Royal College of Anaesthetists

enventure research

Anaesthetic Workforce Census 2025

Numbers, Shortfalls and Consequences for the NHS

Contents

1 Executive summary

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.

This report presents the detailed census findings related to factors such as: the numbers of anaesthetists currently in post; the contributions they make; the shortfalls in provision; the consequences of those shortfalls; the available capacity in the system to accommodate more anaesthetists in training (AiTs); and much more.

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

Methodology and response summary

College tutors' and clinical leaders' surveys

Some of the figures in this summary, such as headcounts, are drawn from data submitted by college tutors and clinical leaders in anaesthesia across the UK. Both surveys were conducted online, with participants invited by email and sent weekly reminder emails to encourage completion.

The college tutors' survey received responses from **100%** of relevant hospitals, the clinical leaders' survey received **97%** response rate by NHS Trust/Board.

Survey of the wider anaesthetic workforce

There was also a survey of the wider anaesthetic workforce conducted online between 24 March and 5 May 2025. Email invitations and reminders were sent to all RCoA members, plus PAAs who had provided their email address to RCoA 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 have been restricted to only those based in the UK.

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

Summary of key findings

NHS numbers and demographics

- The total number of anaesthetic staff working in the NHS in 2025 was 19,759, mainly anaesthetists (19,517), and a much smaller number of qualified PAAs (242).
- The number of consultants in 2025 was 9,858, up from 8,489 in 2020, a 16% increase.
- The number of SAS doctors in 2025 was 2,182, up from 1,635 in 2020, a 33% increase. Broken down by contract, in 2025 there were 1,624 specialty doctors, 361 specialist doctors, and 197 associate specialist doctors.

- Combined, the number of consultants and SAS doctors was 12,040 in 2025, up from 10,124 in 2020, a 19% increase.
- By gender, there were 3,801 female consultants (39%), and 6,056 male consultants (61%). There were 844 female SAS doctors (39%) and 1,338 male SAS doctors (61%).
- There were 2,272 LEDs, including 1,215 males (53%) and 1,055 females (46%). Unfortunately, a direct comparator from 2020 is lacking.
- There were 4,923 AiTs overall, up from 4,479 in 2020, a 10% increase. However, it is unclear exactly how much this rise in headcount represents real rises in the number of whole time equivalent (WTE) AiTs, due to increasing prevalence of less than full time working.
- 2,297 AiTs were female (47%) and 2,625 were male (53%).
- By type of training post, there were 1,330 CT1-3s, 733 ACCS anaesthesia, 1,519 ST4-5s, 1,201 ST6-7+, and 140 other AiTs.

Long term leave

- At the time of the Census, 384 consultant and SAS anaesthetists were taking some form of long term leave.
- This broke down as 139 on maternity/paternity leave, 141 on long term sickness, 87 on a career break or sabbatical, and 17 for other reasons.
- The percentage of the workforce taking some kind of long term leave has decreased very slightly from 3.4% in 2020 to 3.2% in 2025.

NHS completed cases

- On average, consultants reported completing 13.6 cases per week, which translates to an estimated 629 per year.
- Autonomous SAS doctors reported completing 17.5 cases per week, which translates to an estimated 817 per year.
- Across both groups, the mean was 14.1 cases per week, which translates to an estimated 651 per year.
- The majority of cases completed by consultants (51.0%) and autonomous SAS doctors (56.9%) were in elective care.
- The next biggest number of cases completed were in ICU, constituting 19.0% of consultant cases and 13.2% of autonomous SAS doctors' cases.

NHS workforce shortfalls

- The UK faces a shortage of 2,256 anaesthetist consultants and SAS doctors, 16% below what is needed. This has risen from 1,483 in 2020, a 52% increase.
- The current shortfall breaks down as a funded gap of 908, and an unfunded gap of 1,348.
- The combined (funded + unfunded) gap is 1,881(16% below what is needed) in England, 168 (16%) in Scotland, 138 (18%) in Wales, and 69 (19%) in Northern Ireland.
- According to clinical leaders, the hospital service with the greatest pressure was elective surgery, with 48% rating levels anaesthetic staffing as poor and 11% as very poor (59% combined).
- Including all grades of anaesthetist, 797 extra staff were needed to meet demand for elective surgery alone.

Impact of shortages on services

- 88% of clinical leaders reported surgery being postponed due to lack of anaesthetic staff at least sometimes and 43% reported this occurring on a daily or weekly basis.
- In maternity care, 53% reported that women were sometimes **delayed** from getting pain relief due to lack of anaesthetists, with 11% reporting this happening on a daily or weekly basis.
- 19% reported that women in maternity care were sometimes **unable** to receive pain relief due to lack of anaesthetists, with 3% reporting this happening on a daily or weekly basis.

- In urgent and emergency care, 30% reported that surgery was sometimes **delayed** due to lack of anaesthetists. This included 6% who reported this happening on a daily or weekly basis.
- 39% reported that urgent and emergency patients were sometimes **delayed** from getting pain relief due to lack of anaesthetists, with 8% reporting this happening on a daily or weekly basis.
- Staffing shortages can increase the need for expensive external/agency locum staff. Clinical leaders reported 197 external/agency locum consultants and SAS doctors in anaesthesia across the UK.
- The average daily pay rate for external/agency locum staff was £857 for consultants, £532 for specialist doctors and £723 for specialty doctors, suggesting an estimated annual cost to the UK health services of around £57m.

Meeting demand in elective surgery

- Boosting the number of anaesthetists is the single most common factor identified by clinical leaders that could increase the rate of elective surgery, cited by 68% of respondents.
- This is above physical factors such as ward space (50%) and number of operating theatres (42%), and other staffing groups such as Operating Department Practitioners (56%), scrub staff (32%) and surgeons (9%).
- In terms of rating the adequacy of current factors - 75% of clinical leaders rated ward bed capacity as poor or very poor, 59% gave such ratings for anaesthetists, and 58% for Operating Department Practitioners (ODPs).

Recruitment challenges

- Reiterating the finding from above, 60% of the anaesthetic workforce gap is unfunded (i.e. there was no money available for the post to begin with).
- 30% of clinical leaders indicated that there were recruitment freezes in place, including 34% in England, 11% in Scotland, 33% in Wales (low base size), and 17% in Northern Ireland (low base size).
- 46% of clinical leaders reported that they had advertised at least one consultant post that they were unable to fill.
- The most common reason for being unable to fill an advertised consultant post was a lack of appropriately qualified applicants, cited by 73%.
- The most common sub-specialty that could not be filled was General, accounting for 52% of unfilled consultant posts, followed by Adult Critical Care (16%).
- 17% of clinical leaders reported that they had advertised an SAS post that they were unable to fill.
- The most common reason for being unable to fill an advertised SAS post was a lack of appropriately qualified applicants, cited by 76%.

Training pathways, bottlenecks and ratios

- The number of doctors graduating from UK medical schools has increased from 7,356 in 2021 to 9,746 in 2025 (32% increase).
- The number of doctors in second year foundation training has increased from 7,863 in 2021 to 9,060 in 2025 (15% increase).
- The number of international medical graduates applying for specialty training in the UK has increased from 9,456 in 2021 to 25,257 in 2025.
- In 2025, across all medical specialities, and all levels of training, approximately 42,000 individual applicants applied for just 13,000 specialty training posts, leaving 29,000 unable to progress.
- In anaesthesia specifically, in 2025 there were 6,770 applicants for just 539 places at core level – a competition ratio of 12.56 to 1. This has risen from a ratio of 3.61 to 1 in 2021.
- At ST4 level, there were 699 applicants for 423 posts – a competition ratio of 1.65 to 1. This has reduced from a ratio of 2.67 to 1 in 2021.

Training capacity

- Currently there is capacity to take on an extra 526 CT1-3 level AiTs. Given that, typically, these posts last three years, this equates to a yearly intake of 175.
- Currently there is capacity to take on an extra 802 ST4-7+ level AiTs. Given that, typically, these posts last four years, this equates to a yearly intake of 201.
- In terms of increasing training capacity beyond these numbers, there is no single factor that stands out as the primary limiter on a national basis. It is likely this varies considerably hospital by hospital.

2 Introduction

Anaesthetists are vital to UK health services. Without them, 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 quantify the current state of the anaesthetic workforce. This report presents the detailed findings related to factors such as: the numbers of anaesthetists currently in post; the contributions they make; the shortfalls in provision; the consequences of those shortfalls; the bottlenecks in the training pathway; and the available capacity in the system to accommodate more anaesthetists in training (AiTs).

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 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.

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 ±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 (AiTs), 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 NHS numbers and demographics

Introduction

The overwhelming majority of anaesthetic staff work in the NHS. Clinical leaders were asked to report the numbers working in their hospitals.

Key findings

- The total number of anaesthetic staff working in the NHS in 2025 was 19,759, mainly anaesthetists (19,517), and a much smaller number of qualified PAAs (242).
- The number of consultants in 2025 was 9,858, up from 8,489 in 2020, a 16% increase.
- The number of SAS doctors in 2025 was 2,182, up from 1,635 in 2020, a 33% increase. Broken down by contract, in 2025 there were 1,624 specialty doctors, 361 specialist doctors, and 197 associate specialist doctors.
- Combined, the number of consultants and SAS doctors was 12,040 in 2025, up from 10,124 in 2020, a 19% increase.
- By gender, there were 3,801 female consultants (39%), and 6,056 male consultants (61%). There were 844 female SAS doctors (39%) and 1,338 male SAS doctors (61%).
- There were 2,272 LEDs, including 1,215 males (53%) and 1,055 females (46%). Unfortunately, a direct comparator from 2020 is lacking.
- There were 4,923 AiTs overall, up from 4,479 in 2020, a 10% increase. However, it is unclear exactly how much this rise in headcount represents real rises in the number of whole time equivalent (WTE) AiTs, due to increasing prevalence of less than full time working.
- 2,297 AiTs were female (47%) and 2,625 were male (53%).
- By type of training post, there were 1,330 CT1-3s, 733 ACCS anaesthesia, 1,519 ST4-5s, 1,201 ST6-7+, and 140 other AiTs.

Numbers of consultants, SAS doctors and LEDs

Based on figures supplied by clinical leaders and college tutors, in 2025 there were 19,759 anaesthetic staff working in the NHS across all four nations of the UK, of whom 19,517 were anaesthetists. This includes 9,858 consultants, 2,182 SAS doctors and 2,272 LEDs[1] working in the UK. In almost every staff group, at a UK level, there were more male staff than female staff.

It should be noted that figures for gender are estimated as the shorter version of the clinical leaders' survey did not capture the split. 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. It should also be noted that figures in this chapter only relate to those on permanent or fixed term contracts.

Figure 1 – Numbers of consultants, SAS doctors and LEDs by gender and UK nation

Group	UK*	England	Scotland	Wales	Northern Ireland
Consultants - total	9,858	8,332	808	465	253
Male	6,056	5,128	481	302	145
Female	3,801	3,203	327	163	108
Other	2	2	0	0	0
Specialty doctors - total	1,624	1,403	72	108	41
Male	962	830	38	77	17
Female	662	573	34	31	24
Other	0	0	0	0	0
Specialist doctors - total	361	323	16	21	1
Male	242	213	15	14	0
Female	119	110	1	7	1
Other	0	0	0	0	0
Associate specialist doctors - total	197	171	4	19	3
Male	134	119	4	9	2
Female	63	52	0	10	1
Other	0	0	0	0	0
SAS doctors overall - total	2,182	1,897	92	148	45
Male	1,338	1,162	57	100	19
Female	844	735	35	48	26
Other	0	0	0	0	0
Consultants and SAS combined - total	12,040	10,229	900	613	298
Male	7,394	6,290	538	402	164
Female	4,645	3,938	362	211	134
Other	2	2	0	0	0
LEDs – total	2,272	2,096	47	114	16

[1] Excludes Portfolio pathway/CESR fellows and Post CCT fellows

Group	UK*	England	Scotland	Wales	Northern Ireland
Male	1,215	1,105	25	79	6
Female	1,055	989	22	35	10
Other	2	2	0	0	0
Portfolio pathway/CESR fellows - total	220	213	2	5	0
Male	130	123	2	5	0
Female	90	90	0	0	0
Other	0	0	0	0	0
Post CCT fellows – total	62	59	3	0	0
Male	30	27	3	0	0
Female	32	32	0	0	0
Other	0	0	0	0	0

**Some totals may not add up due to rounding based on estimates*

The proportional breakdown by gender shows a similar pattern across staff groups, with men making up the majority in most roles at a UK level. However, there is some variation by nation and staff group, with relatively higher female representation in certain groups, particularly in Northern Ireland.

Within SAS roles, the gender split varies by staff group, with some smaller subgroups showing more pronounced differences. LEDs show the most balanced gender split overall, though there is some variation by nation.

Figure 2 – Gender split amongst consultants, SAS doctors and LEDs by UK nation

Group	UK	England	Scotland	Wales	Northern Ireland
Consultants					
Male	61%	62%	60%	65%	57%
Female	39%	38%	40%	35%	43%
Other	0.02%	0.02%	-	-	-
Specialty doctors					
Male	59%	59%	53%	71%	41%
Female	41%	41%	47%	29%	59%
Other	-	-	-	-	-
Specialist doctors					
Male	67%	66%	94%	67%	-
Female	33%	34%	6%	33%	100%
Other	-	-	-	-	-
Associate specialist doctors					
Male	68%	70%	100%	47%	67%
Female	32%	30%	-	53%	33%

Group	UK	England	Scotland	Wales	Northern Ireland
Other	-	-	-	-	-
SAS doctors overall					
Male	61%	61%	62%	68%	42%
Female	39%	39%	38%	32%	58%
Other	-	-	-	-	-
Consultants and SAS doctors combined					
Male	61%	61%	60%	66%	55%
Female	39%	38%	40%	34%	45%
Other	0.02%	0.02%	-	-	-
LEDs					
Male	53%	53%	53%	69%	38%
Female	46%	47%	47%	31%	63%
Other	0.09%	0.10%	-	-	-
Portfolio pathway/CESR fellows					
Male	59%	58%	100%	100%	-
Female	41%	42%	-	-	-
Other	-	-	-	-	-
Post CCT fellows					
Male	48%	46%	100%	-	-
Female	52%	54%	-	-	-
Other	-	-	-	-	-

Using population data from the Office for National Statistics (ONS) allows us to calculate the number of consultant and SAS anaesthetists per 100,000 population. [1] This shows that Wales has highest number (19.2), followed by England with 17.4, Scotland with 16.2, and Northern Ireland with 15.5.

Figure 3 – Anaesthetists per 100,000 population by UK nation

Group	UK	England	Scotland	Wales	Northern Ireland
Consultants	9,858	8,332	808	465	253
SAS doctors	2,182	1,897	92	148	45
Combined	**12,040**	**10,229**	**900**	**613**	**298**
Population	69,281,437	58,620,101	5,546,900	3,186,581	1,927,855
Anaesthetists per 100,000 population	17.4	17.4	16.2	19.2	15.5

Across England, the number of anaesthetists varies by region. For example, there are 1,526 consultant anaesthetists in London compared to 492 in the North East.

Figure 4 – Numbers of consultants, SAS doctors and LEDs by English region*

Group	East Midlands	East of England	London	North East	North West	South East	South West	West Midlands	Yorkshire and the Humber
Consultants	661	735	1,526	492	1,198	992	1,106	850	810
Specialty doctors	154	200	181	65	215	197	156	111	145
Specialist doctors	34	24	46	7	29	50	65	32	36
Associate specialist doctors	29	14	16	3	18	27	33	18	13
SAS doctors overall	217	238	243	75	262	274	254	161	195
LEDs	141	197	608	69	294	336	77	265	107

**Totals may not add up to previously reported England totals due to rounding based on estimates*

In terms of consultant and SAS anaesthetists per 100,000 population, the South West had the most, with 23.1 and the South East had the least, with 13.1.

Figure 5 – Anaesthetists per 100,000 population by English region*

Group	East Midlands	East of England	London	North East	North West	South East	South West	West Midlands	Yorkshire and the Humber
Consultants	661	735	1,526	492	1,198	992	1,106	850	810
SAS doctors	217	238	243	75	262	274	254	161	195
Combined	878	973	1769	567	1460	1266	1360	1011	1005
Population	5,063,164	6,576,306	9,089,736	2,760,678	7,737,414	9,642,942	5,889,695	6,187,204	5,672,962
Anaesthetists per 100,000	17.3	14.8	19.5	20.5	18.9	13.1	23.1	16.3	17.7

Consultant and SAS doctor number changes since 2020

Between 2020 and 2025, the number of consultants grew across the UK overall, increasing by 16% from 8,489 to 9,858. Increases were seen in England (+18%), Scotland (+13%) and Wales (+7%), while Northern Ireland saw a decrease (-8%).

In the same time period, there has also been a 33% increase in the number of SAS doctors across the UK from 1,635 to 2,182. England has seen the biggest increase (38%), while Scotland remained unchanged (0%) over this period. Both Wales and Northern Ireland also saw increases in the number of SAS doctors (11% and 13% respectively).

Figure 6 – Numbers of consultants and SAS doctors compared with 2020 by UK nation*

Group	UK	England	Scotland	Wales	Northern Ireland
Consultants					
2020	8,489	7,067	714	433	275
2025	9,858	8,332	808	465	253
Difference since 2020	+1,369	+1,265	+94	+32	-22
% change since 2020	+16%	+18%	+13%	+7%	-8%
SAS doctors					
2020	1,635	1,370	92	133	40
2025	2,182	1,897	92	148	45
Difference since 2020	+547	+527	0	+15	+5
% change since 2020	+33%	+38%	0%	+11%	+13%
Combined consultants and SAS doctors					
2020	10,124	8,437	806	566	315
2025	12,040	10,229	900	613	298
Difference since 2020	+1,916	+1,792	+94	+47	-17
% change since 2020	+19%	+21%	+12%	+8%	-5%

**Numbers of LEDs have also likely increased substantially since 2020 but, unfortunately, a comparable baseline is lacking*

PAA numbers

Based on numbers provided by clinical leaders, there were 242 qualified PAAs in the UK in 2025, an increase of 33% since 2023.

Figure 7 – Numbers of qualified PAAs compared with 2023 by UK nation

Group	UK	England	Scotland	Wales	Northern Ireland
2023	182	152	15	12	3
2025	242	199	31	10	2
Difference since 2023	+60	+47	+16	-2	-1
% change since 2023	33%	31%	107%	-17%	-33%

Numbers of student PAAs were obtained directly from universities. At the time of the Census, there were 28 student PAAs across the UK. More recent data we have obtained suggests there are just 3 student PAAs at time of writing in 2026, all of whom are due to graduate shortly.

Figure 8 – Numbers of student PAAs by year

Year	UK
2023	114
2025	28
2026	3

AiT numbers

At an overall level there were 4,923 AiTs across the UK in 2025, split between 2,625 males and 2,297 females.

The distribution of AiTs varies by type of training post, with the largest groups in CT1–3 (1,330), ST4–5 single programme (1,353) and ST6–7+ single programme (1,049). Smaller numbers are seen in dual training programmes (166 and 152) and ACCS Anaesthesia (733). Across all types of training posts, England accounts for the majority of AiTs.

Within each group, male and female AiT numbers are broadly similar, with only small differences between them.

Figure 9 – Numbers of types of AiTs by gender and UK nation

Group	UK*	England	Scotland	Wales	Northern Ireland
CT1-3 - total	1,330	1,054	145	79	52
Male	693	546	71	45	31
Female	637	508	74	34	21
Other	0	0	0	0	0
ACCS Anaesthesia - total	733	642	41	45	5
Male	379	331	20	23	5
Female	353	310	21	22	0

Group	UK*	England	Scotland	Wales	Northern Ireland
Other	1	1	0	0	0
ST4-5 single programme - total	1,353	1,093	131	92	37
Male	689	555	66	48	20
Female	664	538	65	44	17
Other	0	0	0	0	0
ST4-5 dual programme - total	166	140	17	7	2
Male	112	97	10	5	0
Female	54	43	7	2	2
Other	0	0	0	0	0
ST6-7+ single programme - total	1,049	848	113	55	33
Male	585	476	57	35	17
Female	464	372	56	20	16
Other	0	0	0	0	0
ST6-7+ dual programme – total	152	126	19	2	5
Male	99	90	7	0	2
Female	53	36	12	2	3
Other	0	0	0	0	0
All other AiTs – total**	140	116	19	2	3
Male	68	54	12	1	1
Female	72	62	7	1	2
Other	0	0	0	0	0
AiTs overall - total	4,923	4,019	485	282	137
Male	2,625	2,149	243	157	76
Female	2,297	1,869	242	125	61
Other	1	1	0	0	0

**Some totals may not add up due to rounding based on estimates*
***Includes LATs, MTI anaesthetic doctors, LAS anaesthetists and those on the Global Fellowship Scheme*

In 2025, 53% of AiTs overall were male and 47% were female. In England, Wales and Northern Ireland there were greater proportions of males than females, however, there was a 50-50 split in Scotland.

Across most types of training post, the gender split is relatively balanced at a UK level, but for the dual programmes there is a slight shift towards a higher proportion of males (67% male St4-5 dual programme and 65% male ST6-7+ dual programme).

There is also variation across nations, with some smaller subgroups showing more uneven distributions (e.g. 100% male in ACCS Anaesthesia in Northern Ireland and 100% female in ST6–7+ dual programme in Wales), though these are based on small numbers.

Figure 10 – Gender split amongst types of AiTs by gender and UK nation

Group	UK	England	Scotland	Wales	Northern Ireland
CT1-3					
Male	52%	52%	49%	57%	60%
Female	48%	48%	51%	43%	40%
Other	-	-	-	-	-
ACCS Anaesthesia					
Male	50%	50%	49%	51%	100%
Female	48%	48%	51%	49%	-
Other	2%	2%	-	-	-
ST4-5 single programme					
Male	51%	51%	50%	52%	54%
Female	49%	49%	50%	48%	46%
Other	-	-	-	-	-
ST4-5 dual programme					
Male	67%	69%	59%	71%	-
Female	33%	31%	41%	29%	100%
Other	-	-	-	-	-
ST6-7+ single programme					
Male	56%	56%	50%	64%	52%
Female	44%	44%	50%	36%	48%
Other	-	-	-	-	-
ST6-7+ dual programme					
Male	65%	71%	37%	-	40%
Female	35%	29%	63%	100%	60%
Other	-	-	-	-	-
All other AiTs					
Male	49%	47%	63%	50%	33%
Female	51%	53%	37%	50%	67%
Other	-	-	-	-	-

Group	UK	England	Scotland	Wales	Northern Ireland
AiTs overall					
Male	53%	53%	50%	56%	55%
Female	47%	47%	50%	44%	45%
Other	0.22%	0.27%	-	-	-

Across England, the number of AiTs varies by region and type, with London commonly having the highest numbers across most training stages.

Other regions with relatively high trainee numbers include the South East, North West and West Midlands, while the North East generally has the smallest numbers across most grades.

ACCS Anaesthesia numbers show a slightly different pattern, with higher numbers in the West Midlands and Yorkshire and the Humber compared with some other regions.

Figure 11 – Numbers of types of AiTs by English region*

Group	East Midlands	East of England	London	North East	North West	South East	South West	West Midlands	Yorkshire and the Humber
CT1-3	95	99	207	51	150	189	109	71	83
ACCS Anaesthesia	20	51	104	54	57	75	72	108	101
ST4-5 single programme	61	89	214	71	128	171	91	150	118
ST4-5 dual programme	7	5	20	16	13	17	23	21	18
ST6-7+ single programme	60	62	212	52	117	99	83	82	81
ST6-7+ dual programme	6	10	19	8	10	13	22	14	24
All other AiTs	10	28	18	6	20	15	1	9	9

**Totals may not add up to previously reported England totals due to rounding based on estimates*

As shown previously, there were 140 other AiTs across the UK that were not on CT1-3, ST4-5 or ACCS Anaesthesia programmes. MTI anaesthetic doctors accounted for the majority of these (113), while there were also 10 on the Global Fellowship scheme, and 17 were Locum Appointments for Training (LAT) anaesthetic doctors.

The Census also found that there were no Locum Appointments for Service (LAS) anaesthetists in the UK.

Figure 12 – Numbers of other AiTs by UK nation and staff group

Group	UK*	England	Scotland	Wales	Northern Ireland
LATs	17	0	17	0	0
MTI anaesthetic doctors	113	106	2	2	3
Global Fellowship Scheme	10	10	0	0	0
LAS anaesthetists	0	0	0	0	0

Group	UK*	England	Scotland	Wales	Northern Ireland
Other AiTs total	140	116	19	2	3

**Some totals may not add up due to rounding based on estimates*

AiT number changes since 2020

Between 2020 and 2025, the total headcount of anaesthetists in training (AiTs) increased across the UK by 444 (10%), rising to 4,923. This growth was driven primarily by increases in the headcount of core trainees (CT1–3 / Stage 1), which rose by 358 (37%), and ACCS Anaesthesia trainees, which increased by 358 (95%). In contrast, the number of higher trainees (ST4–7+ / Stages 2 and 3) increased more modestly by 158 (6%), while other AiTs decreased by 28 (-17%).

Across nations, growth of the headcount of AiTs since 2020 was most pronounced in England (+11%) and Scotland (+16%), while Wales (-5%) and Northern Ireland (-7%) saw small overall decreases. At a more detailed level, most groups saw increases across England and Scotland, while patterns in Wales and Northern Ireland were more mixed.

However, there are two important reasons why the apparent changes in headcounts should be interpreted with caution.

Firstly, there have been changes to the structure of the training curriculum. In 2020, training comprised two years of core training followed by five years of higher training, whereas it now consists of three years of core training (Stage 1) and four years of higher training (Stages 2 and 3). As a result, the underlying increase in higher trainee numbers may be greater than is reflected in these figures.

Secondly, anecdotally, there have been large increases in less than full time working among AiTs and 'slot sharing' of posts. This may mean that headcount increases do not translate to increases in the number of whole time equivalent (WTE) posts.

Figure 13 – Numbers of types of AiTs compared with 2020 by UK nation

Group	UK	England	Scotland	Wales	Northern Ireland
Core (CT1-3 – Stage 1)					
2020	972	737	99	97	39
2025	1,330	1,054	145	79	52
Difference since 2020	+358	+317	+46	-18	+13
% change since 2020	+37%	+43%	+46%	-19%	+33%
Higher (ST4-7+ Stages 2 & 3)					
2020	2,562	2,064	257	144	97
2025	2,720	2,207	280	156	77
Difference since 2020	+158	+143	+23	+12	-20
% change since 2020	+6%	+7%	+9%	+8%	-21%
ACCS Anaesthesia					
2020	375	328	26	18	3
2025	733	642	41	45	5
Difference since 2020	+358	+314	+15	+27	+2
% change since 2020	+95%	+96%	+58%	+150%	+67%

Group	UK	England	Scotland	Wales	Northern Ireland
Other AiTs					
2020	168	139	16	13	0
2025	140	116	19	2	3
Difference since 2020	-28	-23	+3	-11	+3
% change since 2020	-17%	-17%	+19%	-85%	-
Total AiTs					
2020	4,479	3,618	417	297	147
2025	4,923	4,019	485	282	137
Difference since 2020	+444	+401	+68	-15	-10
% change since 2020	+10%	+11%	+16%	-5%	-7%

5 Long term leave

Introduction

Doctors may take extended periods of leave for a range of reasons, including maternity or paternity leave, long term sickness, career breaks or sabbaticals, and other circumstances. The Census sought to quantify the extent of this across the anaesthetic workforce.

Key findings

- At the time of the Census, 384 consultant and SAS anaesthetists were taking some form of long term leave.
- This broke down as 139 on maternity/paternity leave, 141 on long term sickness, 87 on a career break or sabbatical, and 17 for other reasons.
- The percentage of the workforce taking some kind of long term leave has decreased very slightly from 3.4% in 2020 to 3.2% in 2025.

Long term leave by type

According to clinical leaders, there were a total of 384 anaesthetists on long term leave across the UK in 2025, including 332 consultants and 52 SAS doctors.

The most common reasons for long term leave were sickness (141) and maternity/paternity leave (139), followed by sabbaticals or career breaks (87). A smaller number (17) were reported to be on leave for other reasons.

It should be noted that figures for long term leave 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. Again, it should be noted that figures in this chapter only relate to those on permanent or fixed term contracts.

Figure 14 – Numbers of consultants and SAS doctors taking long term leave by type and UK nation

Group	UK	England	Scotland	Wales	Northern Ireland
Maternity/paternity leave - total	139	119	9	8	3
Consultants	120	105	9	3	3
SAS doctors	19	14	0	5	0
Long term sickness - total	141	125	11	1	4
Consultants	118	105	8	1	4
SAS doctors	23	20	3	0	0
Sabbatical/career break - total	87	82	2	1	2
Consultants	82	79	2	1	0
SAS doctors	5	3	0	0	2
Other long term leave - total	17	17	0	0	0
Consultants	12	12	0	0	0
SAS doctors	5	5	0	0	0
Overall long term leave - total	384	343	22	10	9
Consultants	332	301	19	5	7
SAS doctors	52	42	3	5	2

Long term leave changes since 2020

Between 2020 and 2025, the absolute number of consultants and SAS doctors on long term leave increased by 10%, rising from 349 to 384 – however, this has occurred in the context of overall increases in workforce numbers.

Figure 15 – Numbers of consultants and SAS doctors on long term leave compared with 2020

Group	Maternity/ paternity leave	Long term sickness	Sabbatical/ career break	Other long term leave	Total
2020	129	125	82	13	349
2025	139	141	87	17	384
Difference since 2020	+10	+16	+5	+4	+35
% change since 2020	+8%	+13%	+6%	+31%	+10%

Looked at in terms of the percentage of the workforce on long term leave, the figures changed only very slightly – decreasing from 3.4% in 2020 to 3.2% in 2025.

Figure 16 – Proportion of consultants and SAS doctors on long term leave compared with 2020

Group	Maternity/ paternity leave	Long term sickness	Sabbatical/ career break	Other long term leave	Total
2020 long term leave	129	125	82	13	349
2020 overall numbers	10,124	10,124	10,124	10,124	10,124
2020 % of workforce on leave	1.3%	1.2%	0.8%	0.1%	3.4%
2025 long term leave	139	141	87	17	384
2025 overall numbers	12,040	12,040	12,040	12,040	12,040
2025 % of workforce on leave	1.2%	1.2%	0.7%	0.1%	3.2%

6 NHS completed cases

Introduction

Anaesthetic staff provide care across a wide range of hospital settings, including elective surgery, maternity services, urgent and emergency care, intensive care, and pain services. The Census sought to quantify the number of cases they performed in these settings, by asking anaesthetists in the survey of the wider anaesthetic workforce. The results from consultants and SAS doctors are particularly useful for quantifying the opportunity cost of anaesthetic workforce shortfalls.

Key findings

- On average, consultants reported completing 13.6 cases per week, which translates to an estimated 629 per year.
- Autonomous SAS doctors reported completing 17.5 cases per week, which translates to an estimated 817 per year.
- Across both groups, the mean was 14.1 cases per week, which translates to an estimated 651 per year.
- The majority of cases completed by consultants (51.0%) and autonomous SAS doctors (56.9%) were in elective care.
- The next biggest number of cases completed were in ICU, constituting 19.0% of consultant cases and 13.2% of autonomous SAS doctors' cases.

Data collection

In the survey of the wider anaesthetic workforce, respondents were asked about the number of cases they performed across different categories. While all respondents were asked these questions, the response formats differed between autonomous staff (consultants and autonomous SAS doctors) and non-autonomous staff (AiTs, LEDs, qualified PAAs and non-autonomous SAS doctors).

For consultants and autonomous SAS doctors the response format was relatively straightforward, and produced results that were broadly consistent with prior estimates. This data has, therefore, been considered sufficiently reliable to include in the report.

Unfortunately, the response format for non-autonomous staff was more complex, as it attempted to capture activity by both case type and level of supervision. Unfortunately, the results for these groups differed substantially from figures recorded in logbooks. As a result, there was considerable doubt over the reliability of this data, which led to a decision to exclude it from this report. The college intends to revisit this issue in future work with a view to producing more reliable estimates.

Consultant solo cases

On average, consultants reported completing 13.6 solo cases per week, based on the mean. The most common category of case was elective surgery, with 7.0 performed on average. The next most common cases were in Intensive Care Units (ICUs), with an average of 2.6 per week.

Scaling these figures up to yearly figures by taking into account working weeks and time off for leave, suggests that on average consultants complete 629 solo cases per year, of which 51.0% were elective surgery.

Figure 17 – Solo cases completed in last week by consultants by type
Base: 1,258 (consultants who provided numbers of solo cases and annual leave^)

Activity type	No. of cases per week	No. of cases per year	% of cases per year
Elective	7.0	320.8	51.0%
Maternity/labour	0.9	40.5	6.4%
Urgent and emergency	1.8	83.9	13.3%
ICU	2.6	119.5	19.0%
Pain services	1.2	54.4	8.6%
Other	0.2	9.9	1.6%
Total cases*	13.6	629	

*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

**Figure calculated by multiplying the number of weekly cases by the number of weeks worked, taking annual leave into account, and shown as a whole number; this analysis is an estimate only, given it is based on all respondents working full time and this is not always the case

^Weighted base sizes. Respondents who did not provide a response to the question about annual leave taken in the past year have been excluded from the analysis

Autonomous SAS doctors' solo cases

On average, autonomous SAS doctors reported completing slightly more solo cases per week than consultants - 17.5 cases compared with 13.6.

The most common category of case for autonomous SAS doctors was elective surgery, with 10.0 performed on average. The next most common cases were in Intensive Care Units (ICUs), with an average of 2.2 per week.

Scaling these figures up to yearly figures by taking into account working weeks and time off for leave, suggests that on average autonomous SAS doctors complete 817 solo cases per year, 56.9% of which were in elective surgery.

Figure 18 – Solo cases completed in last week by autonomous SAS doctors by type
Base: 165 (autonomous SAS who provided numbers of solo cases and annual leave^)

Activity type	No. of cases per week	No. of cases per year	% of cases per year
Elective surgery	10.0	464.6	56.9%
Maternity/labour	2.1	98.9	12.1%
Urgent and emergency	1.9	89.2	10.9%

Activity type	No. of cases per week	No. of cases per year	% of cases per year
ICU	2.3	107.6	13.2%
Pain services	0.8	34.7	4.2%
Other	0.5	21.7	2.7%
Total cases*	17.5	817	

*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

**Figure calculated by multiplying the number of weekly cases by the number of weeks worked, taking annual leave into account, and shown as a whole number; this analysis is an estimate only, given it is based on all respondents working full time and this is not always the case

^Weighted base sizes. Respondents who did not provide a response to the question about annual leave taken in the past year have been excluded from the analysis

Combined solo cases

Across both consultants and autonomous SAS doctors, an average of 14.1 cases per week were completed, which translates to an estimated 651 cases per year. Elective surgery constitutes just over half of yearly cases (51.9%).

Figure 19 – Solo cases completed in last week by consultants and autonomous SAS doctors by type
Base: 1,423 (consultants and autonomous SAS doctors who provided numbers of solo cases and annual leave^)

Activity type	No. of cases per week	No. of cases per year	% of cases per year
Elective surgery	7.3	337.5	51.9%
Maternity/labour	1.0	47.3	7.3%
Urgent and emergency	1.8	84.5	13.0%
ICU	2.6	118.1	18.1%
Pain services	1.1	52.1	8.0%
Other	0.2	11.2	1.7%
Total cases*	14.1	651	

*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

**Figure calculated by multiplying the number of weekly cases by the number of weeks worked, taking annual leave into account, and shown as a whole number; this analysis is an estimate only, given it is based on all respondents working full time and this is not always the case

^Weighted base sizes. Respondents who did not provide a response to the question about annual leave taken in the past year have been excluded from the analysis

7 NHS workforce shortfalls

Introduction

Anaesthetists play a critical role across a wide range of hospital services, including elective surgery, maternity services, perioperative care, urgent and emergency care, pain services and paediatrics. However, in many cases, workforce numbers are not sufficient to meet current demand. The Census sought to quantify the extent of these workforce shortfalls.

Key findings

- The UK faces a shortage of 2,256 anaesthetist consultants and SAS doctors, 16% below what is needed. This has risen from 1,483 in 2020, a 52% increase.
- The current shortfall breaks down as a funded gap of 908, and an unfunded gap of 1,348.
- The combined (funded + unfunded) gap is 1,881(16% below what is needed) in England, 168 (16%) in Scotland, 138 (18%) in Wales, and 69 (19%) in Northern Ireland.
- According to clinical leaders, the hospital service with the greatest pressure was elective surgery, with 48% rating levels anaesthetic staffing as poor and 11% as very poor (59% combined).
- Including all grades of anaesthetist, 797 extra staff were needed to meet demand for elective surgery alone.

Shortfall levels

In the Census, clinical leaders were asked to quantify the additional numbers of consultants and SAS doctors that their hospitals needed to meet current demands. This was broken down into a 'funded' shortfall, where the hospitals had the money for a post but had not been able to fill it, and an 'unfunded' shortfall, where hospital lacked the money for the post.

Across the UK, in 2025 the total shortfall was 2,256, of which 908 (40%) was funded and 1,348 (60%) was unfunded. The total shortfall breaks down as 1,881 in England, 168 in Scotland, 138 in Wales, and 69 in Northern Ireland.

Figure 20 – Funded, unfunded, and total shortfall by UK nation and staff group

Group	UK*	England	Scotland	Wales	Northern Ireland
Consultants					
Funded shortfall	687	583	53	37	14
Unfunded shortfall	954	815	61	48	30
Total shortfall	1,641	1,398	114	85	44
SAS doctors					
Funded shortfall	221	175	18	20	8
Unfunded shortfall	394	308	36	33	17
Total shortfall	615	483	54	53	25
Combined consultants and SAS doctors					
Funded shortfall	908	758	71	57	22
Unfunded shortfall	1,348	1,123	97	81	47
Total shortfall	2,256	1,881	168	138	69

**Some totals may not add up due to rounding based on estimates*

The shortfall can also be expressed in terms of how far (in percentage terms) current numbers are below what is needed. Across the UK, numbers are 16% below what is needed. Broken down by UK nation, the figures are 16% for England, 16% for Scotland, 18% for Wales, and 19% for Northern Ireland.

Figure 21 – How far current numbers are below what is needed by UK nation and staff group

Group	UK*	England	Scotland	Wales	Northern Ireland
Consultants	14%	14%	12%	15%	15%
SAS doctors	22%	20%	37%	26%	36%
Combined total	16%	16%	16%	18%	19%

As shown previously, shortfalls vary by nation. They also vary by English region. The area with the biggest shortfall in absolutely numbers is London, with a gap of 255 consultants and 62 SAS doctors.

Figure 22 – Funded, unfunded, and total shortfall by English region* and staff group

Group	East Midlands	East of England	London	North East	North West	South East	South West	West Midlands	Yorkshire and the Humber
Consultants									
Funded shortfall	41	72	105	14	80	60	68	76	69
Unfunded shortfall	55	133	150	23	103	98	73	75	104
Total shortfall	96	205	255	37	183	158	141	151	173
SAS doctors									
Funded shortfall	15	16	16	2	36	26	20	23	24
Unfunded shortfall	17	44	46	13	46	41	27	33	40
Total shortfall	32	60	62	15	82	67	46	56	64
Combined consultants and SAS doctors									
Funded shortfall	56	88	121	16	116	86	88	99	93
Unfunded shortfall	72	177	196	36	149	139	100	108	144
Total shortfall	128	265	317	52	265	225	187	207	237

**Totals may not add up to previously reported England totals due to rounding based on estimates*

Looking at the percentage shortfalls by English region, the greatest shortfalls were in the East of England (21% below what is needed) and in Yorkshire and the Humber (19% below what is needed).

Figure 23 – How far current numbers are below what is needed by English region* and staff group

Group	East Midlands	East of England	London	North East	North West	South East	South West	West Midlands	Yorkshire and the Humber
Consultants	13%	22%	14%	7%	13%	14%	11%	15%	18%
SAS doctors	13%	20%	20%	17%	24%	20%	15%	26%	25%
Combined total	13%	21%	15%	8%	15%	15%	12%	17%	19%

Changes in shortfall numbers since 2020

Across the UK the shortfall has risen from 1,483 in 2020 to 2,256 in 2025. This is an increase of 52%.

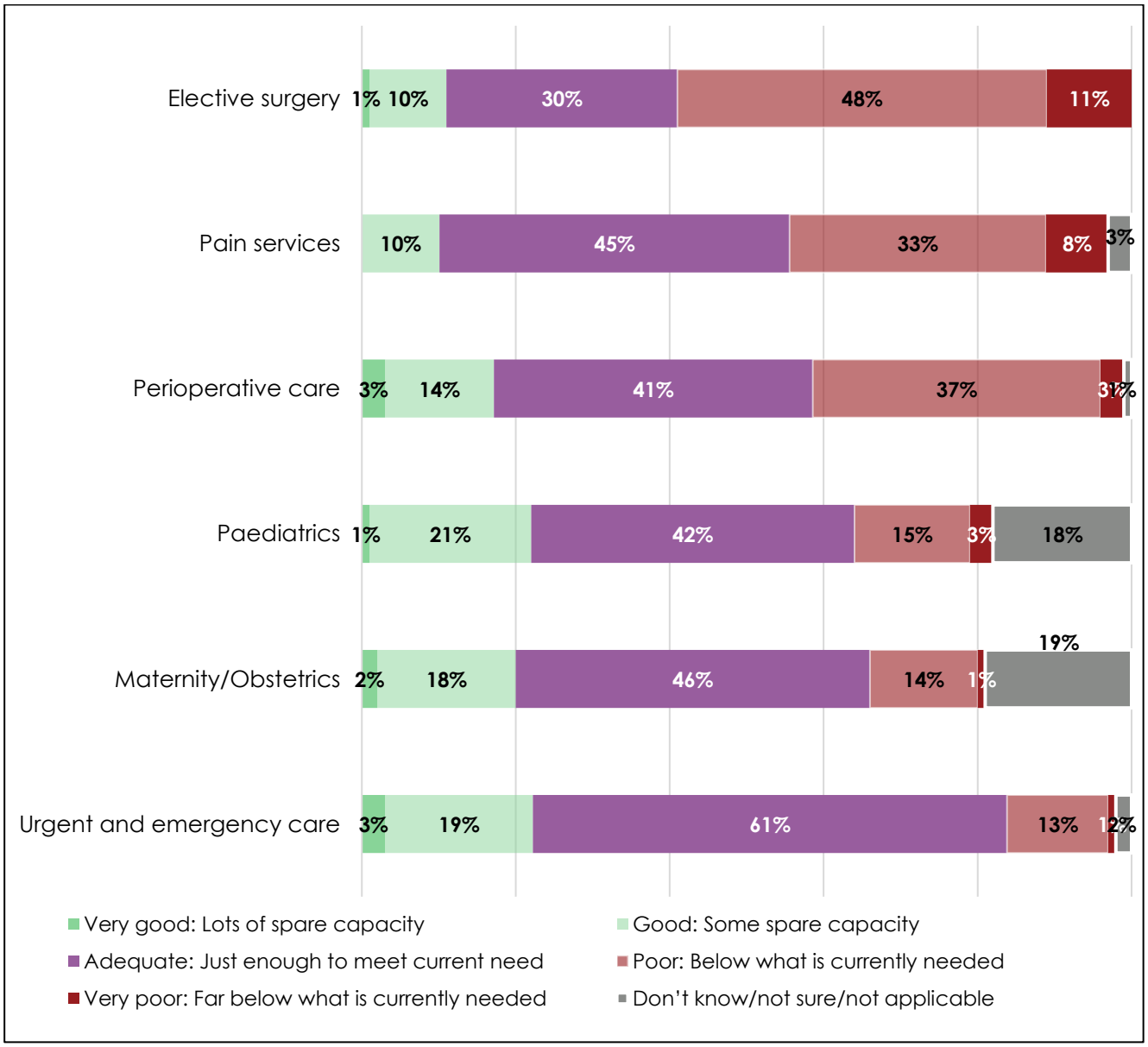
Figure 24 – Shortfall changes since 2020 by UK nation and staff group

Group	UK	England	Scotland	Wales	Northern Ireland
Consultants					
2020	1,121	901	94	97	29
2025	1,641	1,398	114	85	44
Difference since 2020	520	497	20	-12	15
% change since 2020	46%	55%	21%	-12%	52%
SAS doctors					
2020	362	264	48	19	31
2025	615	483	54	53	25
Difference since 2020	253	219	6	34	-6
% change since 2020	70%	83%	13%	179%	-19%
Combined consultants and SAS doctors					
2020	1,483	1,165	142	116	60
2025	2,256	1,881	168	138	69
Difference since 2020	773	716	26	22	9
% change since 2020	52%	61%	18%	19%	15%

Adequacy of anaesthetic staffing by hospital area

Clinical leaders were asked about the adequacy of their staffing in different hospital services where anaesthetic staff work. The area with the most challenges was elective surgery, with 59% rating anaesthetic staffing levels as poor (48%) or very poor (11%).

Figure 25 – In the hospital(s) you are responding on behalf of, how would you judge the adequacy of current anaesthetic staffing in each of the following areas?
Base: 145 (Clinical leaders in the full survey)



By UK nation, clinical leaders in England gave the worst ratings for anaesthetic staffing levels in elective surgery (63% giving poor/very poor ratings), compared to 39% in Scotland, 50% in Wales, and 50% in Northern Ireland. However, the results varied across other areas of hospital function. Regarding maternity and obstetrics, clinical leaders in Wales gave the worst ratings for anaesthetic staffing levels (33% poor/very poor), compared to 14% in England, 17% in Scotland, and 17% in Northern Ireland.

Figure 26 – Adequacy of current anaesthetic staffing in each hospital area by UK nation*
Base: Shown in chart (Clinical leaders in the full survey)

Area	UK (n=145)	England (n=115)	Scotland (n=18)	Wales (n=6)	Northern Ireland (n=6)
Elective surgery					
Very good	1%	-	6%	-	17%
Good	10%	7%	22%	17%	17%
Adequate	30%	30%	33%	33%	17%
Poor	48%	51%	28%	50%	33%
Very poor	11%	11%	11%	-	17%
Total poor	59%	63%	39%	50%	50%
Don't know/not sure/not applicable	-	-	-	-	-
Pain services					
Very good	-	-	-	-	-
Good	10%	12%	6%	-	-
Adequate	45%	42%	72%	17%	50%
Poor	33%	37%	6%	50%	33%
Very poor	8%	6%	17%	17%	17%
Total poor	41%	43%	22%	67%	50%
Don't know/not sure/not applicable	3%	3%	-	17%	-
Perioperative care					
Very good	3%	3%	6%	17%	-
Good	14%	13%	22%	17%	17%
Adequate	41%	44%	28%	-	50%
Poor	37%	34%	44%	67%	33%
Very poor	3%	4%	-	-	-
Total poor	40%	38%	44%	67%	33%
Don't know/not sure/not applicable	1%	2%	-	-	-
Paediatrics					
Very good	1%	-	6%	-	-
Good	21%	22%	11%	33%	33%
Adequate	42%	43%	44%	33%	33%

Area	UK (n=145)	England (n=115)	Scotland (n=18)	Wales (n=6)	Northern Ireland (n=6)
Poor	15%	16%	6%	33%	17%
Very poor	3%	3%	6%	-	-
Total poor	18%	18%	11%	33%	17%
Don't know/not sure/not applicable	18%	17%	28%	-	17%
Maternity/Obstetrics					
Very good	2%	1%	6%	17%	-
Good	18%	20%	6%	17%	17%
Adequate	46%	48%	39%	33%	33%
Poor	14%	13%	11%	33%	17%
Very poor	1%	1%	6%	-	-
Total poor	15%	14%	17%	33%	17%
Don't know/not sure/not applicable	19%	17%	33%	-	33%
Urgent and emergency care					
Very good	3%	3%	6%	17%	-
Good	19%	18%	22%	33%	17%
Adequate	61%	62%	61%	50%	50%
Poor	13%	14%	11%	-	17%
Very poor	1%	1%	-	-	17%
Total poor	14%	15%	11%	-	33%
Don't know/not sure/not applicable	2%	3%	-	-	-

**Findings for Wales and Northern Ireland should be interpreted with caution due to the small number of responses*

Need for extra staffing by service

Clinical leaders were asked how many extra staff were needed in key selected hospital services across all grades of anaesthetists, including consultants, SAS doctors, AiTs and LEDs.

Totalling across these selected areas, 2,156 additional staff were required to meet demand. This figure is very slightly below the overall shortfall figure highlighted earlier in this chapter. However, it must be noted that the list of services here is non-exhaustive. Anaesthetists do substantial work beyond these areas of direct clinical care, such as via the provision of training, educational supervision, research, and governance.

Nevertheless, these figures serve to provide an extra insight into the scale of shortages within key selected services. Of these, the greatest absolute shortages was in elective surgery, which was short of 797 anaesthetists. Elective surgery also had the greatest need in each devolved nation.

It should be noted that figures for extra staffing are estimated as the shorter version of the clinical leaders' survey did not capture these numbers and not all clinical leaders provided completed figures in the full survey. 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 27 – Need for extra staff by hospital area and UK nation*

Area	UK	England	Scotland	Wales	Northern Ireland
Paediatrics	176	141	16	10	8
Elective surgery	797	656	83	34	24
Urgent and Emergency Care	343	278	39	18	8
Maternity/Obstetrics	302	243	34	15	9
Perioperative care services	321	270	28	16	7
Pain services	217	180	22	12	4
Overall	2,156	1,768	222	105	61

**Some totals may not add up due to rounding based on estimates*

8 Impact of shortages on services

Introduction

The anaesthetic staffing shortfalls identified in the last chapter have serious consequences for the NHS and the patients it serves. The Census sought to quantify this.

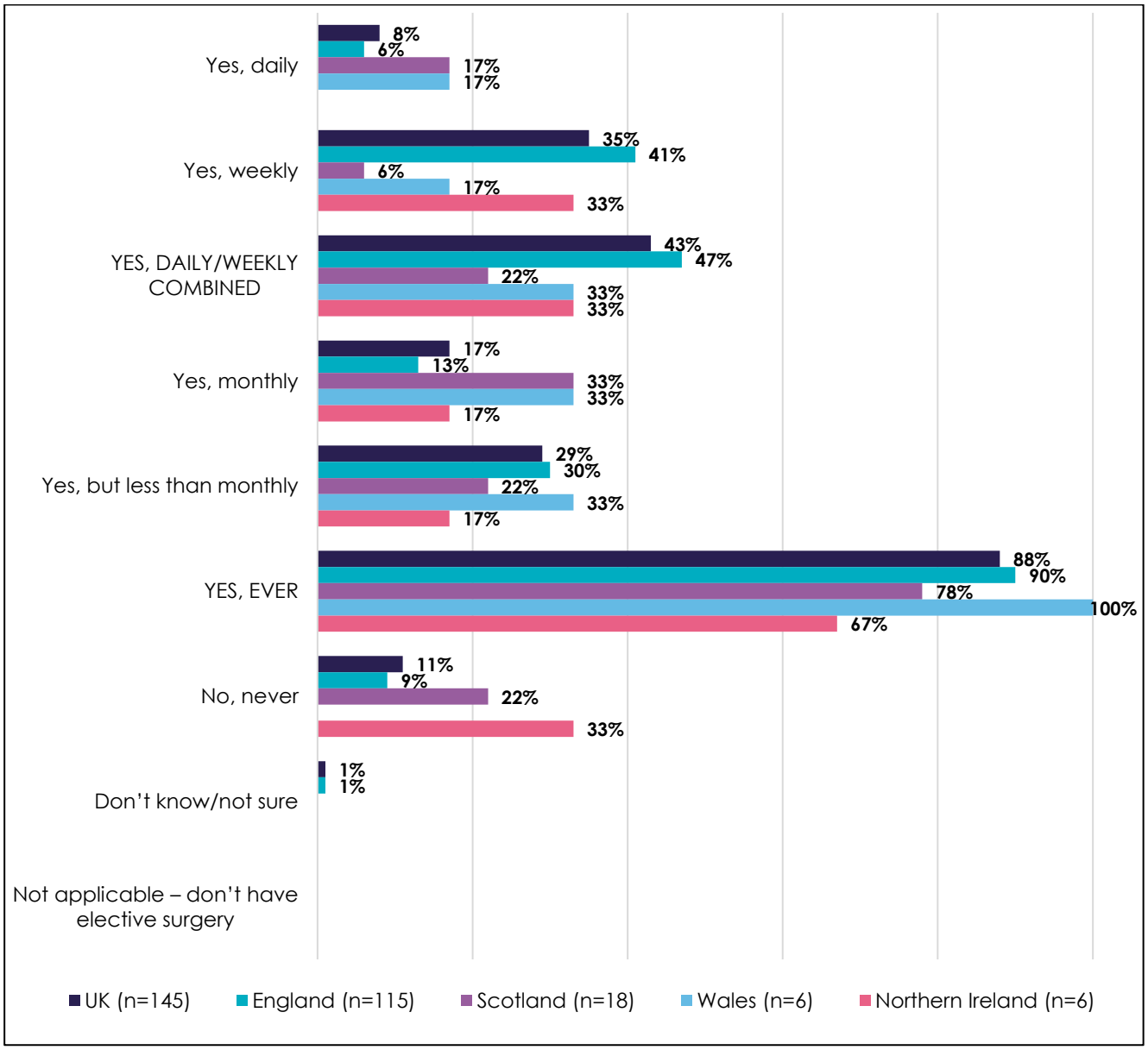
Key findings

- 88% of clinical leaders reported surgery being postponed due to lack of anaesthetic staff at least sometimes and 43% reported this occurring on a daily or weekly basis.
- In maternity care, 53% reported that women were sometimes **delayed** from getting pain relief due to lack of anaesthetists, with 11% reporting this happening on a daily or weekly basis.
- 19% reported that women in maternity care were sometimes **unable** to receive pain relief due to lack of anaesthetists, with 3% reporting this happening on a daily or weekly basis.
- In urgent and emergency care, 30% reported that surgery was sometimes **delayed** due to lack of anaesthetists. This included 6% who reported this happening on a daily or weekly basis.
- 39% reported that urgent and emergency patients were sometimes **delayed** from getting pain relief due to lack of anaesthetists, with 8% reporting this happening on a daily or weekly basis.
- Staffing shortages can increase the need for expensive external/agency locum staff. Clinical leaders reported 197 external/agency locum consultants and SAS doctors in anaesthesia across the UK.
- The average daily pay rate for external/agency locum staff was £857 for consultants, £532 for specialist doctors and £723 for specialty doctors, suggesting an estimated annual cost to the UK health services of around £57m.

Elective surgery

Clinical leaders were asked in the full survey how often elective (planned) surgery had to be delayed due to lack of anaesthetists. 88% of clinical leaders reported this happening at least sometimes and 43% reported this occurring on a daily or weekly basis.

Figure 28 – In the hospital(s) you are responding on behalf of, is elective surgery ever delayed or postponed due to a lack of anaesthetic staff? By UK nation*
Base: Shown in chart (Clinical leaders in the full survey)



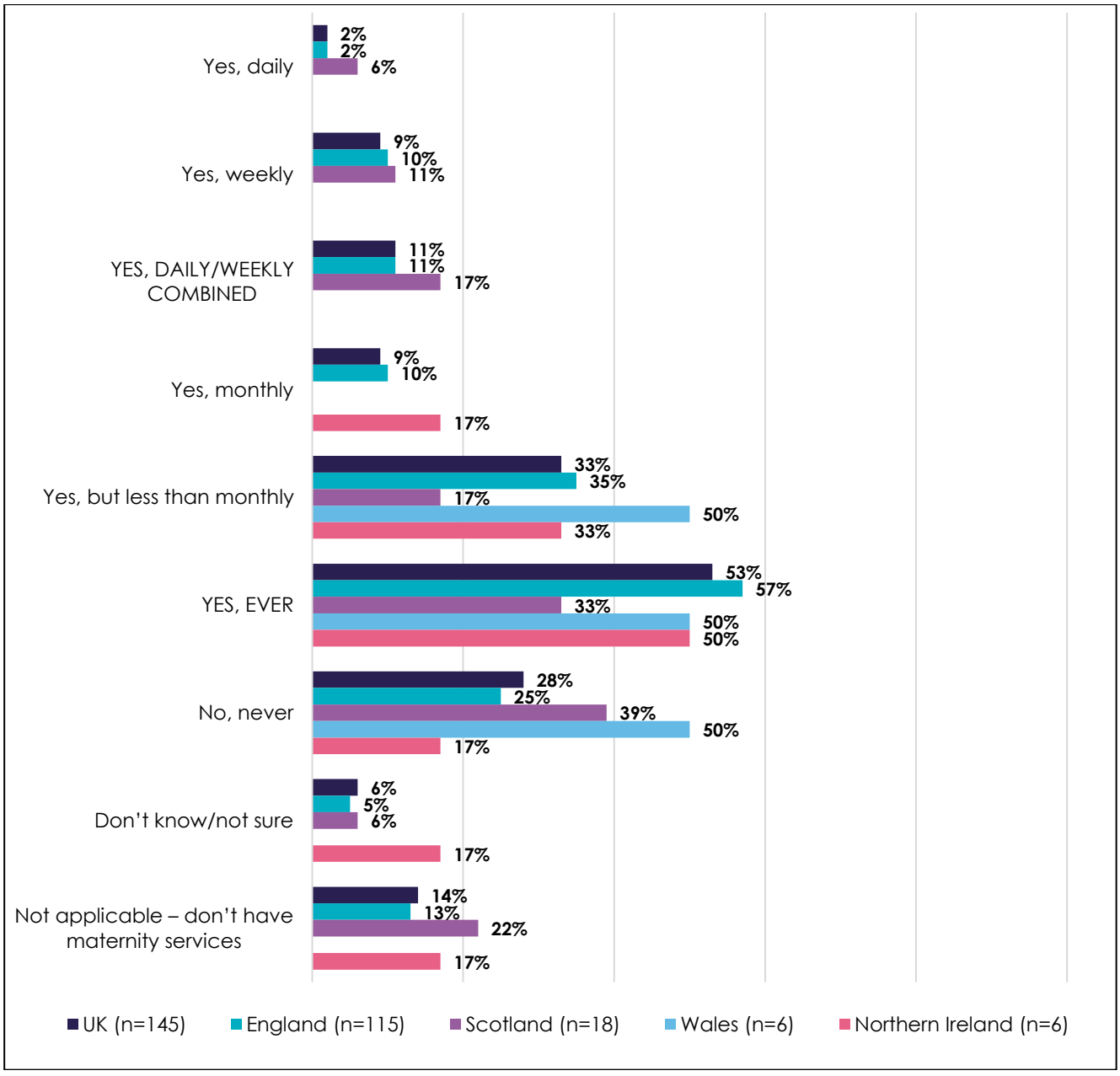
*Findings for Wales and Northern Ireland should be interpreted with caution due to the small number of responses

Maternity services

Over half (53%) of clinical leaders reported women in maternity services experiencing **delays** to receiving pain relief due to a lack of anaesthetists at least some of the time and 11% reported this occurring on a daily or weekly basis.

Figure 29 – In the hospital(s) you are responding on behalf of, are women undergoing childbirth ever delayed from getting appropriate pain relief (e.g. epidurals) due to a lack of anaesthetists? By UK nation*

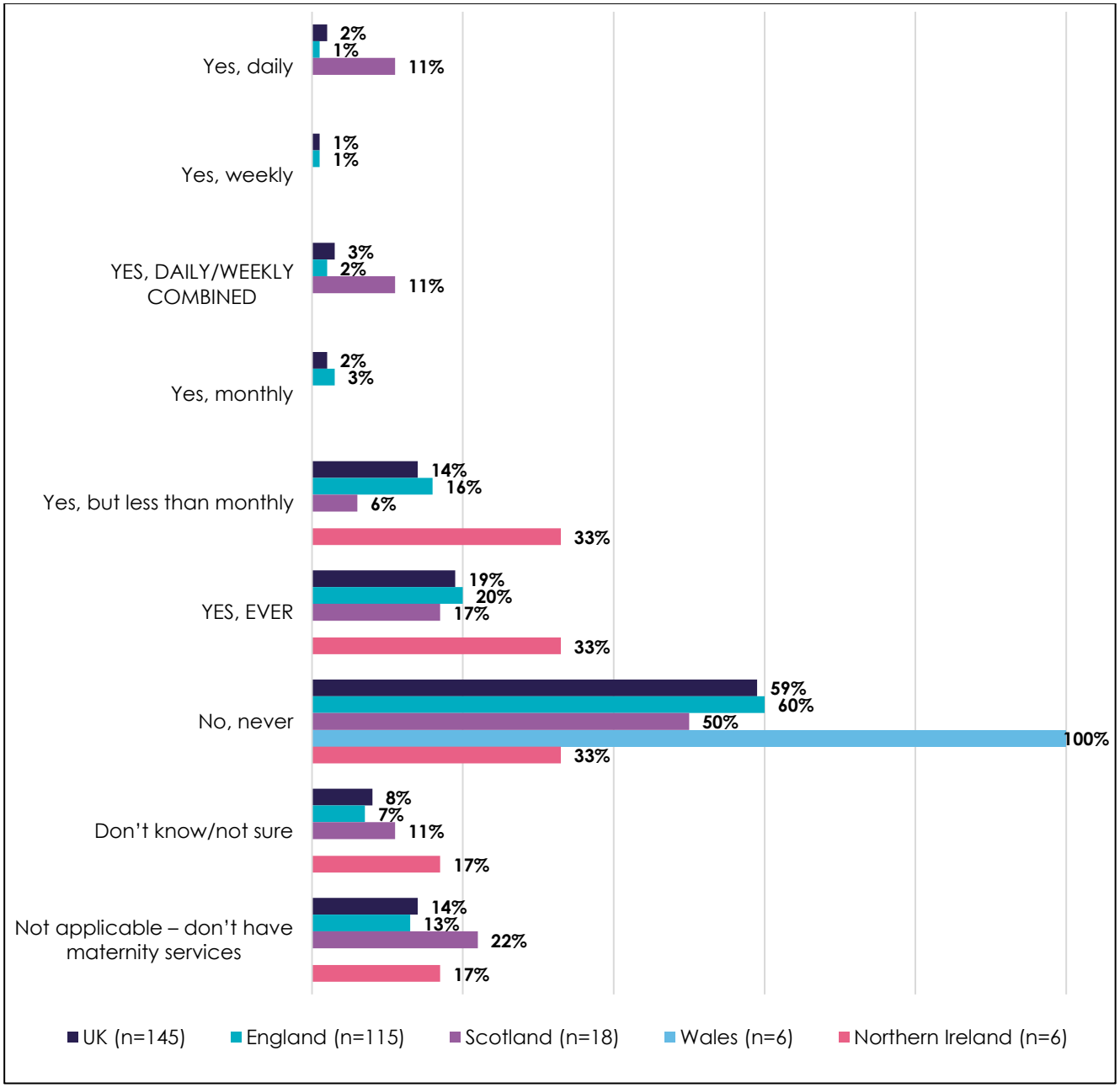
Base: Shown in chart (Clinical leaders in the full survey)



**Findings for Wales and Northern Ireland should be interpreted with caution due to the small number of responses*

Clinical leaders were asked how often women in maternity services were **unable** to get pain relief due to a lack of anaesthetists. A fifth (19%) of clinical leaders reported this happening at least sometimes and 3% reported this occurring on a daily or weekly basis.

Figure 30 – In the hospital(s) you are responding on behalf of, are women undergoing childbirth ever unable to receive appropriate pain relief (e.g. epidurals) due to a lack of anaesthetists? By UK nation*
Base: Shown in chart (Clinical leaders in the full survey)

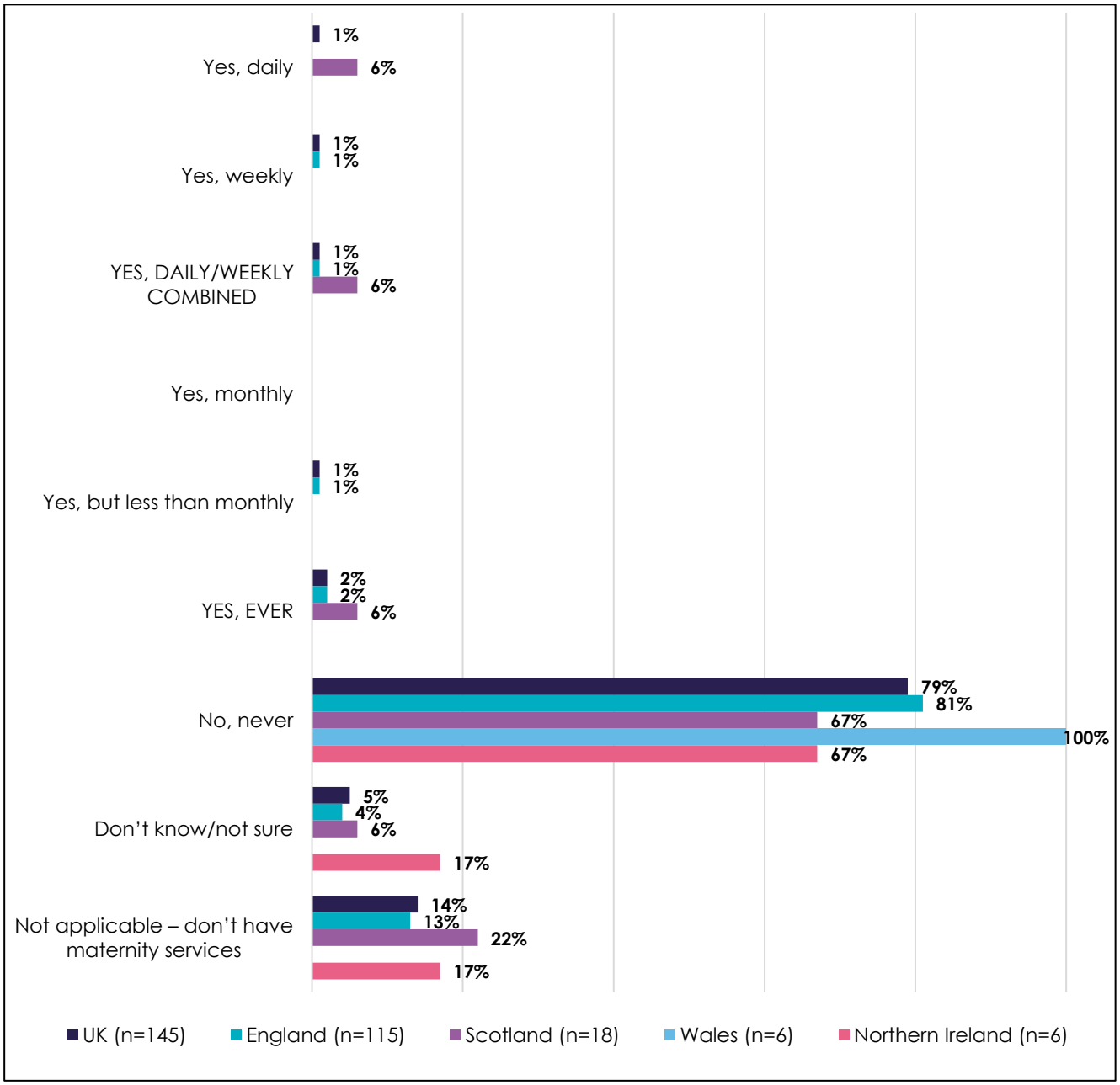


**Findings for Wales and Northern Ireland should be interpreted with caution due to the small number of responses*

Clinical leaders were also asked how often women in maternity services had to be **transferred** to another hospital due to a lack of anaesthetists.

This question was not applicable to some sites and, across the UK, 79% said it never happened. Only 2% of clinical leaders reported this happening at least sometimes.

Figure 31 – In the hospital(s) you are responding on behalf of, do women undergoing childbirth ever have to be transferred to another hospital due to a lack of anaesthetists in your hospital? By UK nation*
Base: Shown in chart (Clinical leaders in the full survey)

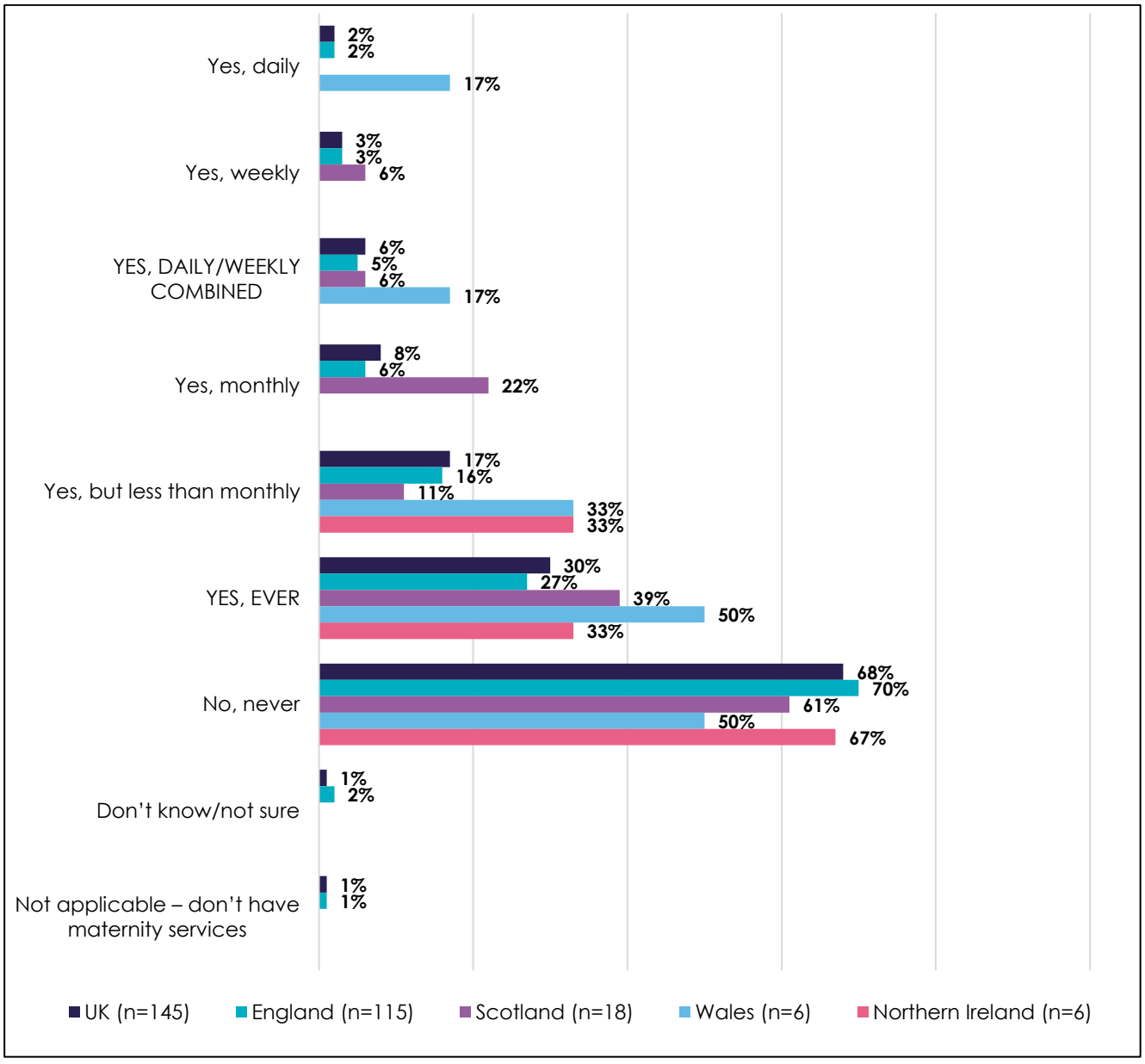


**Findings for Wales and Northern Ireland should be interpreted with caution due to the small number of responses*

Urgent and emergency care

Not all operations are planned in advance; some are required at short notice following incidents such as accidents, strokes or heart attacks. Just like elective surgery, urgent and emergency care also relies on anaesthetists. Clinical leaders were therefore asked how often urgent and emergency surgery had to be delayed due to a lack of anaesthetists. Overall, 30% reported this happening at least sometimes, and 6% reported this occurring on a daily or weekly basis.

Figure 32 – In the hospital(s) you are responding on behalf of, are urgent or emergency operations ever delayed due to a lack of anaesthetists? By UK nation*
Base: Shown in chart (Clinical leaders in the full survey)

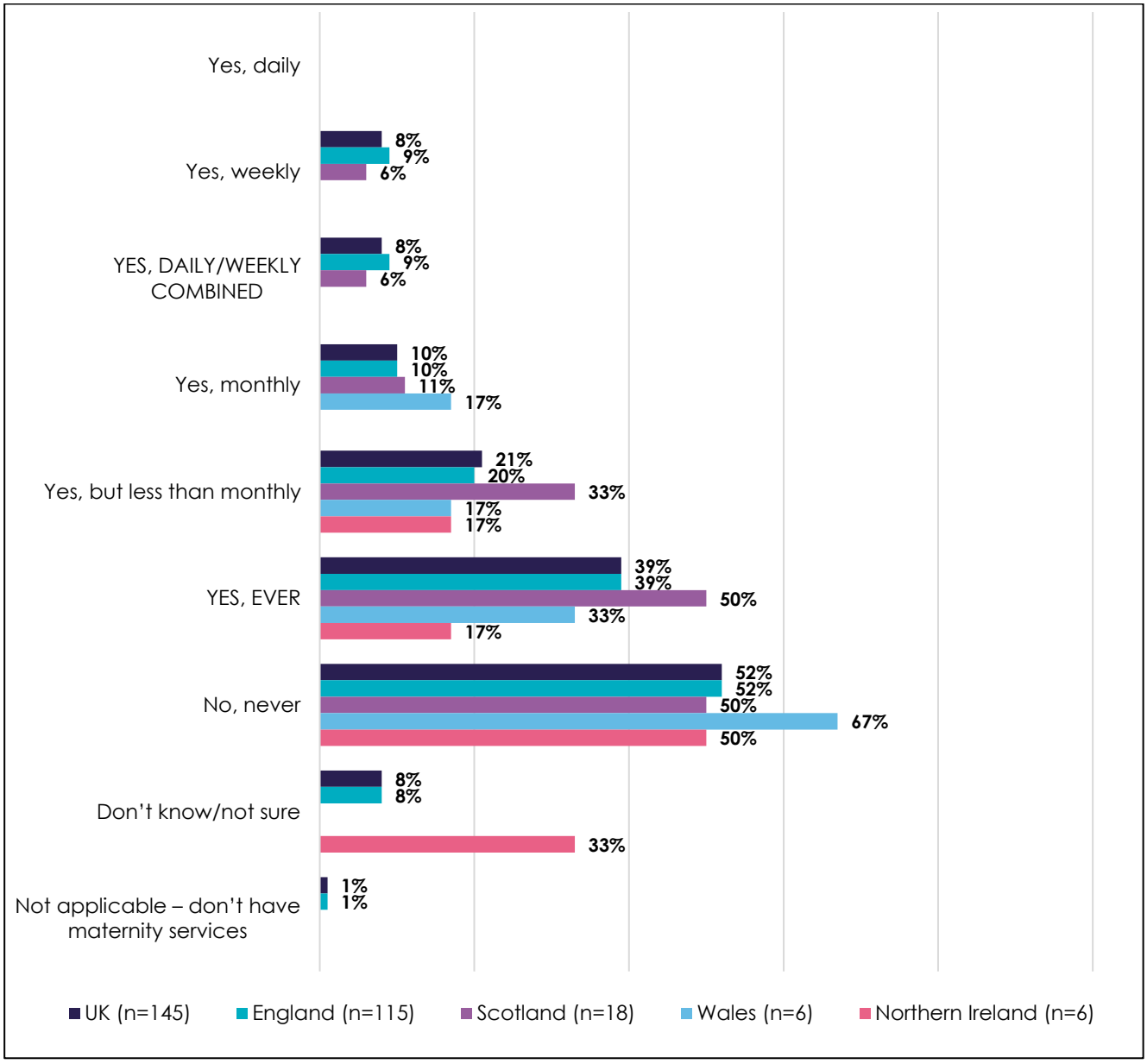


*Findings for Wales and Northern Ireland should be interpreted with caution due to the small number of responses

Not all patients requiring urgent and emergency care require surgery, but they may still require some kind of pain relief. Clinical leaders were asked how often urgent and emergency patients were delayed from receiving pain relief due to lack of anaesthetists. 39% reported this occurring at least sometimes, and 8% reported this happening on a daily or weekly basis.

By nation, 39% of clinical leaders in England reported delays at least sometimes and 9% daily/weekly, while 52% reported that delays never occur.

Figure 33 – Excluding operations and the immediate post-operative period, in the hospital(s) you are responding on behalf of, are patients presenting for urgent or emergency care ever delayed in receiving appropriate pain relief due to a lack of anaesthetists? By UK nation*
Base: Shown in chart (Clinical leaders in the full survey)



**Findings for Wales and Northern Ireland should be interpreted with caution due to the small number of responses*

External/agency locum use

Due to shortages of contracted, salaried anaesthetic staff, hospitals may have to draw on locums paid a daily or sessional rate. Sometimes these are obtained via an agency although others work independently. While there is a need for such locums in some cases, they can be an expensive option.

At the time of the Census, clinical leaders reported 197 external/agency consultant and SAS doctor locums across the UK. This included 156 consultants and 41 SAS doctors, which equates to 2% of the consultant and SAS doctor anaesthesia workforce.

It should be noted that these figures are estimated as the shorter version of the clinical leaders' survey did not capture external/agency locum numbers. The figures presented here are extrapolated from sites that completed the full version of the survey and should be interpreted with this in mind.

Figure 34 – Number of external/agency locums by UK nation

Group	UK	England	Scotland	Wales	Northern Ireland
Consultants					
No. of external/agency locums	156	117	31	1	7
% of workforce	2%	1%	4%	0%	3%
Specialty doctors					
No. of external/agency locums	38	27	3	2	6
% of workforce	2%	2%	4%	2%	13%
Specialist doctors					
No. of external/agency locums	3	3	0	0	0
% of workforce	1%	1%	-	-	-
Associate specialist doctors					
No. of external/agency locums	0	0	0	0	0
% of workforce	-	-	-	-	-
SAS doctors overall					
No. of external/agency locums	41	30	3	2	6
% of workforce	2%	2%	3%	1%	12%
Combined consultants and SAS doctors					
No. of external/agency locums	197	147	34	3	13
% of workforce	2%	1%	4%	0%	4%

External/agency locum rates of pay

As previously mentioned, external/agency locums are paid a daily or sessional rate. Clinical leaders were asked to specify these daily or sessional rates. There are usually two 'sessions' in an NHS working day, which means the figures can be equivalised.

The equivalised mean daily rate of pay for an external/agency locum consultant was £857, £532 for a specialty doctor and £723 for a specialist doctor.

It should be noted that these figures were provided only by a small number of clinical leaders in the full survey and should be interpreted with this in mind. Furthermore, due to small numbers at a devolved nation level, these figures are presented on a UK-wide basis only.

Associate specialist doctors have not been included below as there was no evidence of any use of external/agency locums in this category.

Figure 35 – Mean rates of pay for external/agency locums by staff group

Group	Mean daily rate
Consultants	£857
Specialty doctors	£532
Specialist doctors	£723

Cost of external/agency locums to UK health services

Based on the estimated numbers of external/agency consultant and SAS doctor locums and the UK average daily pay rates, the cost of these to health services can be calculated – which amounts to around £57m per year across the UK.

Figure 36 – Estimated costs of external/agency locum use to health services by UK nation

Group	UK	England	Scotland	Wales	Northern Ireland
Overall cost per day	£156,077	£116,802	£28,163	£1,921	£9,191
Overall cost per year	£56,968,105	£42,632,730	£10,279,495	£701,165	£3,354,715

Taking salary data and making reasonable assumptions of on-costs, such as pensions and national insurance, we estimate that employing one permanent consultant anaesthetist costs the health service around £180,000 per year. This means that if current expenditure on external/agency locum anaesthetists was able to be redirected – an extra 315 permanent/fixed term consultant anaesthetists could be employed across the UK.

Figure 37 – Estimated number of permanent/fixed term consultant anaesthetists that could be employed by UK nation

	UK*	England	Scotland	Wales	Northern Ireland
Potential extra permanent/fixed term consultant anaesthetists	315	237	57	4	19

**Totals do not add up due to rounding*

9 Meeting demand in elective surgery

Introduction

A number of factors can influence the rate of elective surgery. These include the availability of staff such as anaesthetists, and physical factors, such as the number of operating theatres.

Key findings

- Boosting the number of anaesthetists is the single most common factor identified by clinical leaders that could increase the rate of elective surgery, cited by 68% of respondents.
- This is above physical factors such as ward space (50%) and number of operating theatres (42%), and other staffing groups such as Operating Department Practitioners (56%), scrub staff (32%) and surgeons (9%).
- In terms of rating the adequacy of current factors - 75% of clinical leaders rated ward bed capacity as poor or very poor, 59% gave such ratings for anaesthetists, and 58% for Operating Department Practitioners (ODPs).

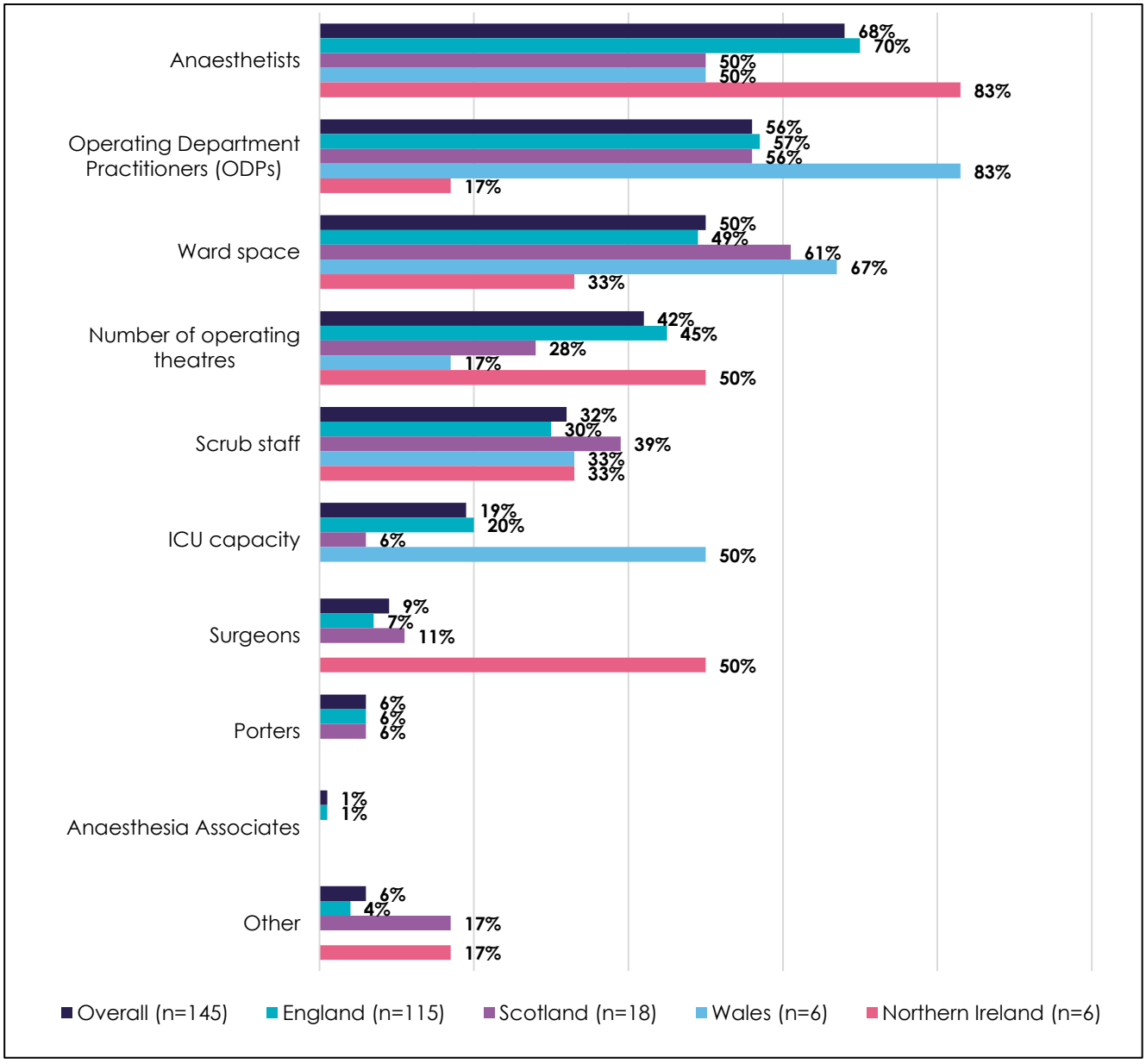
Boosting rates of elective surgery

Clinical leaders were asked about the top three factors that are most important to increase in order to boost the rate of elective activity.

Across the UK, 'Anaesthetists' was the most common response, selected by almost seven in ten (68%). This was above physical factors such as ward space (50%) and the number of operating theatres (42%), and other staffing groups such as Operating Department Practitioners (56%), scrub staff (32%), and surgeons (9%).

Figure 38 – In the hospital(s) you are responding on behalf of, which three of the following factors would you say are the most important to increase in order to boost the rate of elective activity? By UK nation*

Base: Shown in chart (Clinical leaders in the full survey)



**Findings for Wales and Northern Ireland should be interpreted with caution due to the small number of responses*

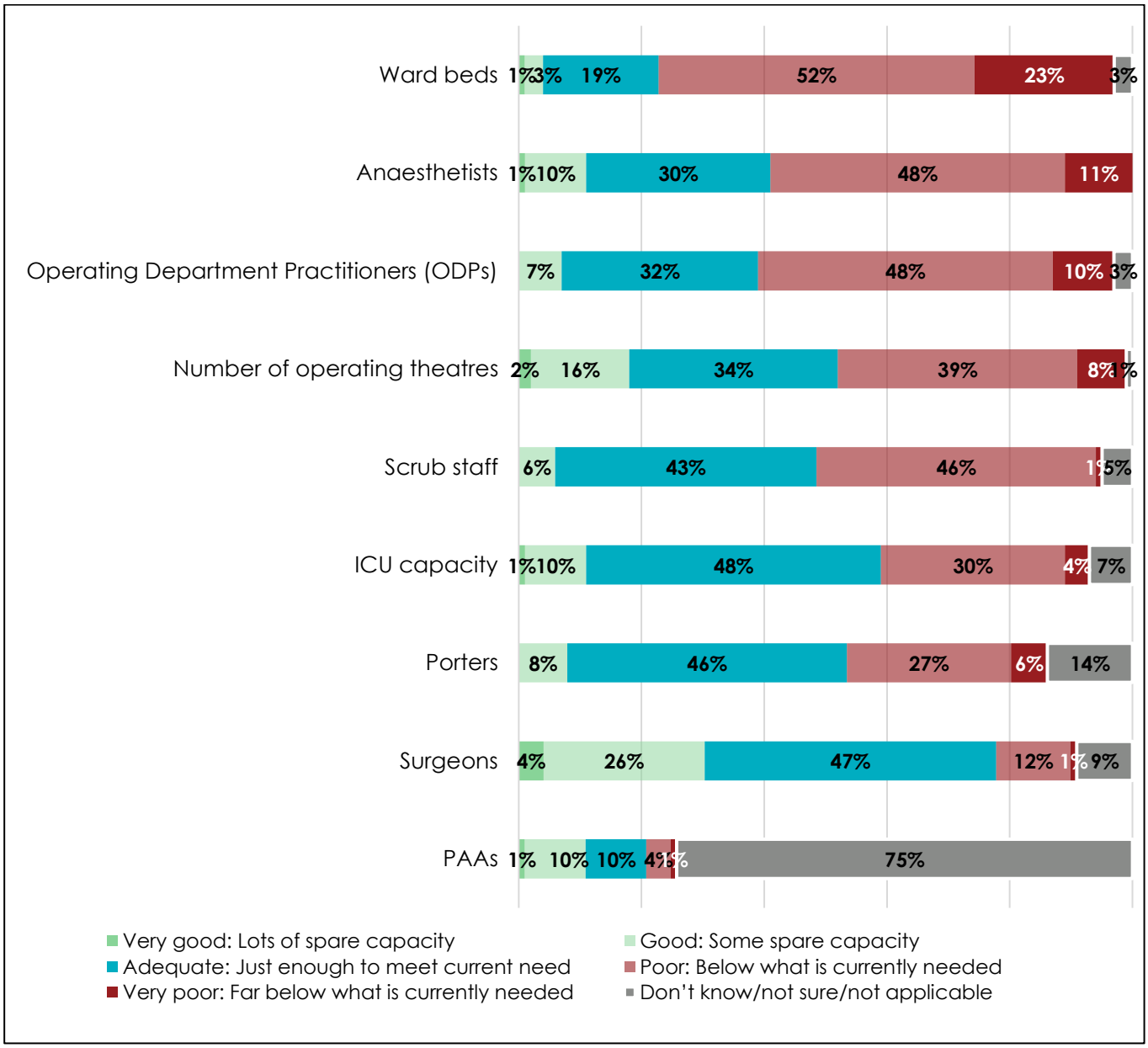
Adequacy of hospital factors

Clinical leaders were asked to rate the adequacy of a number of factors in regard to their hospitals' ability to meet elective demand. The findings show that ward bed capacity receives the most negative ratings across the UK, with 75% rating it as poor (52%) or very poor (23%).

Clinical leaders also gave inadequate ratings to the numbers of certain key staff. 59% of clinical leaders rated anaesthetist numbers as poor/very poor, and 58% gave such ratings for ODPs.

In contrast, surgeons are more often rated as adequate or better (77%), suggesting comparatively fewer perceived shortages in this group. For PAAs, 75% gave don't know/not applicable answers.

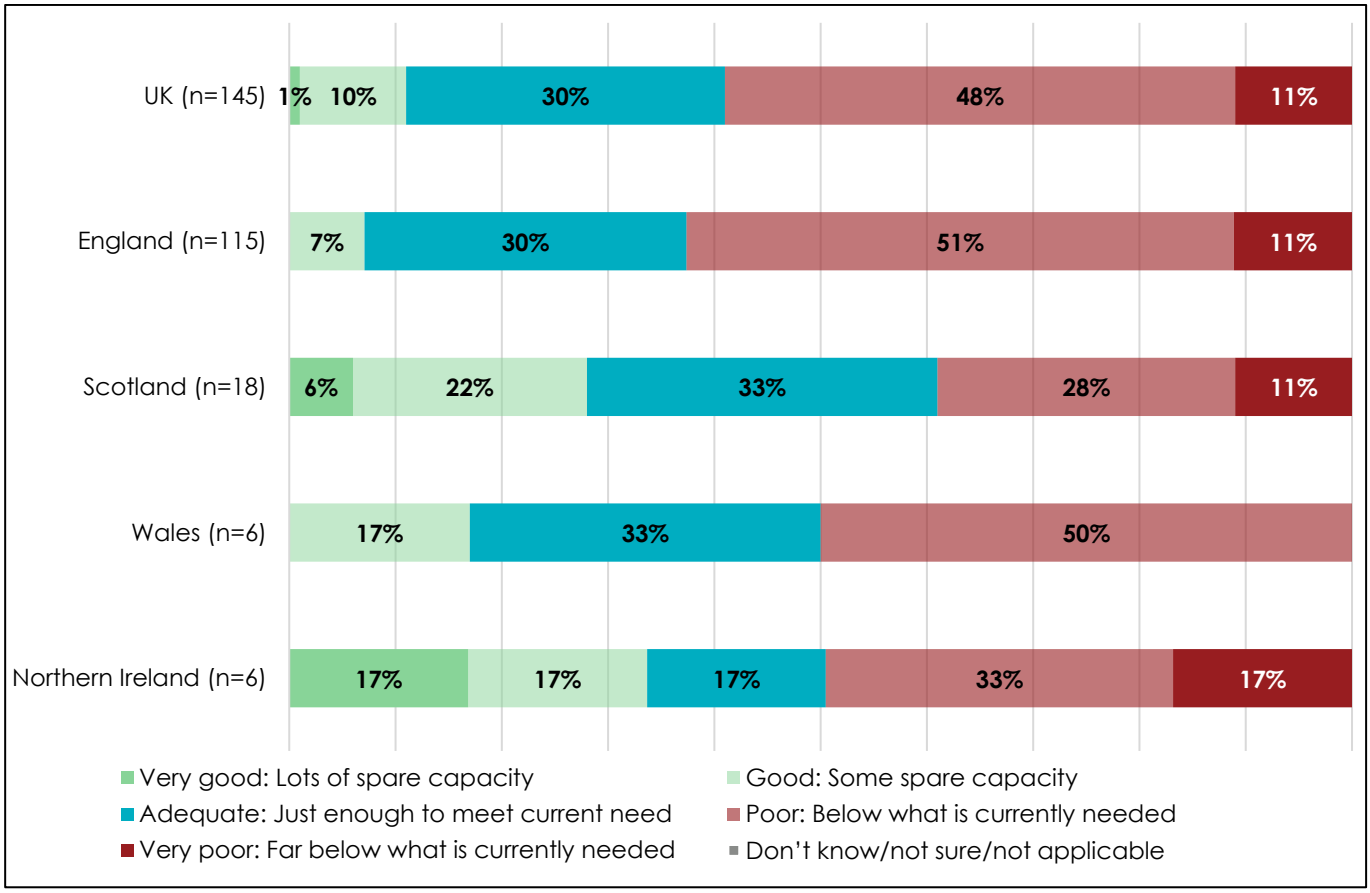
Figure 39 – In the hospital(s) you are responding on behalf of, what is your assessment of the current adequacy of the following factors in regard to your ability to meet elective demand?
Base: 145 (Clinical leaders in the full survey)



Anaesthetists

At a UK level, 59% of clinical leaders rated anaesthetic staffing as poor or very poor. In England this figure is 62%, in Scotland 39%, in Wales 50%, and in Northern Ireland 50%.

Figure 40 – Adequacy of anaesthetists to meet elective demand by UK nation*
Shown in chart (Clinical leaders in the full survey)

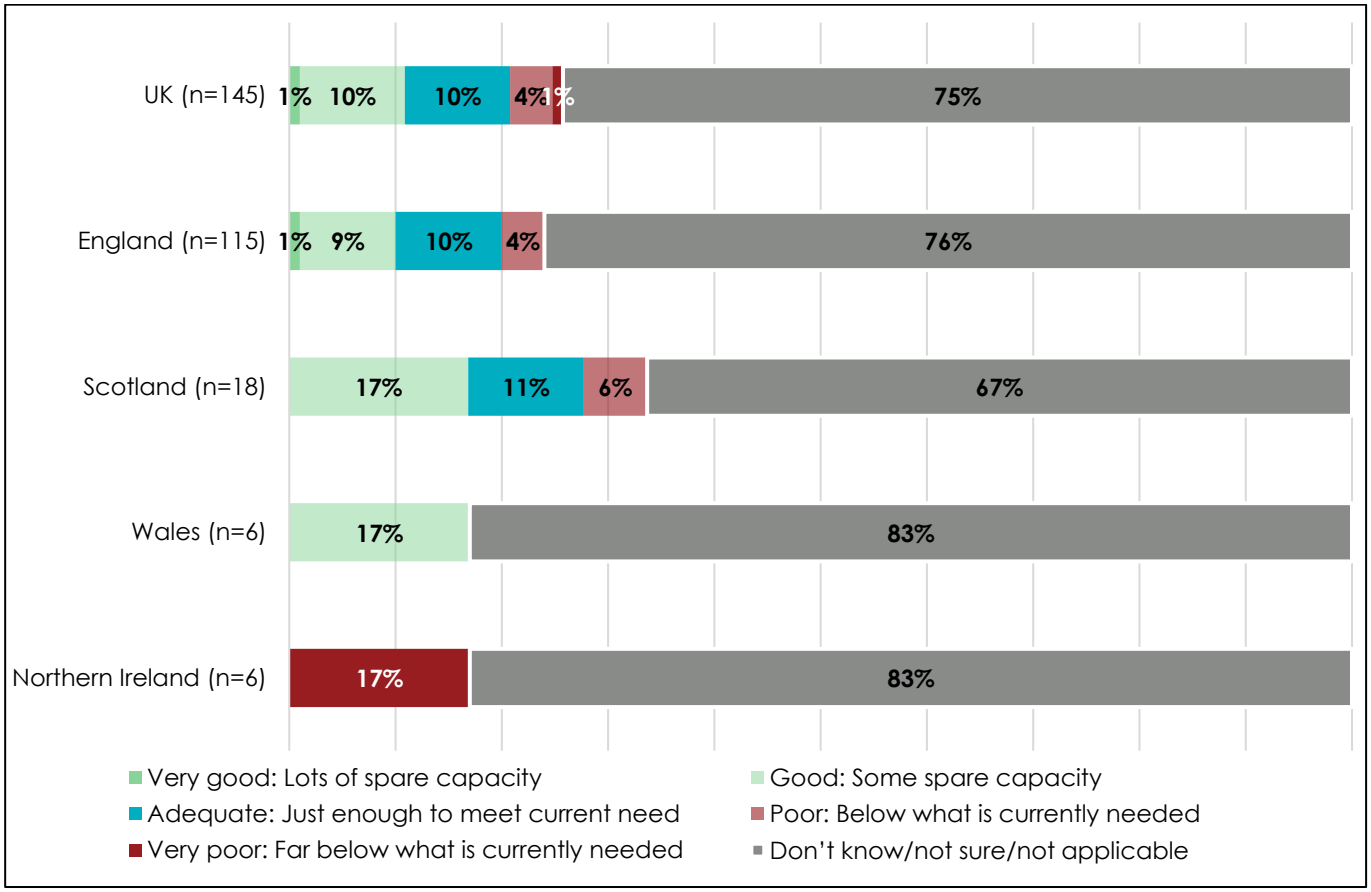


**Findings for Wales and Northern Ireland should be interpreted with caution due to the small number of responses*

PAAs

In regard to the adequacy of PAAs, across the UK the majority of clinical leaders (75%) said this was not applicable to them or they did not know. In England this figure was 76%, in Scotland 67%, in Wales 83%, and in Northern Ireland 83%.

Figure 41 – Adequacy of PAAs to meet elective demand by UK nation*
Shown in chart (Clinical leaders in the full survey)

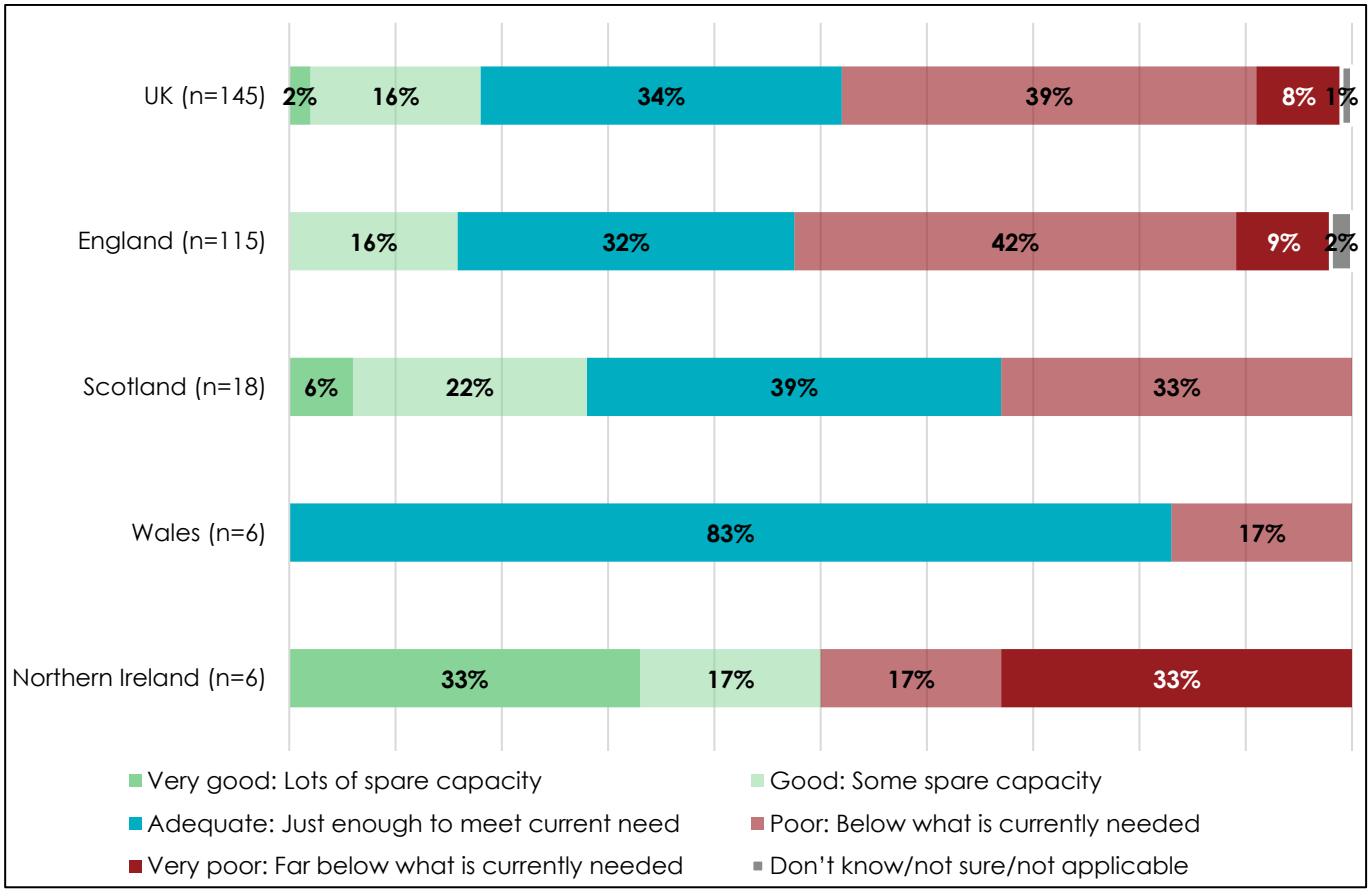


*Findings for Wales and Northern Ireland should be interpreted with caution due to the small number of responses

Number of operating theatres

At a UK level, 47% of clinical leaders rated the number of operating theatres as poor or very poor. This figure was 51% in England, 33% on Scotland, 17% in Wales, and 50% in Northern Ireland.

Figure 42 – Adequacy of number of operating theatres to meet elective demand by UK nation*
Shown in chart (Clinical leaders in the full survey)

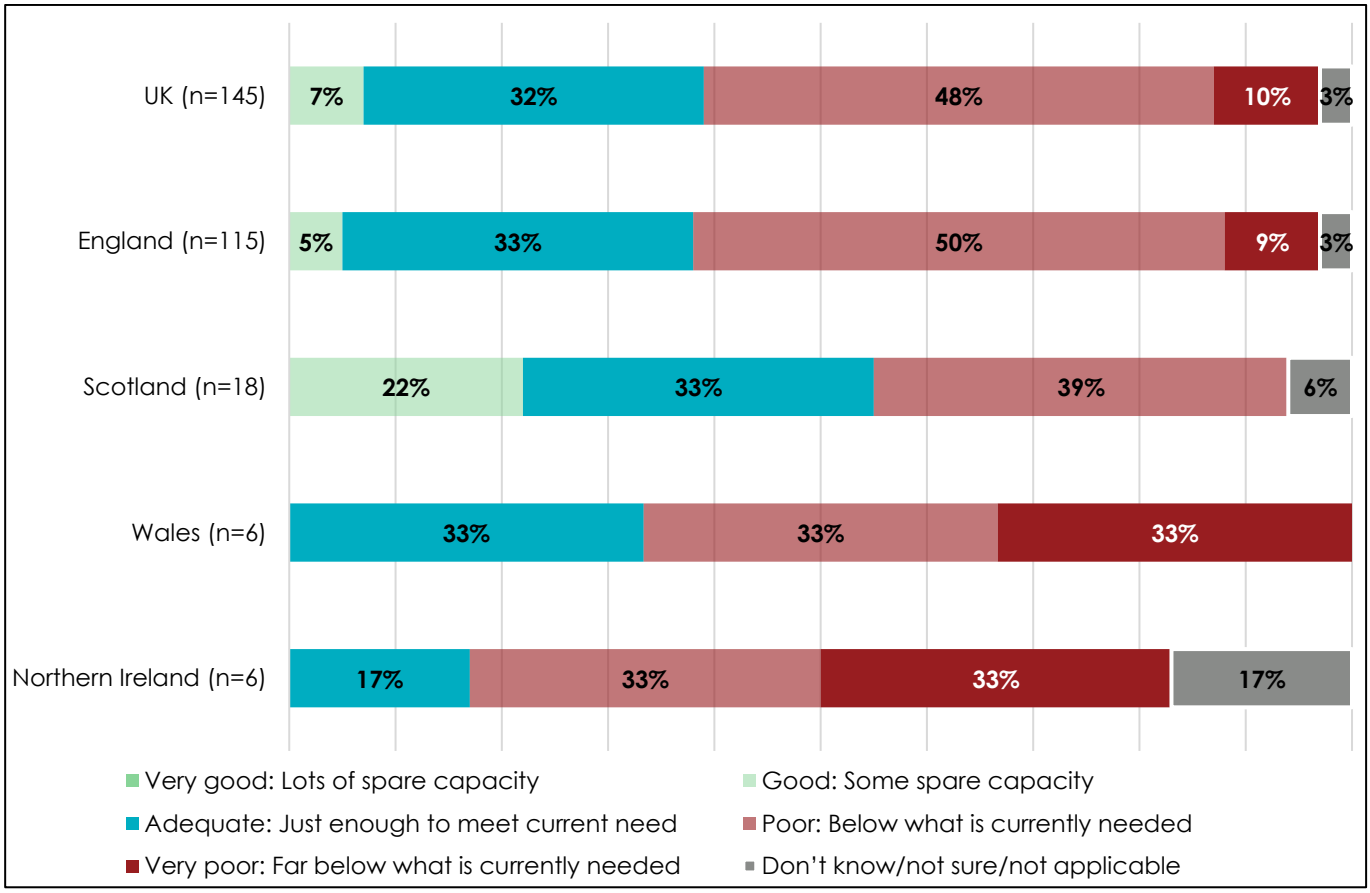


**Findings for Wales and Northern Ireland should be interpreted with caution due to the small number of responses*

Operating Department Practitioners (ODPs)

Across the UK 58% of clinical leaders rated ODP numbers as poor or very poor. In England, this figure was 59%, in Scotland 39%, in Wales 66%, and in Northern Ireland 66%.

Figure 43 – Adequacy of ODPs to meet elective demand by UK nation*
Shown in chart (Clinical leaders in the full survey)

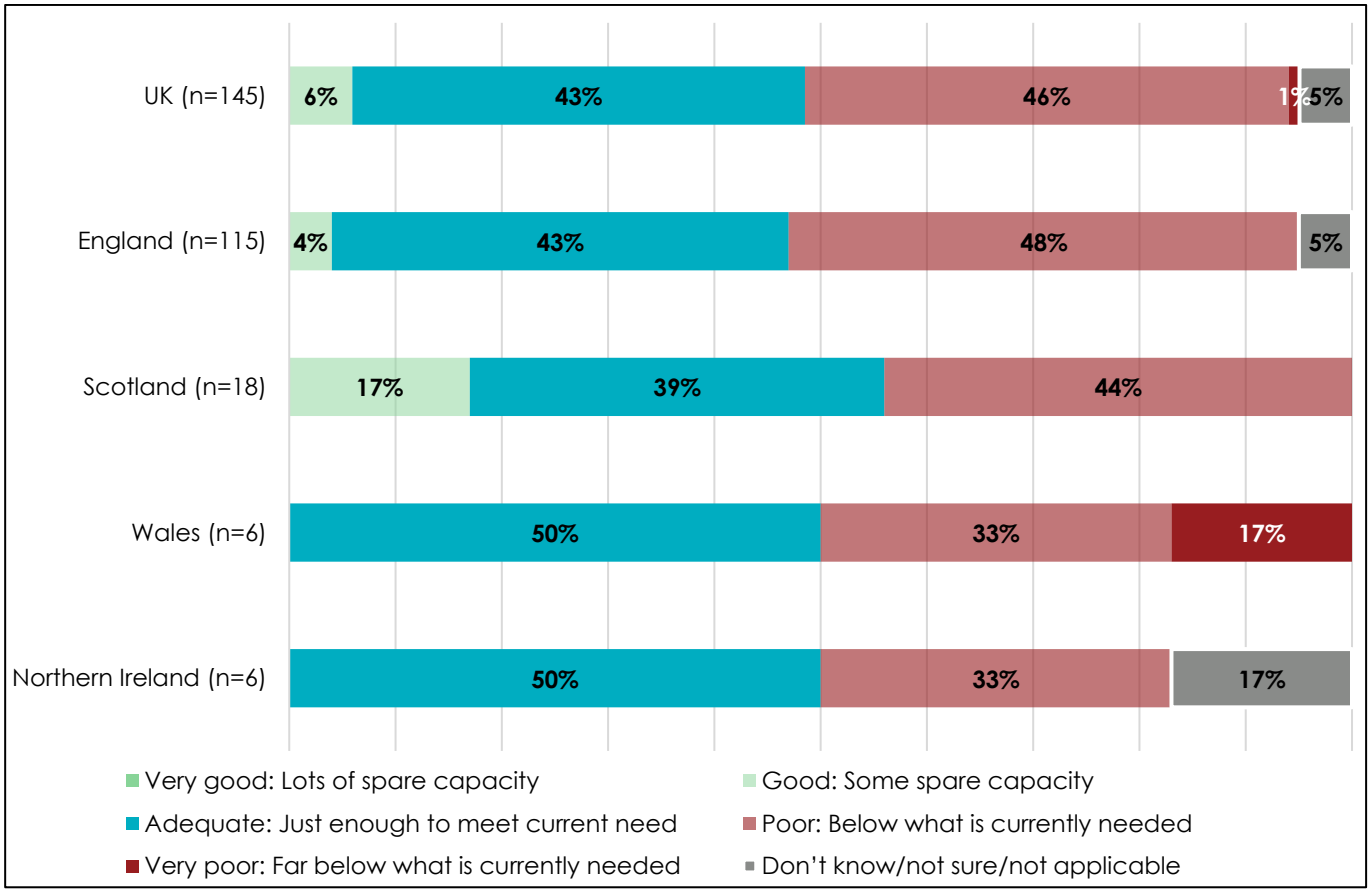


*Findings for Wales and Northern Ireland should be interpreted with caution due to the small number of responses

Scrub staff

Across the UK, 47% of clinical leaders rated scrub staff numbers as poor or very poor. This figure was 48% in England, 44% in Scotland, 50% in Wales, and 33% in Northern Ireland

Figure 44 – Adequacy of scrub staff to meet elective demand by UK nation*
Shown in chart (Clinical leaders in the full survey)

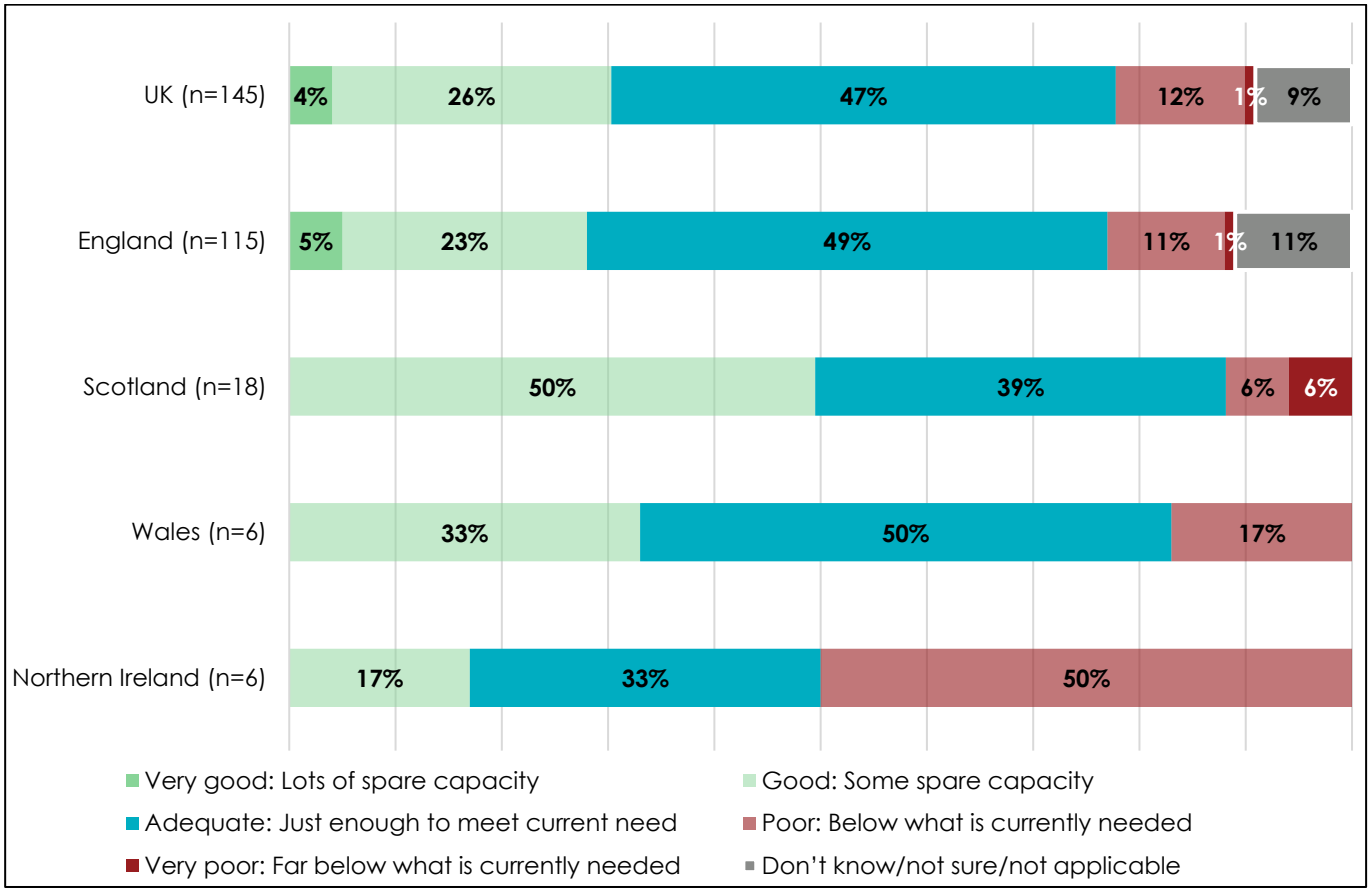


*Findings for Wales and Northern Ireland should be interpreted with caution due to the small number of responses

Surgeons

Surgeon capacity is less frequently seen as a constraint than some of the other factors. Only 13% of clinical leaders across the UK rating it as poor or very poor. This figure was 12% in England, 6% in Scotland, 17% in Wales, but was 50% in Northern Ireland.

Figure 45 – Adequacy of surgeons to meet elective demand by UK nation*
Shown in chart (Clinical leaders in the full survey)

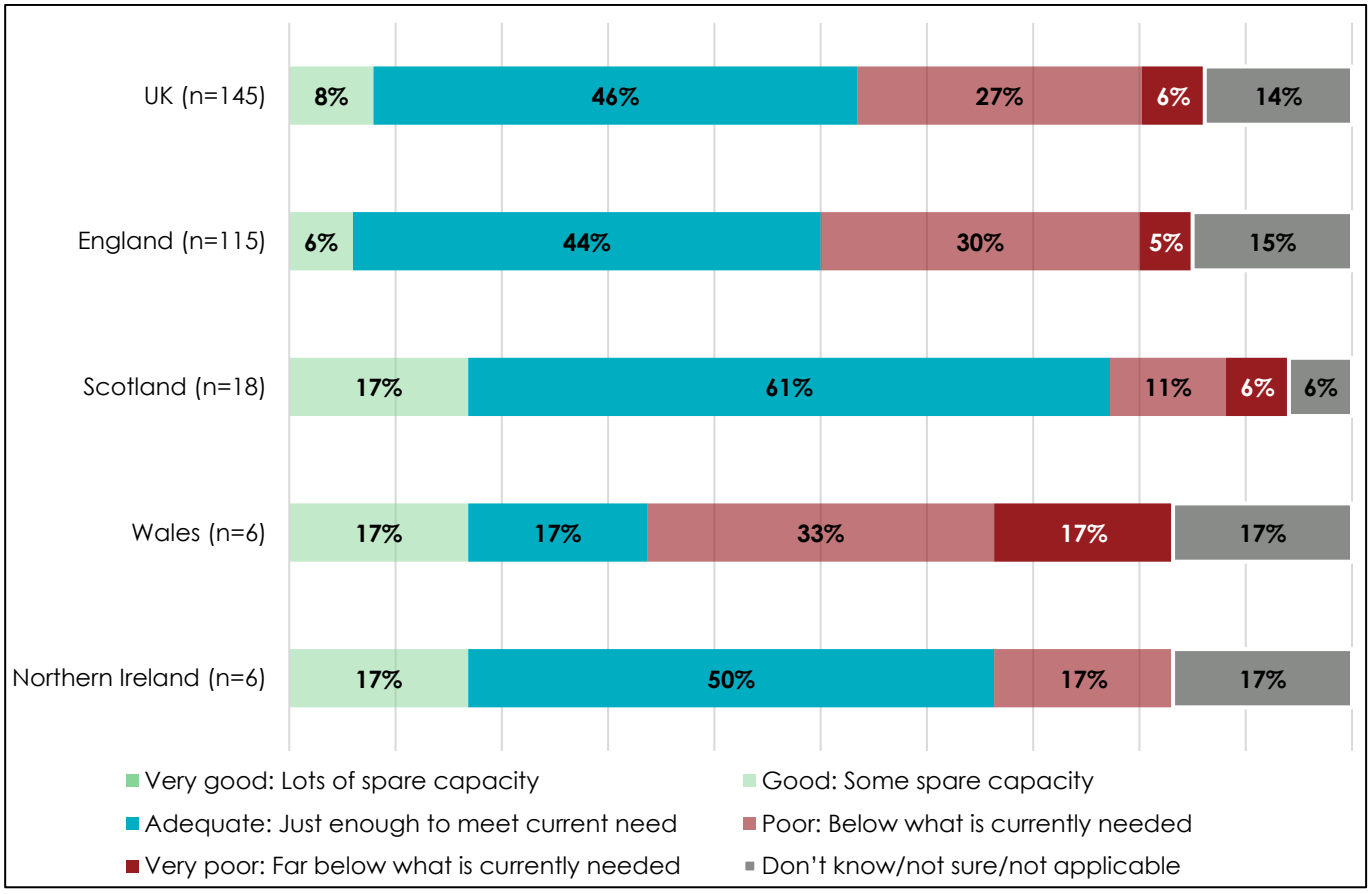


**Findings for Wales and Northern Ireland should be interpreted with caution due to the small number of responses*

Porters

Across the UK 33% of clinical leaders rated the number of porters as poor or very poor. This figure was 35% in England, 17% in Scotland, 50% in Wales, and 17% in Northern Ireland.

Figure 46 – Adequacy of porters to meet elective demand by UK nation*
Shown in chart (Clinical leaders in the full survey)

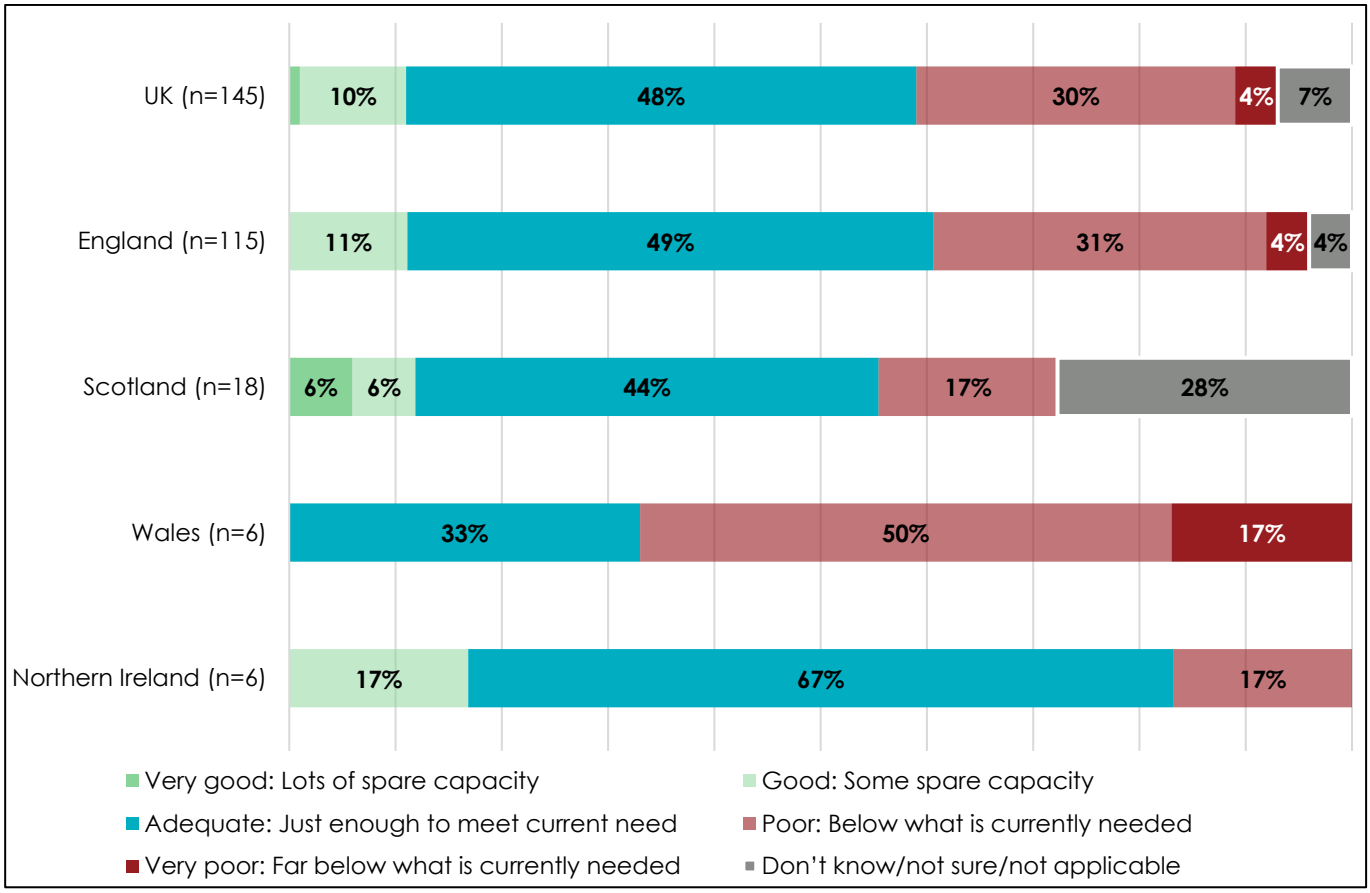


**Findings for Wales and Northern Ireland should be interpreted with caution due to the small number of responses*

ICU capacity

ICU capacity was rated as poor or very poor by 34% of clinical leaders across the UK. This figure was 35% in England, 17% in Scotland, 67% in Wales, and 17% in Northern Ireland.

Figure 47 – Adequacy of ICU capacity to meet elective demand by UK nation*
Shown in chart (Clinical leaders in the full survey)



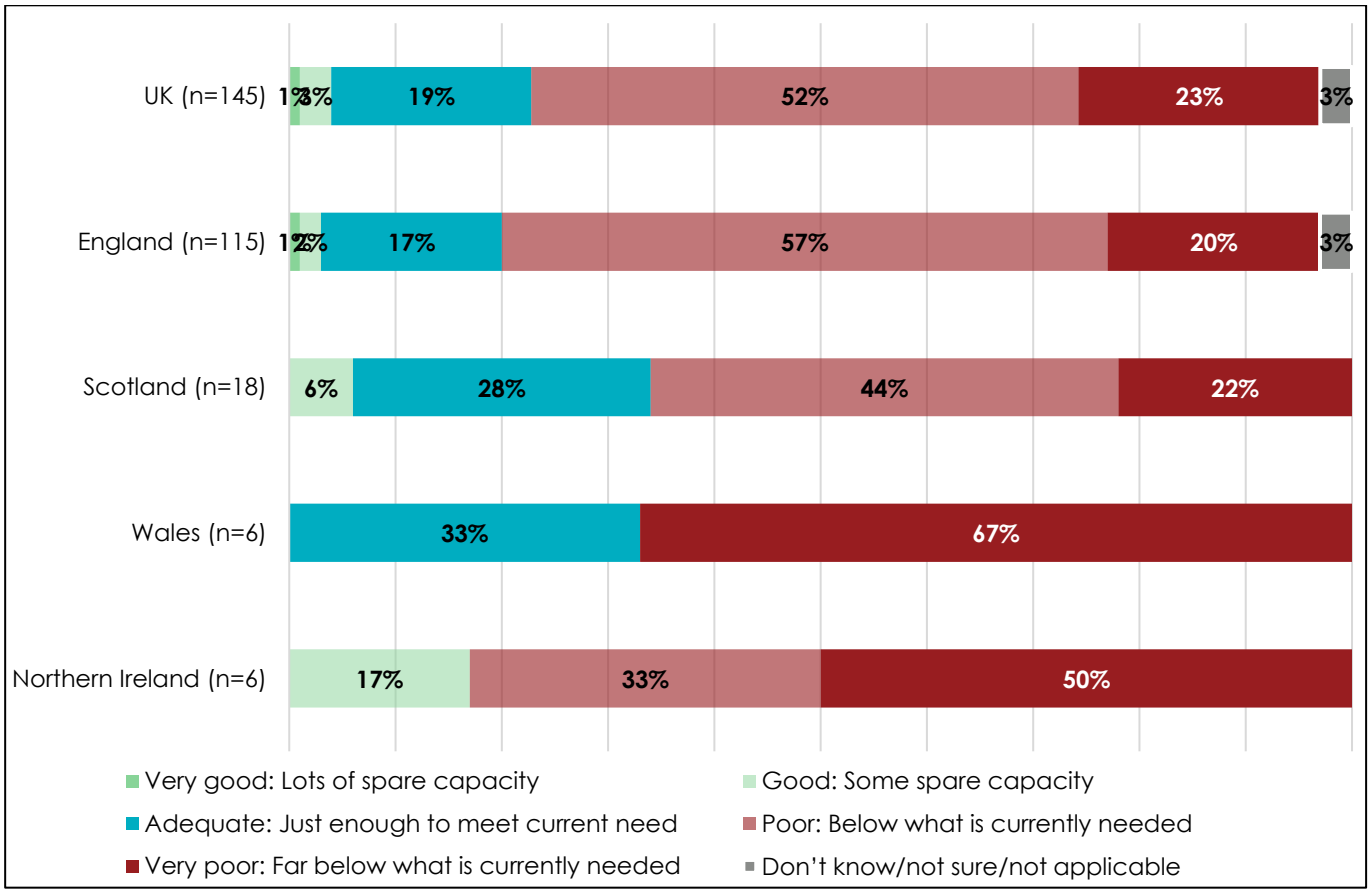
*Findings for Wales and Northern Ireland should be interpreted with caution due to the small number of responses

Ward beds

Ward bed capacity was most the cited factor as being inadequate, with 75% of clinical leaders across the UK rating it as poor or very poor, including 23% as very poor.

In England this figure was 77%, in Scotland 66%, in Wales 67%, and in Northern Ireland 83%.

Figure 48 – Adequacy of ward beds to meet elective demand by UK nation*
Shown in chart (Clinical leaders in the full survey)



**Findings for Wales and Northern Ireland should be interpreted with caution due to the small number of responses*

10 Recruitment challenges

Introduction

As shown in Chapter 7, the UK is short of 2,256 consultant and SAS doctor anaesthetists. Unfortunately, attempts to fill these posts are often stymied. This may be due to lack of funds, recruitment freezes, or a lack of applicants. The Census sought to quantify these factors.

Key findings

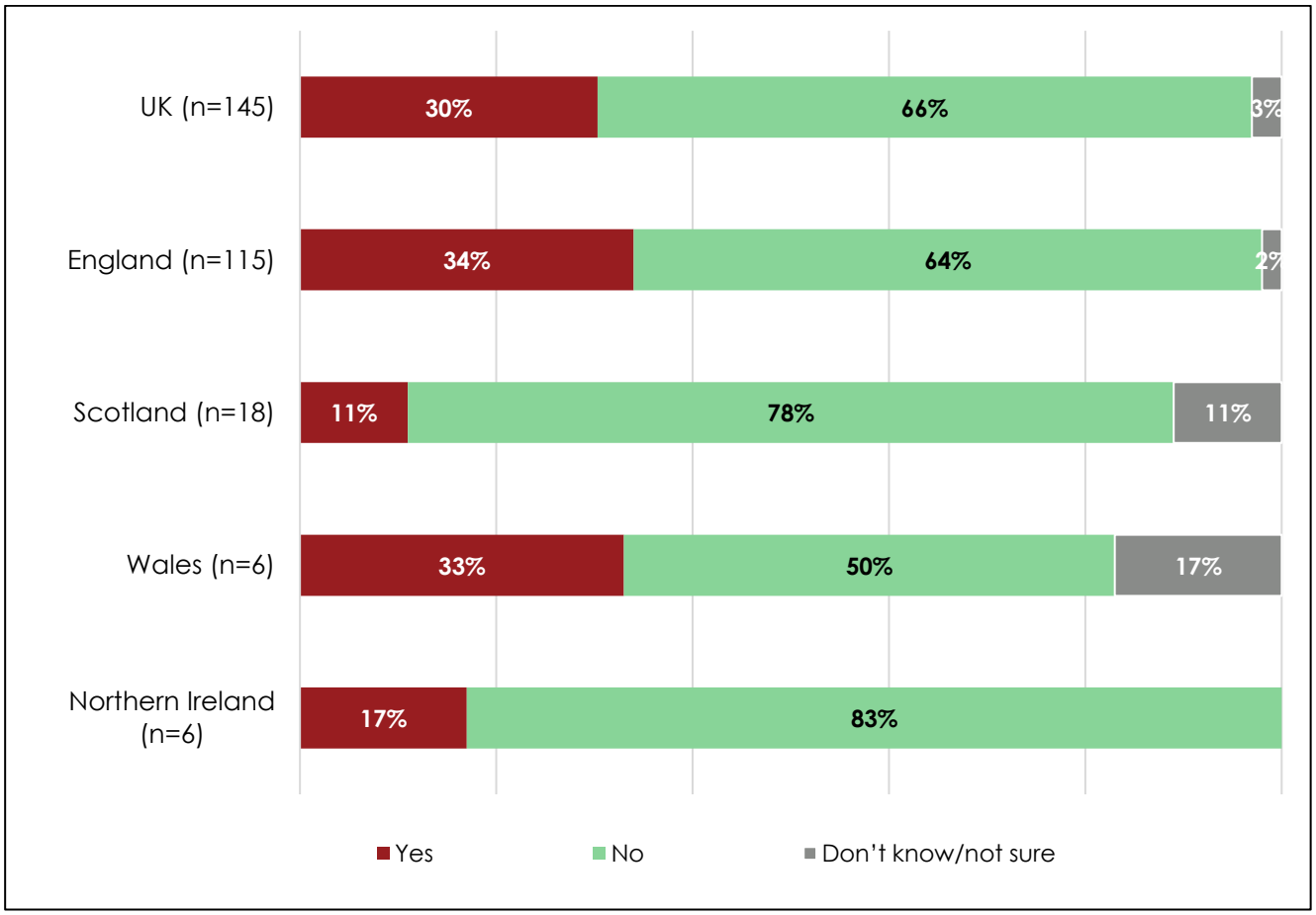
- Reiterating the finding from Chapter 7, 60% of the anaesthetic workforce gap is unfunded (i.e. there was no money available for the post to begin with).
- 30% of clinical leaders indicated that there were recruitment freezes in place, including 34% in England, 11% in Scotland, 33% in Wales (low base size), and 17% in Northern Ireland (low base size).
- 46% of clinical leaders reported that they had advertised at least one consultant post that they were unable to fill.
- The most common reason for being unable to fill an advertised consultant post was a lack of appropriately qualified applicants, cited by 73%.
- The most common sub-specialty that could not be filled was General, accounting for 52% of unfilled consultant posts, followed by Adult Critical Care (16%).
- 17% of clinical leaders reported that they had advertised an SAS post that they were unable to fill.
- The most common reason for being unable to fill an advertised SAS post was a lack of appropriately qualified applicants, cited by 76%.

Pauses on recruitment

In the full survey, clinical leaders were asked if there was a pause on recruitment in the hospitals they were responding on behalf of.

Three in ten (30%) clinical leaders indicated that there were recruitment freezes in place, including 34% in England, 11% in Scotland, 33% in Wales, and 17% in Northern Ireland.

Figure 49 – Currently, in the hospital(s) you are responding on behalf of, is there a pause on recruitment? By UK nation*
Base: Shown in chart (Clinical leaders in the full survey)

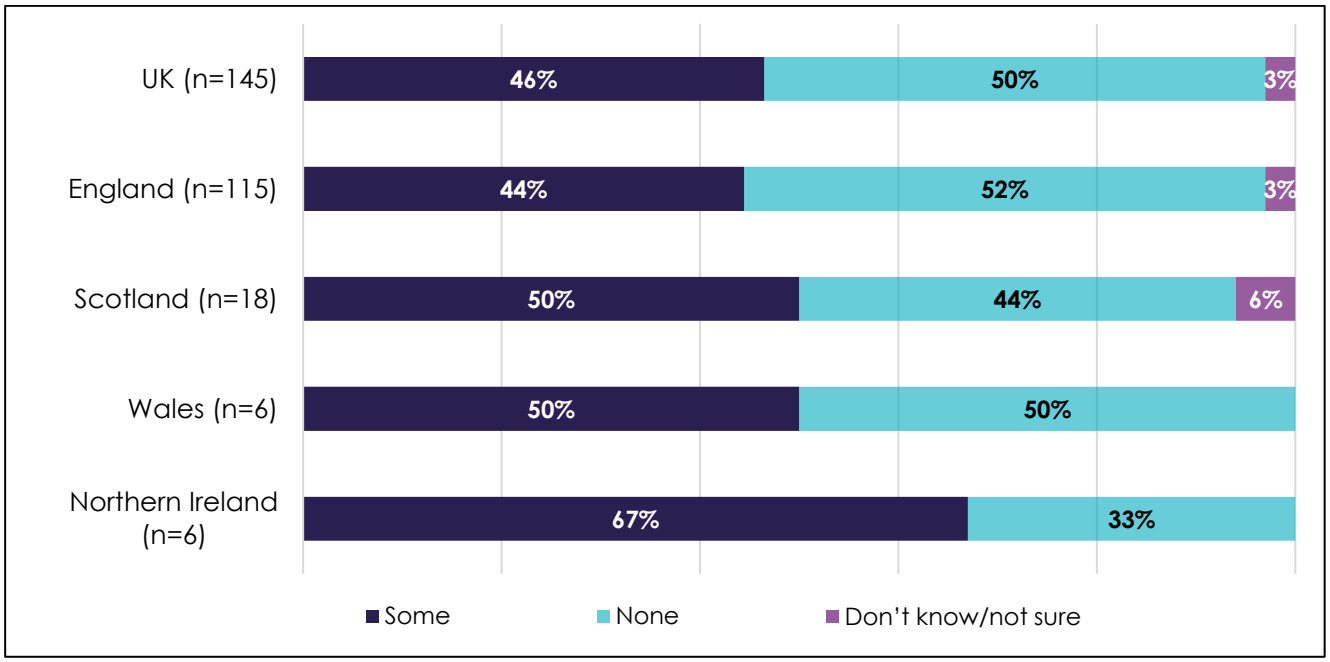


*Findings for Wales and Northern Ireland should be interpreted with caution due to the small number of responses

Lack of applicants for consultant posts

Clinical leaders were asked if there were any consultant posts that they had advertised but had not been able to fill. Across the UK, 46% of clinical leaders said they had advertised at least some consultant posts but been unable to fill them. This was particularly high in Northern Ireland, where 67% of clinical leaders reported that had been some unfilled consultant posts, well above the UK average, but the small base size should be noted.

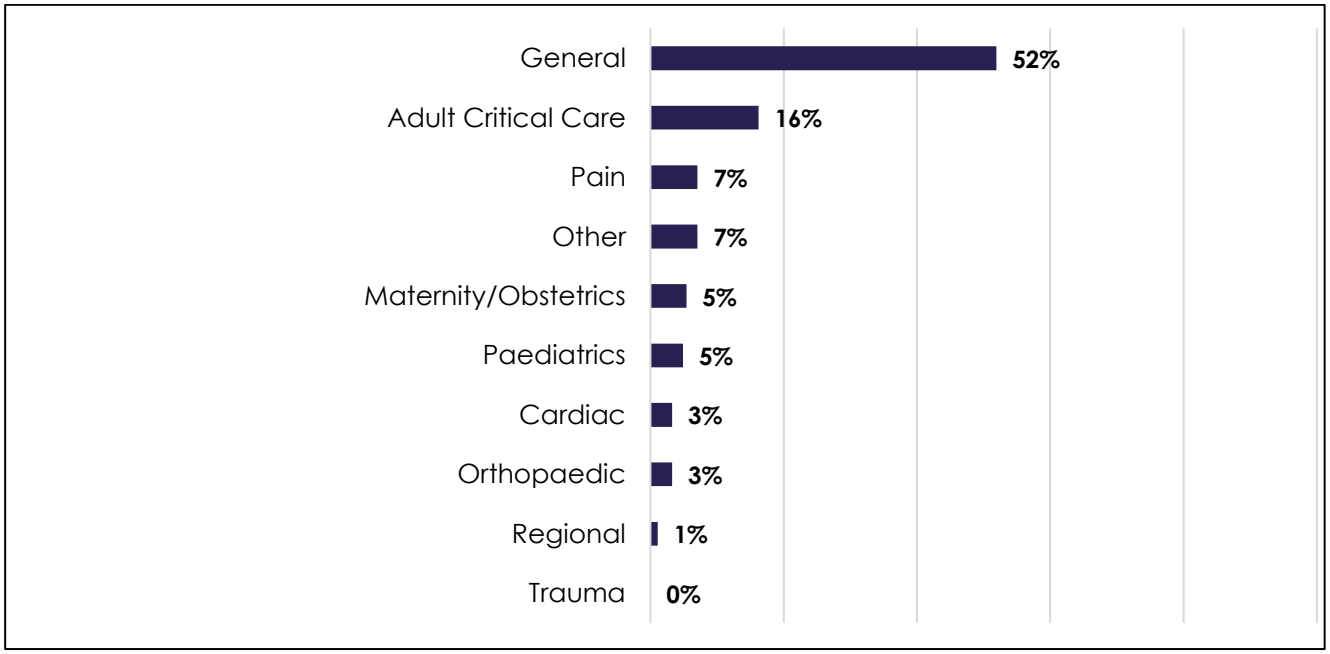
Figure 50 – In the hospital(s) you are responding on behalf of, are there any consultant posts that you advertised but were unable to fill? By UK nation*
Base: Shown in chart (Clinical leaders in the full survey)



**Findings for Wales and Northern Ireland should be interpreted with caution due to the small number of responses*

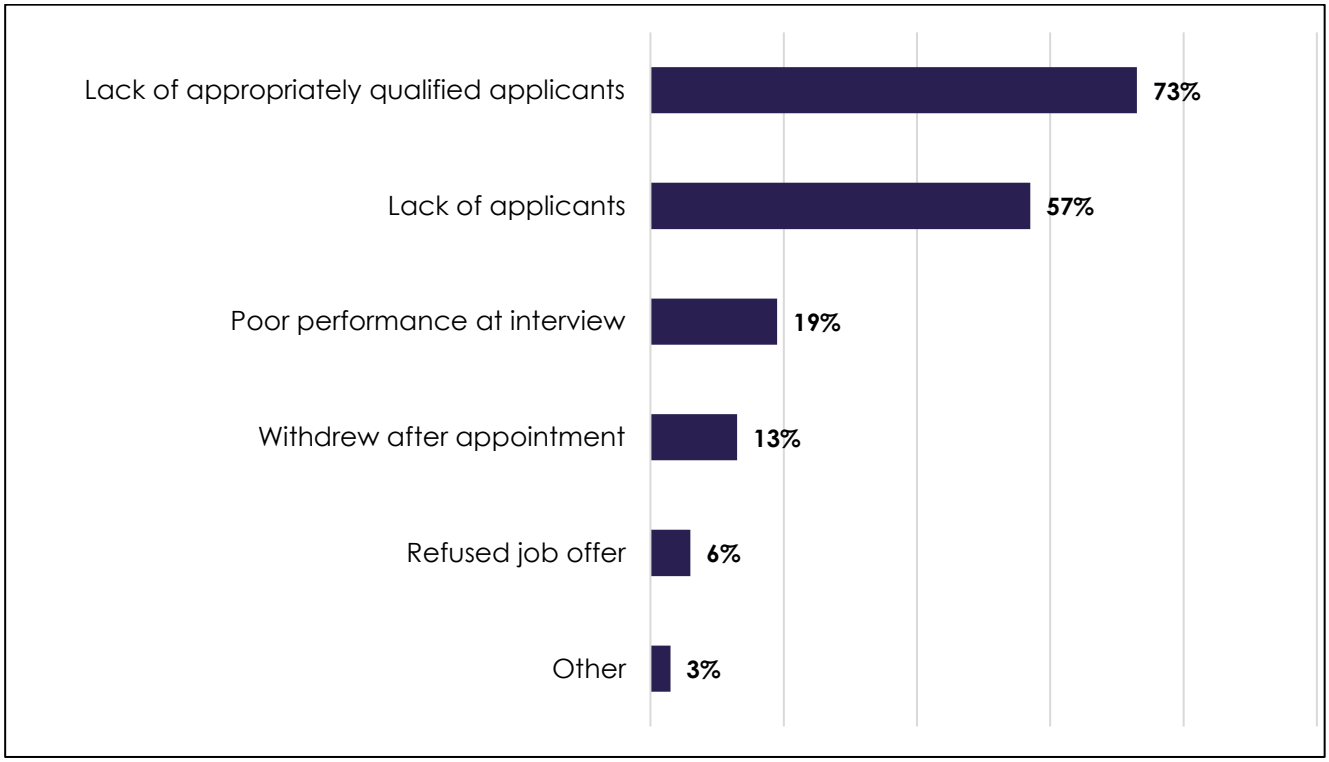
The most common sub-specialty that could not be filled across the UK was General, accounting for 52% of unfilled consultant posts, followed by Adult Critical Care (16%).

Figure 51 – How many consultant posts in each sub-specialty did you advertise but were unable to fill?
Base: 67 (Clinical leaders in the full survey with some unfilled consultant posts)



The most common reason provided by clinical leaders for not being able to fill consultant posts was a lack of appropriately qualified applicants (73%), followed by a lack of applicants in general (57%). It is unclear whether these results genuinely indicate a lack of *qualified* applicants is a bigger issue than lack of applicants in general – as 'lack of appropriately qualified applicants' could be interpreted either way. Future work will attempt to distinguish between these categories more clearly.

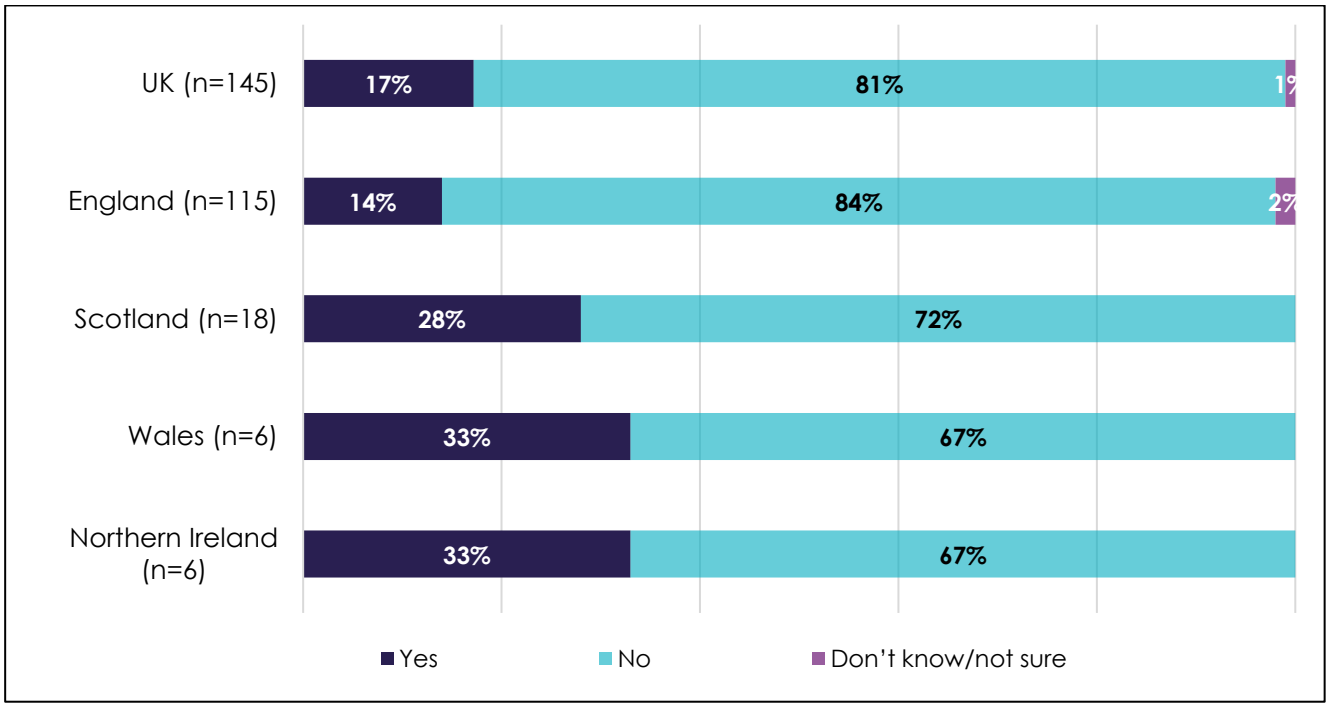
Figure 52 – Why were you unable to fill those advertised consultant posts?
Base: 67 (Clinical leaders in the full survey with some unfilled consultant posts)



Lack of applicants for SAS doctor posts

Clinical leaders were also asked about filling SAS doctor posts in the full survey. Across the UK, 17% said that there were one or more SAS posts that were advertised in the last year, but that could not be filled.

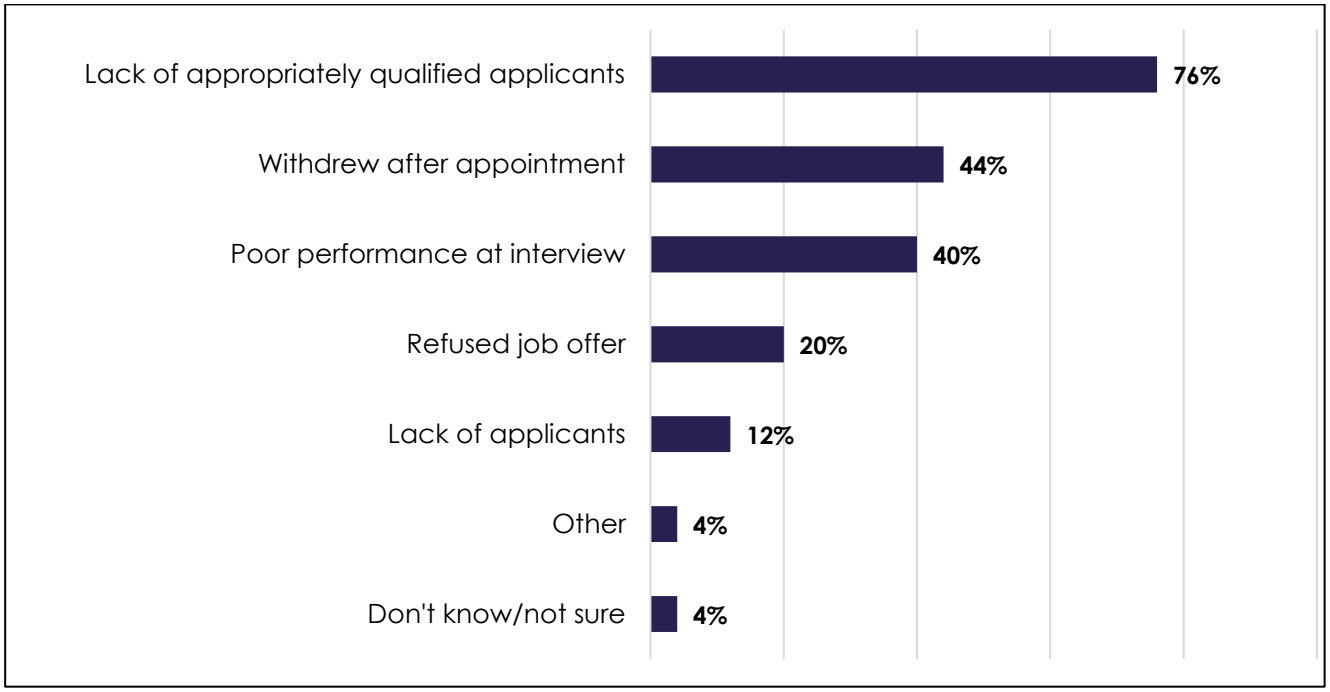
Figure 53 – Within the last year did you advertise one or more SAS posts but were unable to fill them? by UK nation*
Base: Shown in chart (Clinical leaders in the full survey)



**Findings for Wales and Northern Ireland should be interpreted with caution due to the small number of responses*

The most common reason provided by clinical leaders for not being able to fill SAS posts was a lack of appropriately qualified applicants (76%), but the small base size should be noted.

Figure 54 – Why were you unable to fill those advertised SAS posts?
Base: 25 (Clinical leaders in the full survey with some unfilled consultant posts)



11 Training pathways, bottlenecks and ratios

Introduction

In the UK, the pathway to becoming a doctor starts with medical school. This typically lasts five years and is followed by two or more years of general NHS foundation training. After that point, doctors may apply to start an area of specialty training, such as surgery, pathology, general practice, or anaesthesia.

Specialty training in anaesthesia involves a three-stage process. The entry stage, referred to as 'stage 1' or 'core' anaesthetics training, typically lasts for three years (CT1, CT2, and CT3). As an alternative, there is also a four year 'acute care common stem' (ACCS) programme. After this point, doctors may be able to access the SAS 'specialty' contract.

If a doctor wishes to become a consultant anaesthetist – the staffing group with the largest absolute shortfall – they must further complete higher training. This is broken down into 'stage 2' (years ST4-5) and 'stage 3' (years ST6-7+). These stages typically take two years each, or four years in total.

Unfortunately, all the way along this pathway, doctors encounter bottlenecks that hinder progression. This chapter draws on external data to show the extent of these bottlenecks as context for our census findings.

Key findings

- The number of doctors graduating from UK medical schools has increased from 7,356 in 2021 to 9,746 in 2025 (32% increase). [2]
- The number of doctors in second year foundation training has increased from 7,863 in 2021 to 9,060 in 2025 (15% increase). [3]
- The number of international medical graduates applying for specialty training in the UK has increased from 9,456 in 2021 to 25,257 in 2025. [4]
- In 2025, across all medical specialities, and all levels of training, approximately 42,000 individual applicants applied for just 13,000 specialty training posts, leaving 29,000 unable to progress. [4]
- In anaesthesia specifically, in 2025 there were 6,770 applicants for just 539 places at core level – a competition ratio of 12.56 to 1. This has risen from a ratio of 3.61 to 1 in 2021. [5]
- At ST4 level, there were 699 applicants for 423 posts – a competition ratio of 1.65 to 1. This has reduced from a ratio of 2.67 to 1 in 2021. [5]

Medical school graduates

In the UK the journey to become a doctor starts with medical school. GMC data shows that the number of doctors graduating from medical school has increased from 7,356 in 2021 to 9,746 in 2025 – a 32% increase. [2]

Figure 55 – Number of medical graduates from UK universities by year

Year	UK
2021	7,356
2022	7,810
2023	8,279
2024	9,262
2025	9,746

Foundation training

After medical school, doctors enter NHS foundation training, which generally lasts for two years. Foundation training involves doctors rotating around different hospital speciality areas to gain a wide understanding of what it means to be a doctor, how the NHS functions, and what area of medicine they may wish to specialise in.

Similar to medical school places, the number of doctors undergoing foundation training has increased. Looking at those in their second year of foundation training, there were 7,863 in 2021, a figure which has risen to 9,060 in 2025 – a 15% increase. [3]

Figure 56 – Number of second year foundation doctors by year

Year	UK
2021	7,863
2022	7,830
2023	7,786
2024	8,487
2025	9,060

It is possible to calculate a crude estimate of the UK/international composition of second year foundation doctors by comparing their numbers in 2025 (9,060) to the number of medical graduates the UK produced two years before, in 2023 (8,279). It can hence be deduced that in 2025 around 93.4% of second year foundation doctors (around 8,300 individuals) were UK medical graduates, and around 6.6% were IMGs (around 800).

Specialty training applicants and posts

After finishing foundation training, doctors may apply for specialty training in a competitive process. In 2025, for entry level specialty training posts (levels CT1, ACCS, and ST1), approximately 34,000 individual applicants applied for just 9,500 posts. Of these, around 12,000 were UK medical graduates and 21,000 were international medical graduates (IMG) – with the remainer being made up by non-medical graduates.

It may be instantly apparent that:

- **The number of individual applicants in 2025 (34,000 individuals) was considerably larger than the approximately 9,000 doctors finishing NHS foundation training in the same year.** [4]
- **The number of IMGs applying for specialty training (21,000) far exceeds the estimated 800 IMGs who have undergone UK foundation training**. A logical deduction from this is that there must be high numbers of such applicants who have not gone through NHS foundation training. It is possible that some (or many) of these maybe based overseas and applying for specialty training with the hope of entering the UK system. It is also possible that some have already entered the UK and are employed in LED or SAS positions prior to making an application for a training place. [4]
- **The number of UK medical graduates who applied for core-level specialty training (12,000) in 2025 is greater than the estimated 8,300 UK medical graduates who are finishing UK foundation training** [4]**.** It is possible but this is due to doctors who have missed out on getting training places in previous years and subsequently entered LED roles, who are now reapplying back into the system.

Figure 57 – Numbers of CT1/ACCS/ST1 applicants, posts available and the competition ratio by year

Group	2021	2022	2023	2024	2025
Total applicants	17,226	18,320	20,354	26,102	33,870
UK medical graduate applicants	9,710	9,159	9,147	10,635	12,316
International medical graduate applicants	6,913	8,404	10,404	14,871	20,807
Non-medical graduate applicants	610	761	809	606	762
CT1/ACCS/ST1 posts	9,247	9,235	9,194	9,331	9,479
Competition ratio	1.86:1	1.98:1	2:21:1	2.80:1	3.57:1

Regarding higher training, in 2025, around 8,500 individual applicants applied for around 3,400 posts. These included approximately 3,500 UK medical graduates and around 5,000 IMGs. [4]

Figure 58 – Numbers of ST3/ST4 applicants, posts available and the competition ratio by year

Group	2021	2022	2023	2024	2025
Total applicants	6,213	6,137	6,564	7,095	8,481
UK medical graduate applicants	3,246	2,868	3,046	3,161	3,528
International medical graduate applicants	2,967	3,273	3,519	3,934	4,953
ST3/ST4 posts	2,331	2,869	3,484	3,412	3,354
Competition ratio	2.67:1	2.14:1	1.88:1	2:08:1	2.53:1

Putting the figures together, in 2025, across all medical specialties and all levels of training, approximately 42,000 individual applicants applied for just 13,000 specialty training posts, leaving 29,000 without places. [4]

Figure 59 – Numbers of total applicants, posts available and the competition ratio by year

Group	2021	2022	2023	2024	2025
Total individual applicants	22,858	23,715	26,208	32,623	41,727
UK medical graduate applicants	12,799	11,850	12,038	13,683	15,723
International medical graduate applicants	9,456	11,113	13,368	18,344	25,257
Non-medical graduate applicants	610	761	809	606	762
Posts available	11,579	12,105	12,680	12,743	12,833
Competition ratio	1.97:1	1.95:1	2.07:1	2.56:1	3.25:1

Specialty training in anaesthetics

Looking at specialty training in anaesthetics specifically, in 2025 there were 6,770 applicants for just 539 places at core level – a competition ratio of over 12 to 1 [5]. It must be noted that an individual applicant can apply to more than one specialty, and anaesthetics may not be the first choice of all of these applicants.

At ST4 level, there were 699 applicants for 423 posts – a competition ratio of 1.65 to 1. [5]

Figure 60 – Numbers of core anaesthesia/ACCS and higher anaesthesia applicants, posts available and the competition ratio by year

Group	2021	2022	2023	2024	2025
Core anaesthesia/ACCS					
Individual applicants	2,046	2,337	2,604	3,522	6,770
Posts available	566	558	545	542	539
Competition ratio	3.61:1	4.19:1	4.78:1	6.50:1	12.56:1
Higher anaesthesia					
Individual applicants	1,056	N/a	640	640	699
Posts available	396	N/a	399	391	423
Competition ratio	2.67:1	N/a	1.60:1	1.64:1	1.65:1

Competition ratios have reduced at higher level due to a lack of increase in core places and the granting of extra higher places in 2022.

These bottlenecks, particularly at core level, are hugely problematic for doctors who likely have already dedicated at least seven years of their lives to medicine. They are also intolerable at a time when the NHS faces doctor shortages, both in anaesthesia and in other specialties.

12 Training capacity

Introduction

As shown in Chapter 7, the UK is short of 2,256 consultant and SAS doctor anaesthetists. Also, as shown in the 'Training pathways, bottlenecks, and ratios' section there is no shortage of applicants who want to specialise in anaesthesia. The barrier is lack of training posts.

Any new posts require government funding to cover the salary costs of the doctors while they train and the costs of the training itself. As such, RCoA has long pushed the UK governments to provide such funding. However, in order to make any asks realistic, it is important to know how much capacity there is in the system to take on new posts if such funding were made available.

Key findings

- Currently there is capacity to take on an extra 526 CT1-3 level AiTs. Given that, typically, these posts last three years, this equates to a yearly intake of 175.
- Currently there is capacity to take on an extra 802 ST4-7+ level AiTs. Given that, typically, these posts last four years, this equates to a yearly intake of 201.
- In terms of increasing training capacity beyond these numbers, there is no single factor that stands out as the primary limiter on a national basis. It is likely this varies considerably hospital by hospital.

Capacity

College tutors were asked how many additional AiTs their hospital has the capacity to take on, leaving aside funding and taking into account only trainer capacity, physical infrastructure and appropriate case mix and number.

Across the UK there is an estimated capacity for 526 AiTs at CT1-3 (stage 1) and 802 at ST4-7+ (stage 2 & 3) levels.

Given stage 1 training typically lasts 3 years and stage 2 & 3 training (taken together) typically lasts 4 years, dividing the aforementioned figures by three and four respectively gives a figure for the maximum additional yearly intake. This means that 175 extra CT1-3s could be recruited each year, and 201 AiTs at ST4-7+ level.

It must be noted that these figures are based on capacity to take on additional AiTs at a hospital level. It is, however, possible that there may be pinch points in specific areas of training that could introduce additional training constraints. Nevertheless, there is still likely considerable capacity to train more AiTs and provision of adequate funding could rapidly unlock this.

Figure 61 – Training capacity numbers per year for AiTs by UK nation*

Capacity/intake per year	UK	England	Scotland	Wales	Northern Ireland
Total capacity CT1-3 (stage 1)	526	434	60	19	13
Intake per year CT1-3 (stage 1)	175	145	20	6	4
Total capacity ST4-7+ (stage 2 & 3)	802	667	86	24	25
Intake per year ST4-7+ (stage 2 & 3)	201	167	22	6	6
Total capacity	1,328	1,101	146	43	38
Total intake per year	376	311	42	12	10

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

Further expansion

The Census not only attempted to ascertain how many additional AiTs could be accommodated within current capacity, but also explored which factors may constrain further expansion.

To do this, college tutors were asked to assume that the additional posts identified in the previous question had been filled. They were then asked to estimate, in percentage terms, how much further capacity their hospital would have across the following areas:

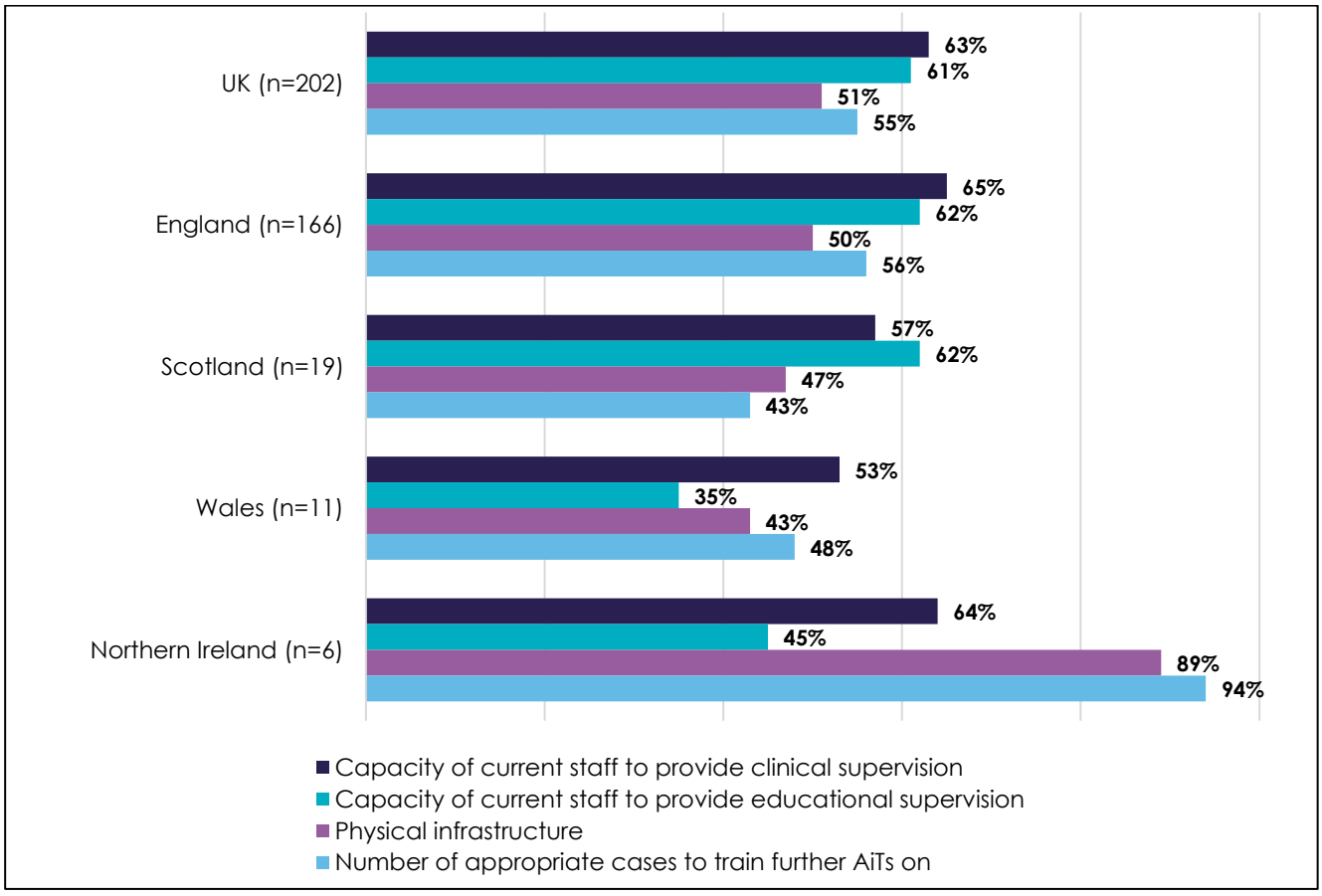
- Clinical supervision
- Educational supervision
- Physical infrastructure (e.g. numbers of theatres or teaching space to accommodate further training)
- Number of appropriate cases

In this context, lower reported percentages indicate more limited remaining capacity and therefore suggest potential constraints on further expansion. At a UK aggregate level, no one factor stood out as a dramatic constraint. On average, spare capacity was reported as 51% for physical infrastructure, 55% for appropriate cases, 61% for educational supervision, and 63% for clinical supervision. It seems likely, therefore, that constraining factors are highly variable between hospitals.

It should be noted that 18 college tutors did not provide data for these questions, and this should be taken into account when interpreting the findings.

Figure 62 – In terms of taking on even more AiTs, over and above the figures you listed in the previous question, how much spare capacity does your hospital have regarding the following factors...? By UK nation

Base: Shown in chart (College tutors who gave a response)



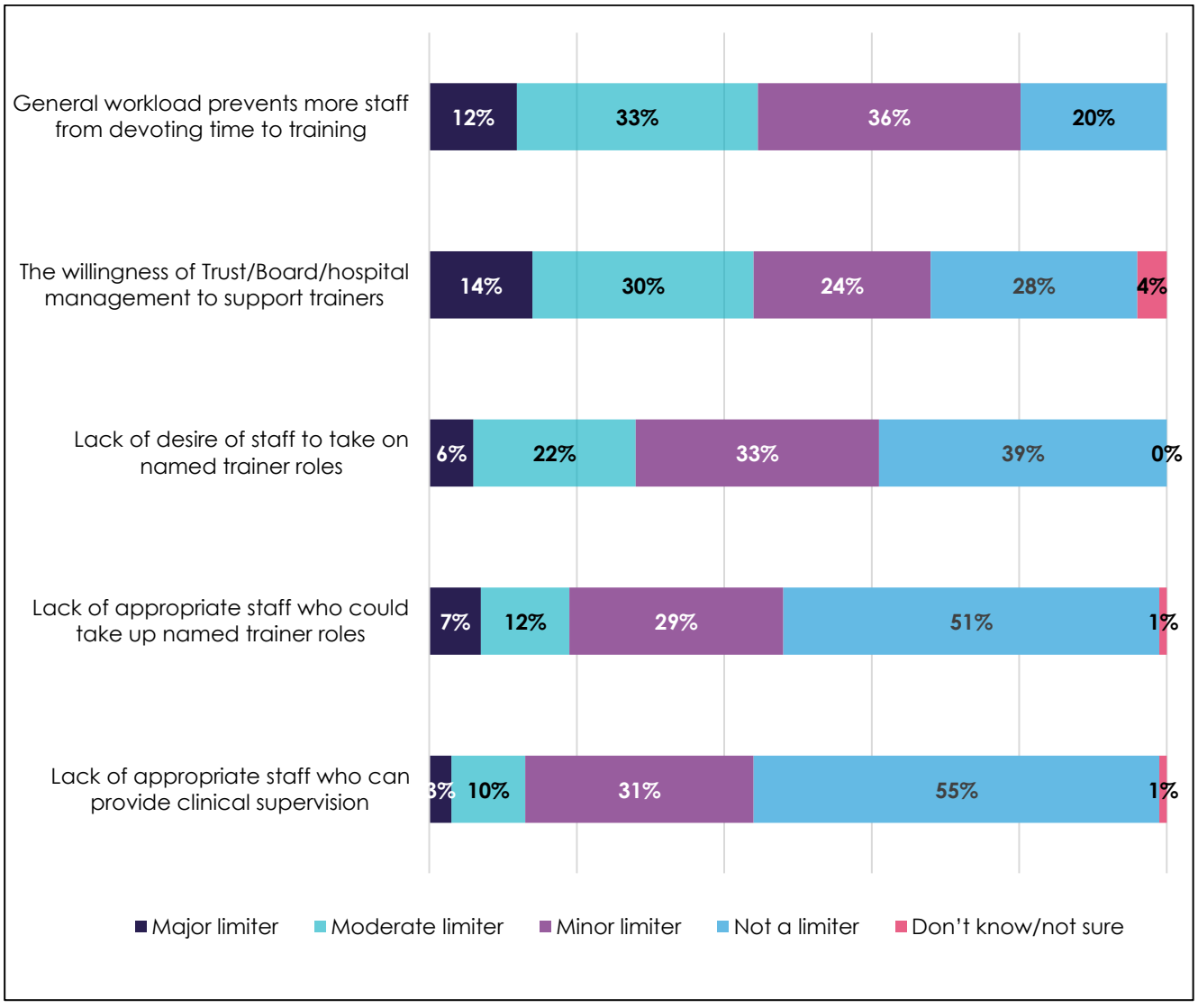
Staffing constraints

The Census also took a deeper look at the factors that may constrain the ability of anaesthetic staff to deliver extra training.

General workload emerges as a key constraint, with 45% of respondents identifying it as a major or moderate limiter (12% major, 33% moderate). Similarly, the willingness of Trust/Board/hospital management to support trainers is seen as a constraint by 44% (14% major, 30% moderate).

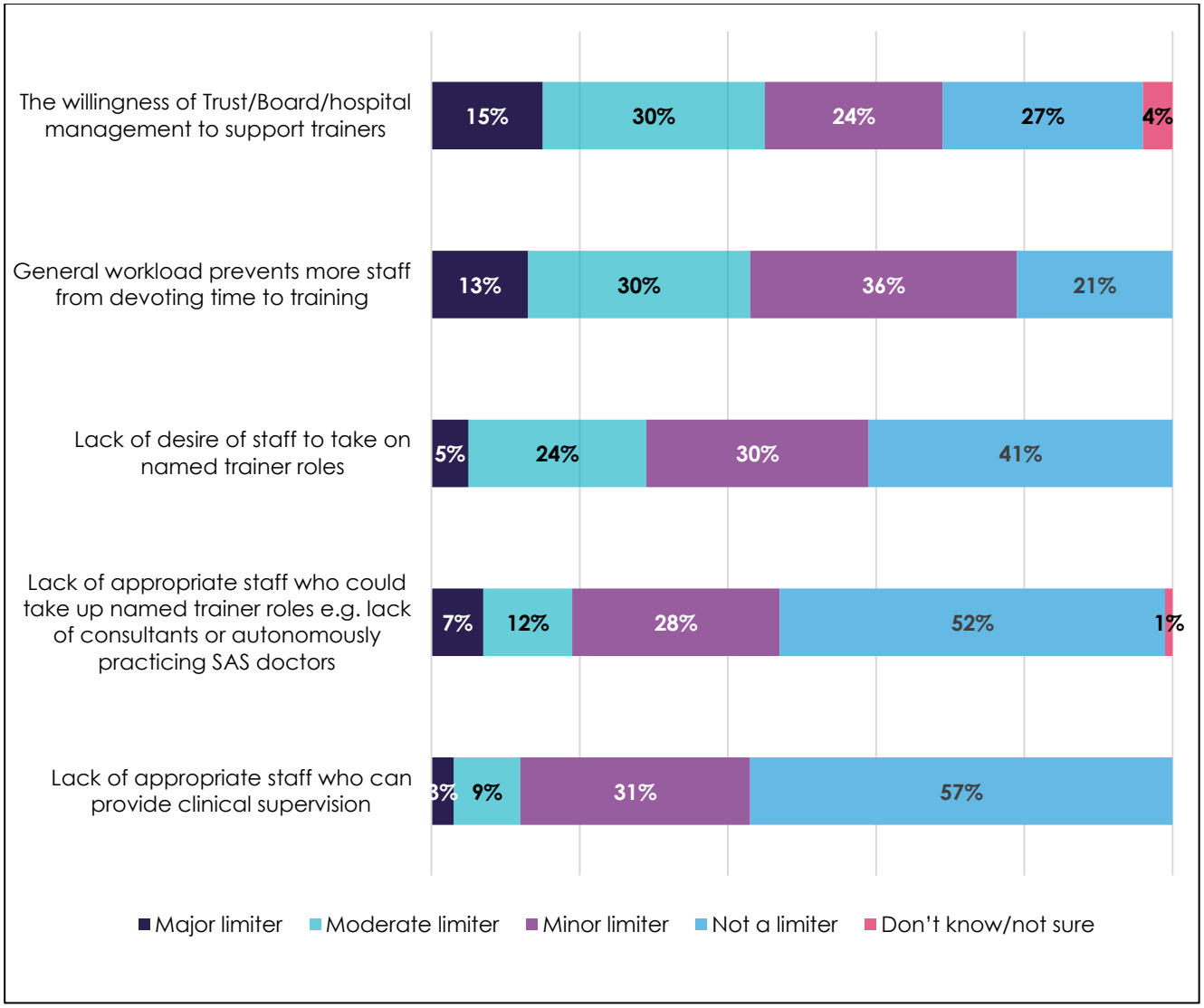
Other factors are less frequently identified as significant constraints. For example, only 19% reported that a lack of appropriate staff to take up named trainer roles is a major or moderate limiter, while 13% said the same for a lack of appropriate staff to provide clinical supervision. Lack of desire among staff to take on named trainer roles was also less commonly cited, with 28% identifying this as a major or moderate limiter.

Figure 63 – To what extent do the following factors limit your anaesthetic staff's capacity to provide training and supervision? – UK
Base: 220 (All college tutors)



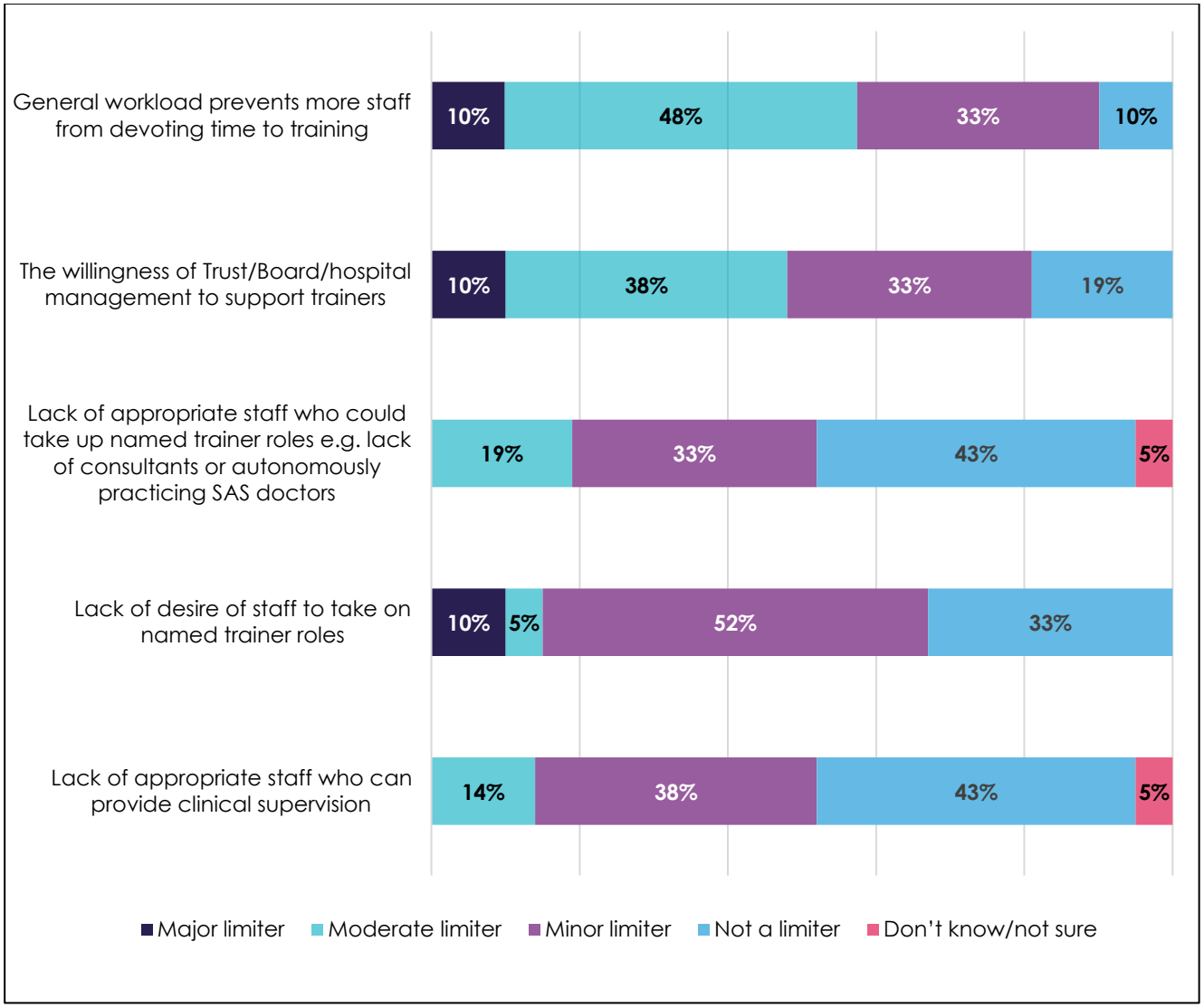
In England, the pattern is similar to the UK overall. General workload (43%) and the willingness of Trust/Board/hospital management to support trainers (45%) are most commonly identified as major or moderate limiters.

Figure 64 – To what extent do the following factors limit your anaesthetic staff's capacity to provide training and supervision? – England
Base: 181 (College tutors in England)



In Scotland, general workload (58%) and the willingness of Trust/Board/hospital management to support trainers (48%) are most commonly identified as major or moderate limiters, with workload in particular standing out as a more prominent constraint than in England.

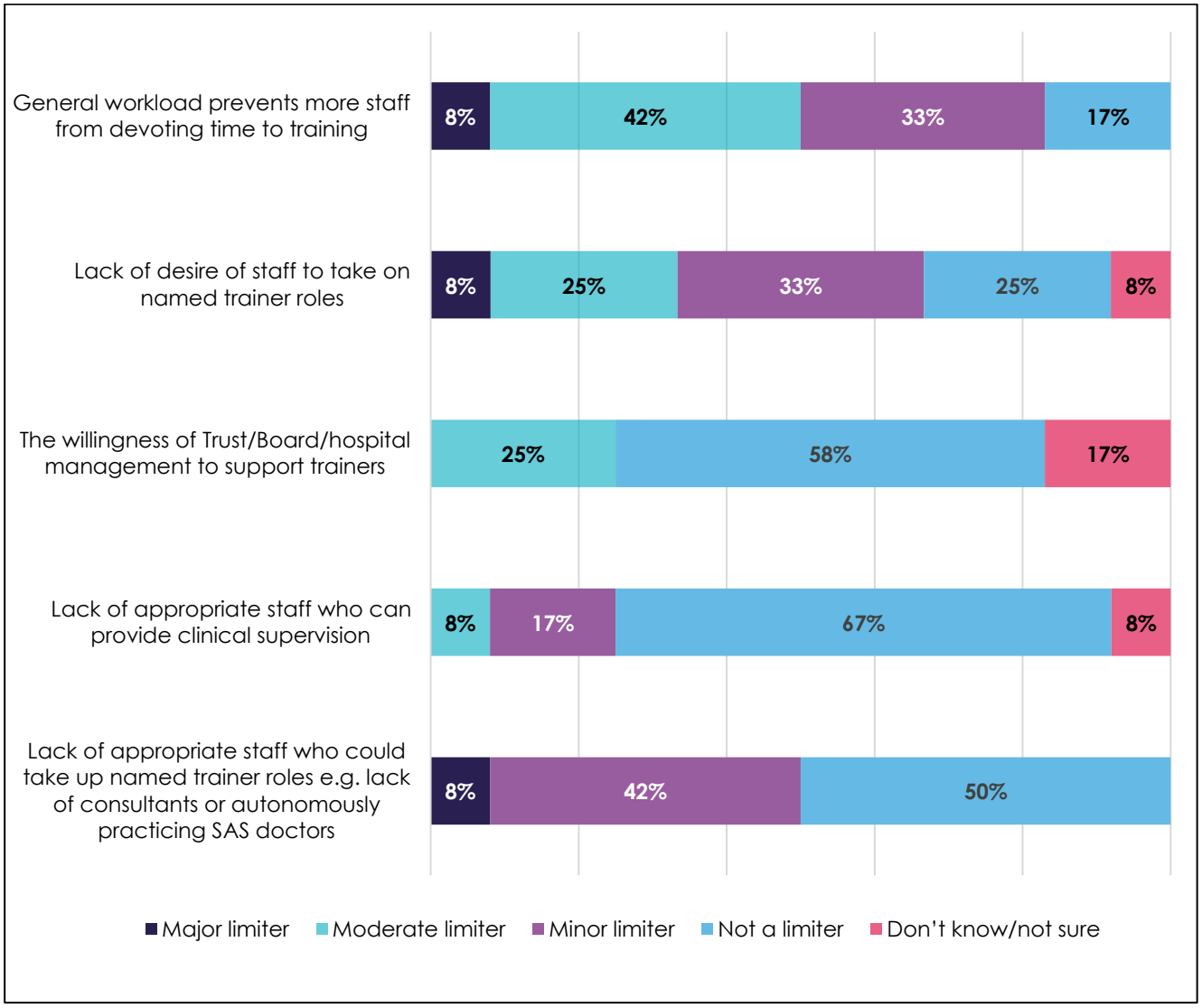
Figure 65 – To what extent do the following factors limit your anaesthetic staff's capacity to provide training and supervision? – Scotland
Base: 21 (College tutors in Scotland)



In Wales, general workload is the most commonly identified constraint, with 50% reporting it as a major or moderate limiter.

These findings, however, should be interpreted with caution due to the small number of responses.

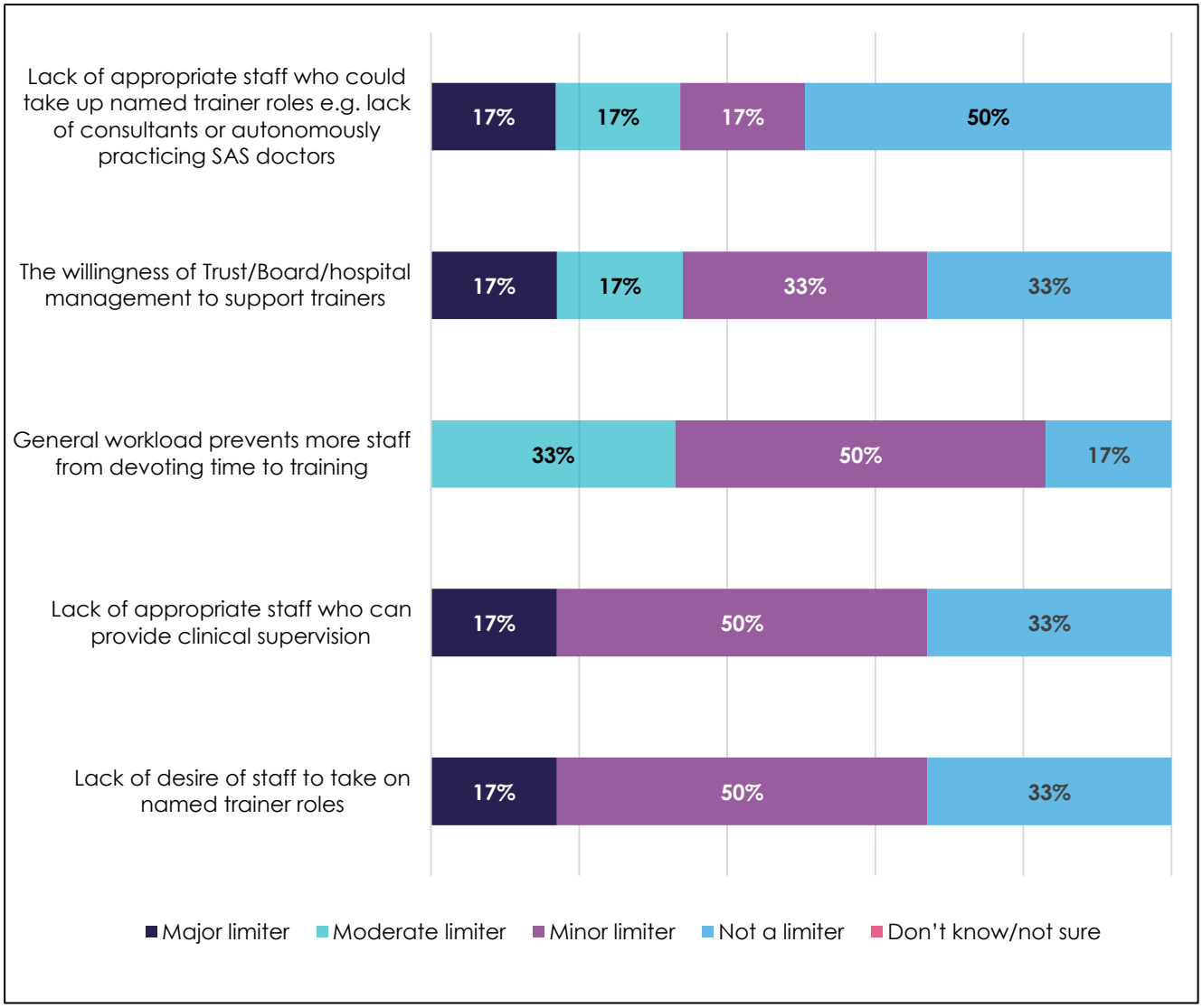
Figure 66 – To what extent do the following factors limit your anaesthetic staff's capacity to provide training and supervision? – Wales
Base: 12 (College tutors in Wales)



In Northern Ireland, several factors are reported at similar levels, with management support (34%), availability of staff to take up named trainer roles (34%,) and general workload (33%), all identified as major or moderate limiters.

These findings, however, should be interpreted with caution due to the very small number of responses.

Figure 67 – To what extent do the following factors limit your anaesthetic staff's capacity to provide training and supervision? – Northern Ireland
Base: 6 (College tutors in Northern Ireland)



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