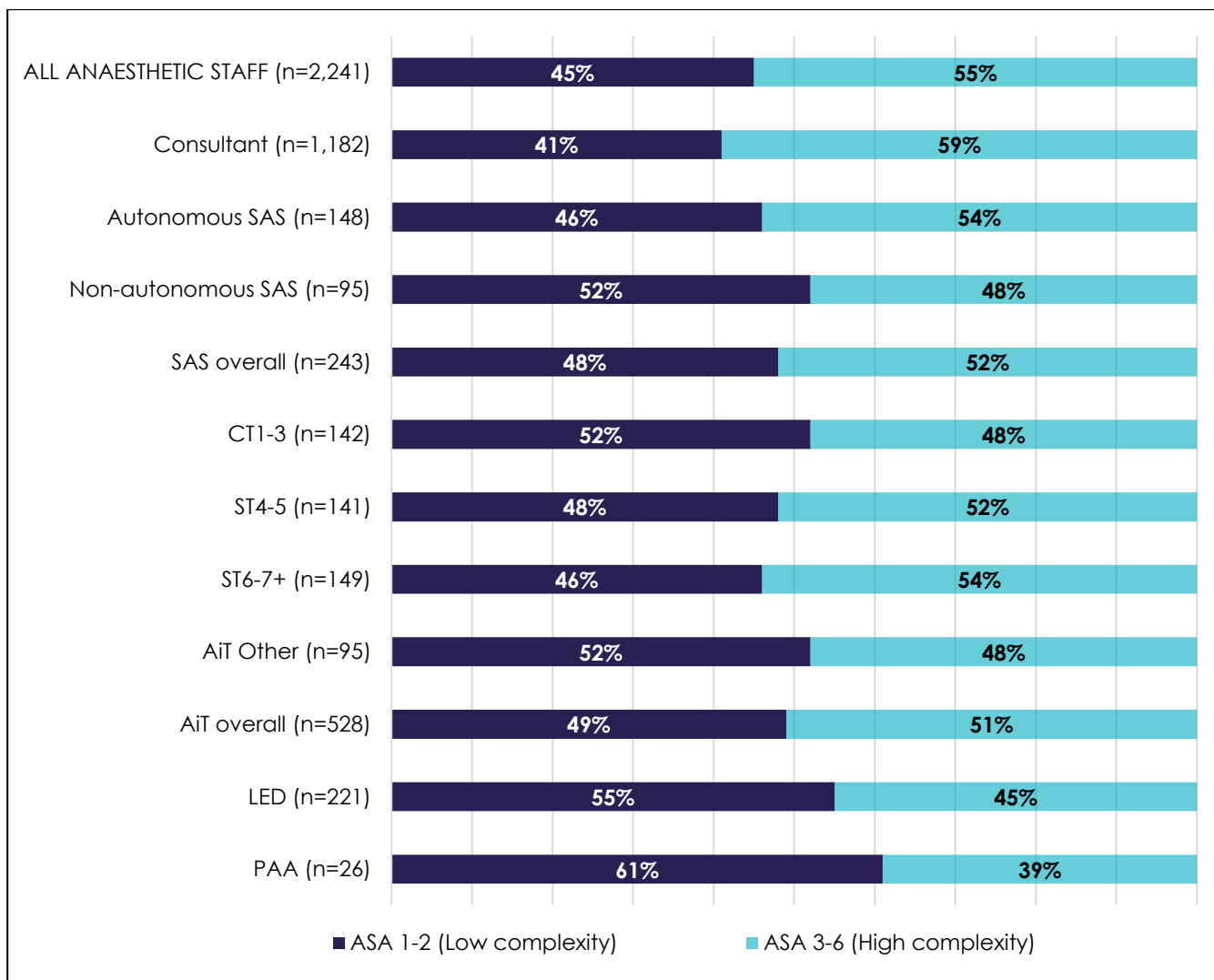
- Across all staff groups, 45% of cases on average were classed as low complexity (ASA 1–2) and 55% as high complexity (ASA 3+).
- PAAs had the highest proportion of low complexity cases, with 61% of their caseload falling into this category.
- Consultants had the highest proportion of high complexity cases, at 59%, followed by autonomous SAS doctors at 54%.

## High and low complexity cases

At an overall level, across all staff groups, 45% of cases on average were low complexity and 55% were high complexity. The proportion of low complexity cases was highest for PAAs (61%), and the proportion of high complexity cases was highest for consultants (59%), followed by autonomous SAS doctors (54%).

**Figure 40 – Percentage of cases of high and low complexity by staff group**

Base: Shown in chart (Those who gave an answer)



# 16 College tutor role

## Introduction

College tutors (CTs) are anaesthetists who, as part of their job plan, act as educational leads for anaesthetic training within their department and ensure that the educational, pastoral and career planning needs of trainees are being addressed.

Unfortunately, anecdotally, this job requires far more time to perform than is actually allocated in job plans. The Census sought to explore and quantify this.

## Key findings

- On average, college tutors were allocated 1.0 PAs in their job plans for college tutor work. However, on average, college tutors actually devoted 1.6 PAs to this work, with this pattern consistent by nation.

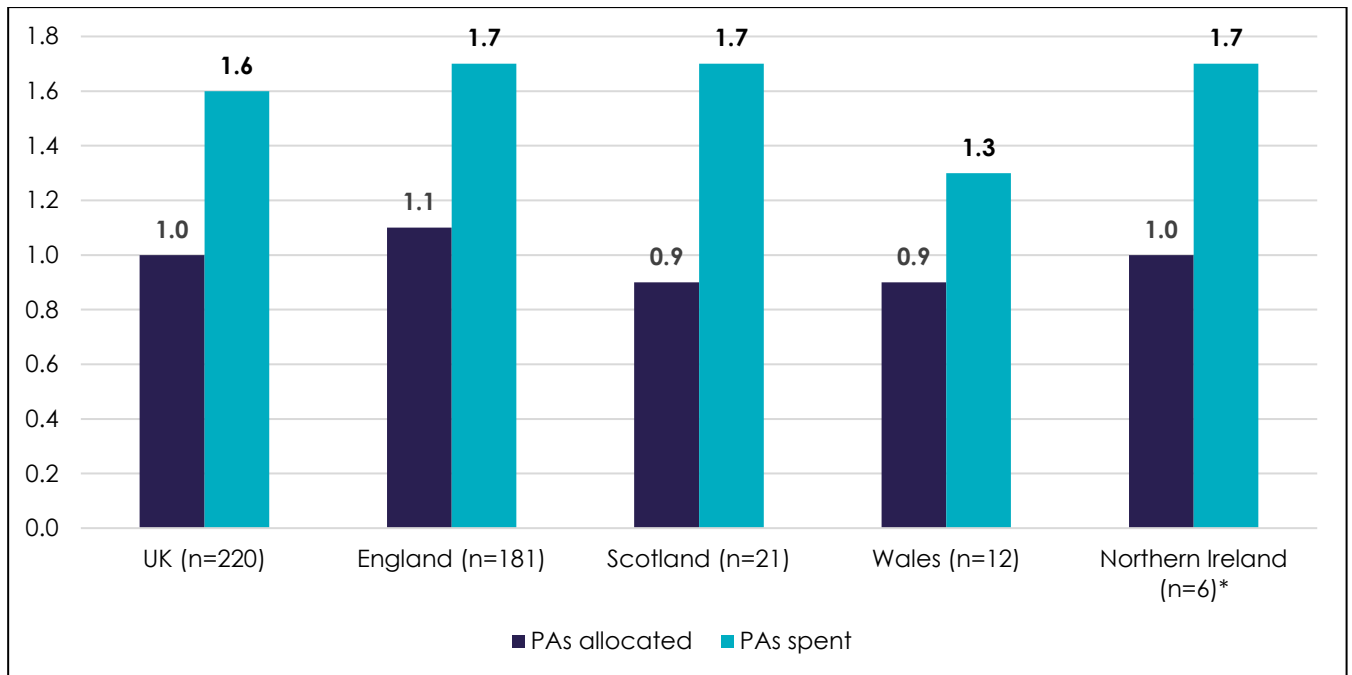
## Programmed Activities for college tutor role

College tutors were asked how many PAs they had allocated in their job plan (on average) per week to their CT role and how many PAs they in reality spend.

Across the UK, college tutors had one PA allocated per week for their role on average but are spending 1.6 PAs carrying out this work. This was consistent by nation.

**Figure 41 – Number of PAs allocated and spent on average per week on college tutor role by nation**

Base: Shown in chart (College tutors)



\*Small base size – results based on very small numbers may not be reliable

# 17 Independent sector work

## Introduction

As reported in Chapter 5, one in five anaesthetic staff (17.8%) undertake at least some work in the independent sector. These are almost always consultants who do independent sector work on top of their NHS work. The Census sought to examine the number of hours contributed by those working in the independent sector.

Very few respondents in other staff groups worked in the independent sector, so this section of the report focuses exclusively on consultants.

## Key findings

- Among the subset of consultants who undertake at least some independent sector work, the average number of hours devoted to this is 9.0 per week.
- Among the very small subset of consultants who work exclusively in the independent sector (n=16), the average numbers of hours worked was 32.1 per week.
- On average, male consultants worked more hours per week in the independent sector than female consultants (9.5 vs 7.2).
- On average, consultants aged 60+ worked the most hours in the independent sector (11.9 per week).

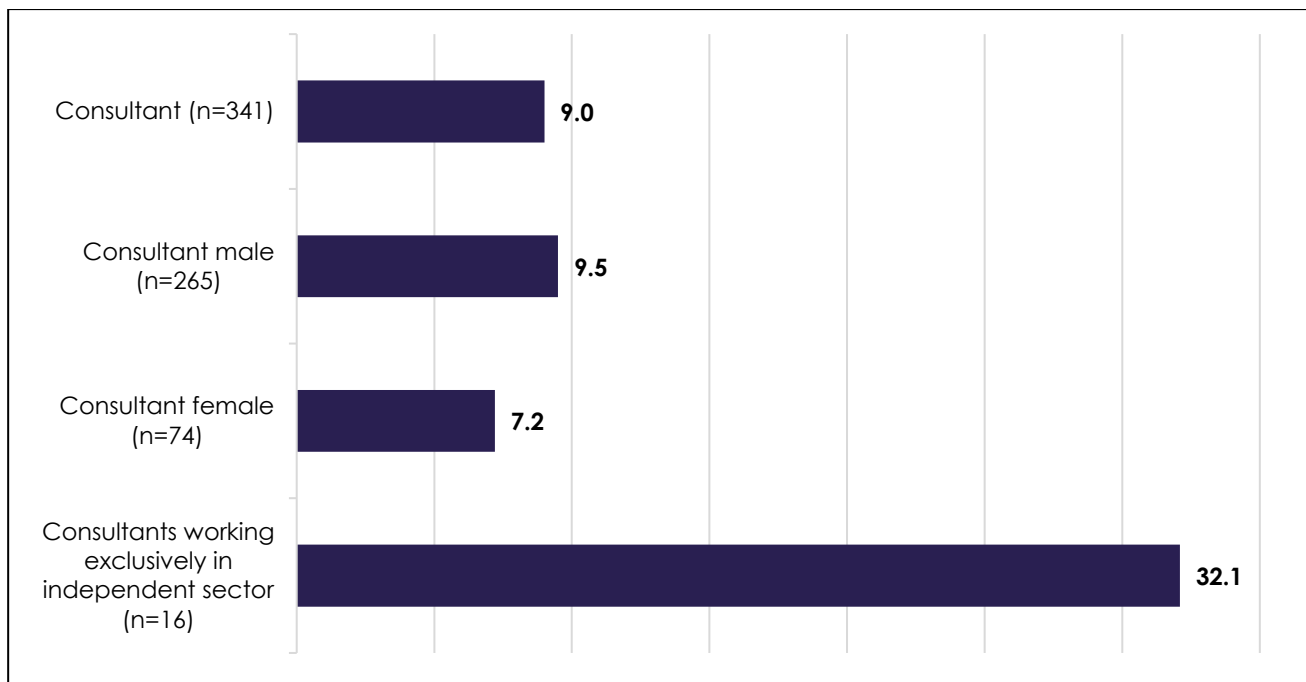
## Time working in the independent sector

Amongst consultants working in the independent sector, the mean number of hours per week was 9.0. The mean number was higher for males (9.5 hours per week) than females (7.2 hours).

Among the very small subset of consultants (n=16) who work exclusively in the independent sector, the average number of hours worked was 32.1 per week.

**Figure 42 – Mean number of independent sector hours amongst consultants by gender**

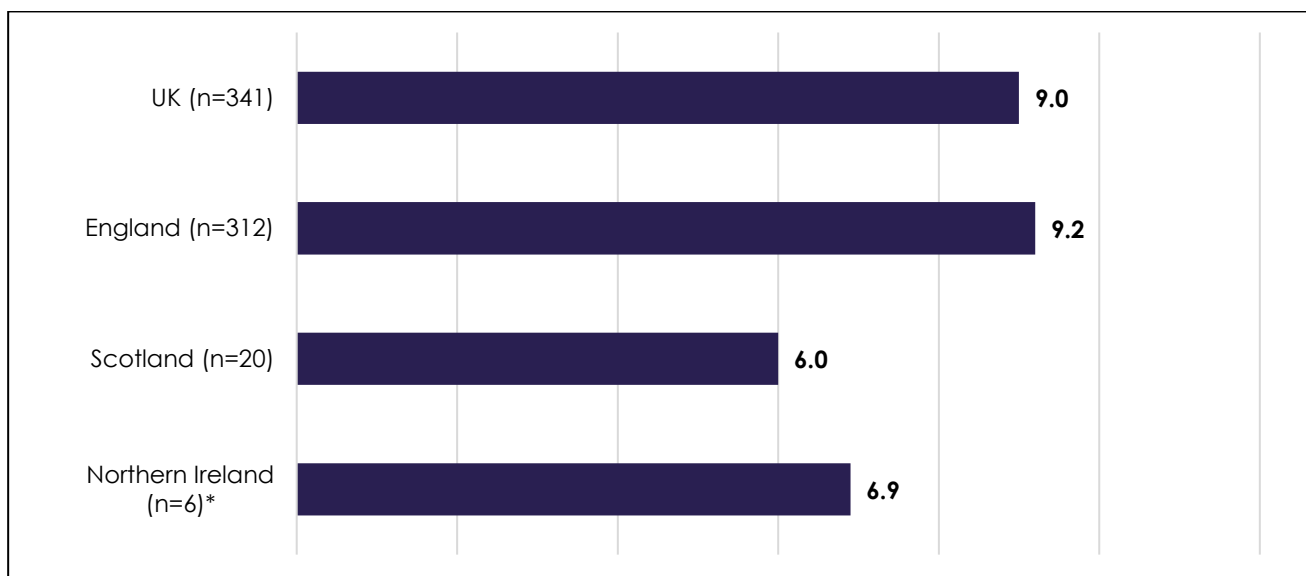
Base: Shown in chart (Consultants who worked in the independent sector and gave an answer)



There was some variation by nation, with consultants in England working more hours on average per week (9.2) in the independent sector than in other nations, although base sizes are too small for meaningful comparison.

**Figure 43 – Mean number of independent sector hours amongst consultants by nation<sup>^</sup>**

Base: Shown in chart (Consultants who worked in the independent sector and gave an answer)



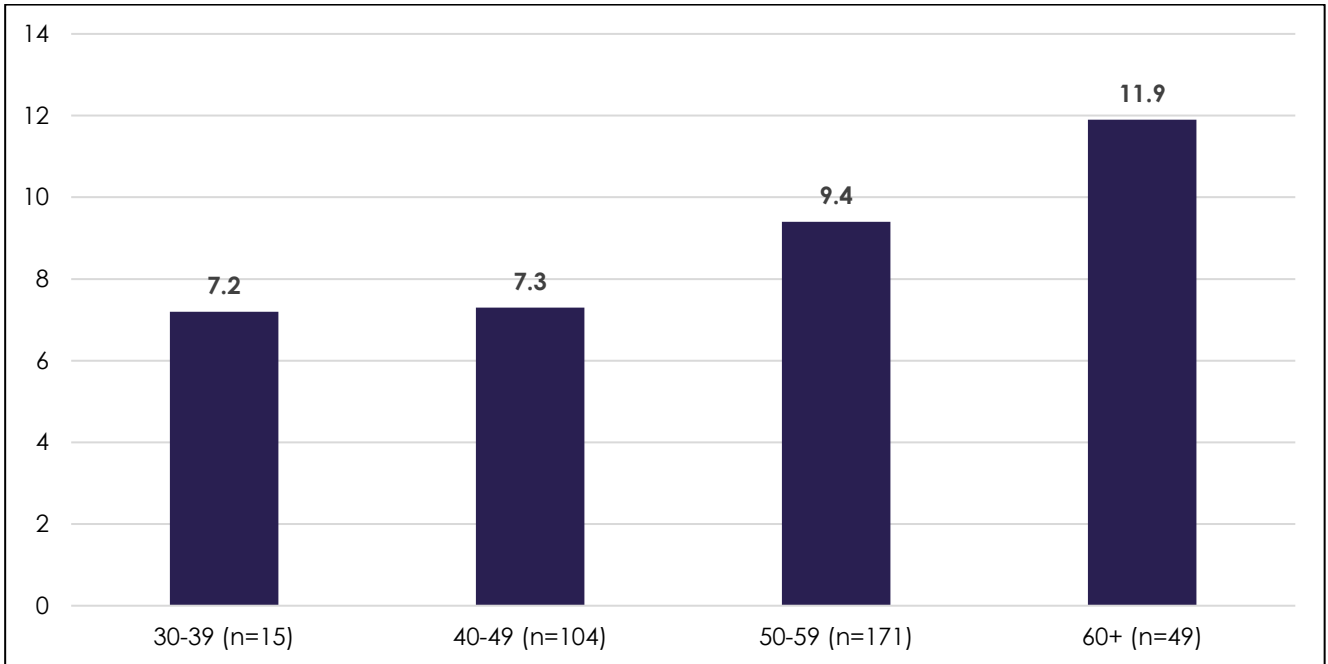
<sup>^</sup>Wales has been omitted due to the very small base size

\* Small base size – results based on very small numbers may not be reliable

The mean number of hours worked by consultants in the independent sector increased with age, with those aged 60+ recording the highest mean (11.9 hours per week).

**Figure 44 – Mean number of independent sector hours amongst consultants by age**

Base: Shown in chart (Consultants who worked in the independent sector and gave an answer)



# 18 Earnings

## Introduction

Anaesthetists are highly skilled doctors who make critical, often life-saving decisions on a daily basis, providing care before, during and after surgery, and in many other settings. Their role combines advanced medical knowledge, clinical judgement and the ability to respond under extreme pressure.

Reaching consultant level in anaesthesia requires a substantial commitment of time and training - typically a minimum of 14 years from the start of medical school. This pathway includes undergraduate study, foundation training, core and higher anaesthetic training, and the completion of professional examinations. Alongside this, many undertake research, teaching, or leadership responsibilities during their career development.

Given the length of training, the high level of responsibility, and the pivotal role anaesthetists play in delivering safe surgical and perioperative care, their earnings are key considerations both for the profession and for workforce planning in the NHS.

The Census sought to explore the earnings of anaesthetic staff from different sources, including NHS work, independent sector activity, medicolegal work, and income from events or other professional activities, to provide a comprehensive picture of earnings within the specialty.

## Key findings

- Consultants had the highest total annual income, averaging £145,696 before tax.
- Among other doctors, LEDs had the lowest total income per year (£63,308).
- Among all anaesthetic staff, PAAs had the lowest total income per year (£55,474).

## Earnings by staff group

Across the UK, by anaesthetic staff group, consultants were the highest earners. They reported total earnings of £145,696 on average before tax, including £123,598 from NHS work. Of other doctors, the lowest earners were LEDs. They reported total earnings of £63,308, including £63,101 from NHS work.

The very lowest earners were PAAs who reported £55,474 total earnings, including £55,191 from NHS work.

### Figure 45 – Mean total earnings across UK by staff group

Base: Shown in chart (Those who provided a total income of between £10,000 and £1m per annum excluding agency/locum work)<sup>^</sup>

Group	Contracted NHS work	NHS overtime	Clinical award	Total NHS work	Military work	Independent sector	Medico-legal	Event doctor event	Other	Total earnings*
Consultant (n=849)	£113,016	£8,227	£2,355	<b>£123,598</b>	£1,524	£18,994	£399	£66	£1,114	<b>£145,696</b>
Autonomous SAS (n=108)	£87,096	£5,585	£70	<b>£92,751</b>	£0	£331	£28	£85	£15	<b>£93,211</b>
Non-autonomous SAS (n=76)	£72,725	£8,213	£0	<b>£80,938</b>	£0	£1,500	£0	£0	£120	<b>£82,558</b>
Overall SAS (n=185)	£81,158	£6,671	£41	<b>£87,870</b>	£0	£814	£17	£50	£59	<b>£88,809</b>
CT1-3 (n=98)	£64,996	£866	£0	<b>£65,863</b>	£2,296	£0	£0	£3	£3	<b>£68,165</b>
ST4-5 (n=121)	£67,042	£2,386	£437	<b>£69,864</b>	£1,831	£283	£0	£134	£0	<b>£72,113</b>
ST6-7+ (n=117)	£83,221	£1,270	£0	<b>£84,491</b>	£2,161	£704	£0	£64	£639	<b>£88,060</b>
AiT Other (n=81)	£61,350	£1,534	£0	<b>£62,884</b>	£842	£105	£0	£60	£53	<b>£63,944</b>
AiT overall (n=417)	£69,988	£1,550	£127	<b>£71,665</b>	£1,841	£300	£0	£69	£190	<b>£74,065</b>
LED (n=136)	£60,545	£2,556	£0	<b>£63,101</b>	£0	£89	£0	£22	£96	<b>£63,308</b>
PAA (n=19)	£52,358	£733	£2,100	<b>£55,191</b>	£0	£0	£0	£0	£283	<b>£55,474</b>

\*Figures shown in the tables are to one decimal place; as a result, the breakdowns may not add exactly to the reported totals due to rounding

<sup>^</sup>It has been assumed that respondents who provided a total income outside of these parameters made an error when inputting their earnings

## Consultant earnings by nation

By nation, consultants in England reported earning the most overall: £147,747 on average per year, before tax. While consultants in England actually had the lowest NHS earnings (£122,903), their overall totals were boosted considerably by earnings from other sources, mainly independent sector work (£21,150).

The highest earners from purely NHS work were consultants in Wales, earning £137,212 from that source – with overall earnings of £142,946. Consultants in Northern Ireland earned £137,546 in total, including £130,623 from NHS (technically HSC) work. Consultants in Scotland earned the lowest overall (£131,817), including £123,804 from NHS work.

It must be noted that NHS earnings figures reported here do not just reflect different pay rates by nation – they also reflect different working hours.

Analysis by nation for other staff groups has not been included due to very small base sizes.

### Figure 46 – Mean total earnings amongst consultants by nation

Base: Shown in chart (Consultants who provided a total income of between £10,000 and £1m per annum excluding agency/locum work)^

Group	Contracted NHS work	NHS overtime	Clinical award	Total NHS work	Military work	Independent sector	Medico-legal	Event doctor	Other	Total earnings*
Consultants overall (n=849)	£113,016	£8,227	£2,355	<b>£123,598</b>	£1,524	£18,994	£399	£66	£1,114	<b>£145,696</b>
Consultants England (n=686)	£111,521	£8,966	£2,416	<b>£122,903</b>	£1,882	£21,150	£486	£77	£1,250	<b>£147,747</b>
Consultants Scotland (n=102)	£116,532	£3,923	£3,349	<b>£123,804</b>	£17	£7,931	£9	£26	£30	<b>£131,817</b>
Consultants Wales (n=40)	£130,990	£6,222	£0	<b>£137,212</b>	£0	£3,556	£111	£22	£2,044	<b>£142,946</b>
Consultants Northern Ireland (n=19)	£121,123	£9,500	£0	<b>£130,623</b>	£0	£6,727	£0	£0	£196	<b>£137,546</b>

\*Figures shown in the tables are to one decimal place; as a result, the breakdowns may not add exactly to the reported totals due to rounding

^It has been assumed that respondents who provided a total income outside of these parameters made an error when inputting their earnings

# 19 Operating theatres

## Introduction

Anaesthetic staff are essential to the safe and effective delivery of care in operating theatres, supporting surgical activity and patient outcomes. The Census sought to quantify the number of operating theatres in the UK.

## Key findings

- There are an estimated 4,445 operating theatres across the UK: 3,724 in England, 384 in Scotland, 208 in Wales and 129 in Northern Ireland.

## Number of operating theatres

Based on data supplied by clinical leaders, there are 4,445 operating theatres across the UK, with the majority of these in England (3,724).

It should be noted that the figures below are estimated as the shorter version of the clinical leaders' survey did not capture this information. The figures presented here are based on estimates extrapolated from sites that completed the full version of the survey and should be interpreted with this in mind.

**Figure 47 – Number of operating theatres by UK nation**

Nation	Number
England	3,724
Scotland	384
Wales	208
Northern Ireland	129
<b>Total UK</b>	<b>4,445</b>

In England, London, the North West and the South East had the largest numbers of operating theatres.

**Figure 48 – Number of operating theatres by English region**

Nation	Number
East Midlands	287
East of England	345
London	567
North East	215
North West	594
South East	542
South West	422
West Midlands	379
Yorkshire and the Humber	373

### Report authors

Andrew Cameron  
 Research Director  
 Enventure Research

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