Royal College of Anaesthetists

The Anaesthetic Workforce: UK State of the Nation Report

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Contents

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Executive summary

1. Anaesthetists are vital for the NHS and Government health plans

- Anaesthetists are the single largest group of hospital doctors, with around 19,000 in post in the NHS.
- They provide essential care in a range of health settings, such as operating theatres, maternity wards, intensive care units, and pain services – including managing chronic pain conditions in the community.
- Anaesthetists are key to addressing the NHS waiting list crisis – and boosting NHS productivity – because most operations cannot take place without them.
- UK Governments have also proposed a series of 'shifts' that they want to see in health services, including 'from sickness to prevention', 'from hospital to community' and 'analogue to digital'.
- Anaesthetists are vital to delivering these shifts by identifying patients' health problems well before surgery, helping them make positive behavioural changes, minimising the time that they need to spend in hospital, and developing innovating digital tools to support the surgical journey.

2. Numbers of anaesthetists have grown, but not by enough

- Although numbers of non-training grade[†] anaesthetists in the UK rose from around 10,150 in 2020 to around 12,050 in 2025, demand has increased further.
- Numbers are 16% lower than what is needed, with a shortfall of around 2,250 anaesthetists across the UK.
- The biggest part of the shortfall is in consultants – the most senior grade of anaesthetist. The consultant shortfall is around 1,640 or 73% of the total shortfall.

3. Anaesthetic workforce shortages severely impact NHS performance

- Of clinical leaders, 88% report surgery being postponed due to a lack of anaesthetists, with 43% reporting this happening on a daily or weekly basis.
- Long waiting lists for surgery are bad for patients – 31% reported a decline in their mental health while waiting, and 36% reported a decline in physical health.
- Long waiting times are associated with the following: additional use of healthcare services; increased likelihood that patients will seek financial compensation; and a greater risk that patients' health deteriorates to the point that they can no longer work. These issues are expensive for the NHS and the economy.
- 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 followed by 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%).
- Addressing the current anaesthetic workforce shortages could enable up to 1.5 million extra operations and procedures per year.
- Anaesthetist shortages also have impacts on women's access to pain relief during childbirth, pandemic preparedness, and increased use of expensive external/agency locums.

† Non-training grade, in this context, applies to consultant and specialty, associate specialist and specialist (SAS) doctors. It excludes anaesthetists in training (AiTs) and locally employed doctors (LEDs)

4. Anaesthetic workforce shortages are driven by a lack of funded training places

- The UK-wide anaesthetic workforce shortfall has been worsening by an average of 155 anaesthetists per year.
- The first logical step to address this is to train more.
- In the UK, the training pathway for doctors involves completing 5 years of medical school, then 2 years of general NHS foundation training and, after that, doctors specialise. Specialty anaesthetics training involves 'core' and 'higher' levels – progression through both is required to be a consultant anaesthetist.
- Unfortunately, there are huge bottlenecks in the medical training system: in 2025 there were 6,770 applicants for just 539 core anaesthetics training places.
- As of 2025, NHS hospitals across the UK had the capacity to take on around 380 extra training posts per year, including around 180 at core level and around 200 at higher level.
- If the aforementioned posts were fully funded and filled, the workforce shortfall would finally start to close.
- In England, 312 extra posts should be created, including around 145 at core (CT1) level and 167 at higher (ST4) level.
- The funding arrangements behind these posts must be sufficiently generous to enable and incentivise NHS trusts to take them on.
- In Scotland, 24 extra posts should be created, 12 at core level and 12 at higher level.
- Scottish funding rules for AiTs must be reformed to allow departments to reinvest unused funds – such as when AiTs reduce their hours – into creating additional anaesthetic training posts.
- In Wales, six extra training posts should be created – with precise allocation between levels to be determined.
- In Northern Ireland, eight extra posts should be created, including four at core level and four at higher level.

5. Retention of existing staff is essential

- Almost one in five anaesthetic staff (19%) expects to leave the NHS in the next 5 years.
- Boosting retention involves a number of factors, including engaging with doctors constructively on pay issues and addressing ongoing issues with the current pension taxation regime.

6. Open and transparent workforce planning is urgently required

- There has been no open and transparent modelling of the current and future needs of the NHS workforce for around a decade – and the last modelling that took place for anaesthesia specifically was in 2015. UK Governments need to urgently commission and publish such work.
- UK Governments should work collaboratively with the RCoA to make this happen, as recommended by the Leng Review. This involves utilising our extensive workforce data on headcounts, shortfalls, and training capacity.

7. Workforce wellbeing needs to be improved

- The wellbeing of the anaesthetic workforce is lower than that of the average UK population.
- Of anaesthetists, 56% report being at least 'somewhat' burnt out.
- This is bad for the staff affected and bad for the system. Each year, 184,000 working hours are lost due to sick leave related to stress, burnout, anxiety, or depression – preventing up to 60,000 operations and procedures from taking place.
- The biggest sources of dissatisfaction in the working lives of anaesthetic staff revealed by survey work are poor IT systems and current pension taxation rules.
- Other key sources of dissatisfaction are hospital staff parking charges, and a lack of rest and refreshment facilities. Cancellation of lists is also cited as a major source of frustration.
- All these issues can and should be addressed.

8. SAS doctors and LEDs need better support

Anaesthetists on specialty, associate specialist and specialist (SAS) contract (LED) contracts are growing in number and face unique challenges in their working lives.

SAS doctors

- Lack of opportunity for career progression is the single biggest source of dissatisfaction in SAS doctors' working lives, cited by 55% of SAS doctors.
- Within SAS categories, specialty doctors who meet the criteria for the more senior specialist contract must be allowed to progress to it.
- Lack of fair treatment is a concern for 28% of SAS doctors.
- Greater use of SAS advocates, including SAS staff in clinical governance meetings and providing sufficient 'supporting professional activities' (SPA) time, could help provide greater fairness.

LEDs

- LEDs have lower wellbeing and higher burnout than any other anaesthetic staff group.
- As with SAS doctors, desire for progression is high – only 5% want to remain in their posts indefinitely.
- The vast majority of LEDs (81%) work on fixed-term contracts. This gives this group of staff far less job security than other groups.
- To help rectify this, LEDs should be given assured transition to the specialty doctor contract after a maximum of 2 years in the role.

For both groups

- NHS trusts and boards should promote progression opportunities – and national Governments should expand training places (as per Chapter 4).

9. Anaesthetists drive NHS productivity, but are being held back

- **Optimising the surgical pathway**: anaesthetists are proven innovators and leaders when it comes to developing and embedding interventions that improve NHS productivity. These interventions can reduce the number of operations that need to be postponed, prevent surgical complications that keep patients in hospital for prolonged periods, and facilitate fast recovery. UK Governments must support these efforts.
- **IT systems**: unfortunately, NHS IT systems are often slow, waste time, and do not give clinicians quick and easy access to critical patient information. Of anaesthetic staff, 89% say that their productivity would increase if systems were improved.
- **Pension taxation**: of consultant and SAS anaesthetists, 26% report reducing their hours due to current pension taxation rules – which must be urgently reviewed. The current rules result in up to 1.5 million hours of lost clinical anaesthetic time per year, which could allow up to 460,000 extra patients to be seen.

10. Action is needed now

- The anaesthetic workforce gap needs to be urgently addressed.
- This involves increasing training places and retaining existing staff.
- Retention involves tackling pay issues and the pension taxation rules, and supporting progression opportunities.
- Open and transparent workforce modelling is needed for evidence-based assessment for future workforce needs.
- Better support for the wellbeing of the anaesthetic workforce also helps improve retention and reduces time off due to stress, anxiety, burnout or depression.
- SAS doctors and LEDs need improved progression opportunities.
- Anaesthetists' efforts to optimise the surgical pathway need support, promotion and investment.
- IT systems need improving.

Foreword

Our *State of the Nation* report sets out just how vital anaesthetists are to UK health services and the patients they serve. It is written for elected representatives, civil servants, and NHS leaders, with practical, achievable recommendations to reduce waiting lists and improve patient care.

Anaesthetists are the largest single group of hospital doctors, working across the full surgical pathway from preoperative assessment through to recovery and discharge. This gives them a unique, system-wide perspective on how health services are functioning across England, Scotland, Wales and Northern Ireland.

They are highly trained to safely deliver anaesthetic, pain relief, resuscitation, pre-operative assessment, and other interventions to the ever-more complex patients the NHS has to treat, adapting to fast-moving and ever-changing environments

Unfortunately, anaesthetic workforce shortages are chronic.

The central message of this report is clear. Despite moderate growth, anaesthetist numbers remain too low to meet rising demand in hospitals across the UK. The shortfall restricts surgical capacity, contributes to long waiting lists and limits the NHS's ability to deliver its own ambitions for productivity and reform.

The solution is sustained investment in anaesthetists, from more funded training places to better retention and support of our existing workforce. This would give the NHS the skilled, senior doctors it needs to make life-or-death clinical decisions, deal with growing numbers of patients with challenging issues, and work across the full range of cases where anaesthesia or pain relief is needed.

The evidence we present comes from our members: thousands of hard-working anaesthetists, who took the time to share their experiences with us. You have made this report possible. Thank you.

Now, we'll tell those in power what you have told us.

Dr Claire Shannon
President, Royal College of Anaesthetists

1. Anaesthetists are vital for the NHS and Government health plans

Key messages

- Anaesthetists are the single largest group of hospital doctors, with around 19,000 in post in the NHS.
- They provide essential care to patients in a range of health settings, such as operating theatres, maternity wards, intensive care units, and pain services – including managing chronic pain conditions in the community.
- Anaesthetists are key to addressing the NHS waiting list crisis – and boosting NHS productivity – because most operations cannot take place without them.
- UK Governments have also proposed a series of 'shifts' that they want to see in health services, including 'from sickness to prevention', 'from hospital to community', and 'analogue to digital'.
- Anaesthetists are vital to delivering these shifts by identifying patients' health problems well before surgery, helping them make positive behavioural changes, minimising the time that they need to spend in hospital and developing innovative digital tools to support the surgical journey.

Introduction

UK health services cannot function without anaesthetists – and, with just under 20,000 in post, they are the single largest group of hospital doctors working in the NHS.‡

Most operations require anaesthetists and, without them, surgical wating lists would simply grind to a halt. In maternity services, if it were not for anaesthetists, women would not get epidurals or receive an anaesthetic during caesarean sections. For those suffering with chronic pain in the community, an absence of anaesthetists would mean an absence of high-quality pain relief. As such, anaesthetists are vital to ensuring that health services can deliver safe, timely and effective patient care

However, the direct provision of anaesthesia and pain relief is not all that anaesthetists do – they often work across the surgical pathway. Their role includes: screening patients ahead of operations; manging the support that they need to prepare for surgery; ensuring swift post-surgical recovery; and helping to properly plan for patients' discharge. In these roles, anaesthetists keep health services functioning smoothly and efficiently.

Sadly, as shown in Chapter 2, UK health services suffer from a shortfall of around 2,250 anaesthetists (16% below what is needed). Primarily, this shortfall has been precipitated by the failure of successive Governments to fund sufficient anaesthetic training places.

Waiting lists

Waiting lists remain at near-record levels, at 7.1 million in England[1], 570,000 in Scotland,[2] 530,000 in Wales,[3] and 440,000 in Northern Ireland.[4] Many of those waiting are waiting for a surgical procedure.

If surgical waiting lists are to be tackled, it is vital that hospitals increase the number of operations that they perform – and doing this requires more trained anaesthetists.

The potential gains from increased anaesthetist numbers are huge. As we show later in Chapter 3, we estimate that current anaesthetic workforce shortages could be preventing up to 1.5 million operations and procedures per year.

‡ The figure cited here is from our own workforce census work. A full breakdown is set out in Chapter 4. However, comparative figures are provided by bodies such as NHS England. These figures may differ slightly from our own, due to them being England only, and based on slightly different definitions and time frames of data collection. Also, NHS England's figures are based on full-time equivalent (FTE) levels compared with our own headcount figures.

Government plans

Since the last iteration of this report in 2024, the Westminster Government has published its 10 Year Health Plan for England.[5] This sets a target for 2% year-on-year productivity improvements. It also sets out three shifts that it wants to see in the NHS: sickness to prevention, hospital to community, and analogue to digital. Plans with similar themes have also been published in the devolved nations. This includes 'The Health and Social Care Service Renewal Framework' in Scotland,[6] 'A Healthier Wales: Long term plan for health and social care',[7] and the 'Health and Social Care NI – Three year plan' in Northern Ireland.[8]

Anaesthetists are critical to the delivery of these plans. With regard to productivity, sufficient numbers of anaesthetists are essential for ensuring that operations can go ahead and the efficient running of the health service.

In terms of sickness to prevention: early screening and optimisation services embedded in the surgical pathway are typically led by anaesthetists. These detect health issues, support patients to manage them, and help promote long-term behavioural change.

To support the hospital-to-community shift, anaesthetists work on enhancing recovery services and facilitating discharge that minimise the time that patients need to spend in hospital, and ensure a rapid return to the community. Also, many anaesthetists are already embedded in the community delivering chronic pain services.

With regard to analogue to digital, anaesthetists are often at the forefront of developing and implementing digital tools to ensure information sharing within the health system – such as a recently developed system for identifying and addressing patient risks at Guy's and St Thomas's. Details of all of these interventions are set out in Chapter 9.

Progress on training numbers by nation

The most logical starting place to increase anaesthetist numbers is to train more. Training to the level of a consultant in the UK typically involves five years at medical school, two years of general NHS foundation training, followed by training in a specialty area such as anaesthesia. Anaesthetics training is further subdivided into 'core' (or 'stage 1') level, which typically takes 3 years, and 'higher' (or 'stage 2 and 3') levels, which typically take 4 years in total.

Progress on anaesthetic training numbers has varied by UK nation. In Scotland, 15 new higher posts were created in anaesthetics in 2022–23, followed by a further 6 in 2023–24 – giving a total of 21 extra higher posts since 2022. The RCoA has called for recurring funding for an additional 12 core posts and 12 higher posts in its recent Scottish Manifesto.[9]

In Wales, the last uplift in anaesthetic training places occurred in 2023, when six new higher places were created. A further six posts were requested for August 2026; however, due to the absence of additional Government funding for specialty training, these posts were not granted.

In Northern Ireland, one new recurrent anaesthetic training post was created in 2025, alongside seven non-recurrent training posts funded by the Strategic Planning and Performance Group (these posts are funded all the way from core to higher). Plans are also in place to introduce a further four posts in 2026 (one core and three higher). Over and above this, The RCoA is calling for a further four core posts and four higher posts.

In England, 70 extra higher anaesthetic training places were granted annually from 2022, which was an important step forward. Unfortunately, since then, further progress was promised, but has not yet been delivered.

In the 10 Year Health Plan for England published in 2025,[5] 1,000 extra training places were announced across all medical specialties. In February 2026, we heard that 200 of these would be allocated to anaesthesia, mainly at core level – the first stage of anaesthetics training. Unfortunately, these proposed posts were not backed with sufficient funding, then, in April 2026, the offer was withdrawn.[10] This constitutes a heavy blow for the NHS in England and the patients whom it serves.

The Government linked the withdrawal of the extra posts to ongoing industrial action among resident doctors.[10] It also occurred in the context that the Government appeared to be struggling to get NHS trusts to take on the proposed posts, because the funding offer behind them was insufficient.

It is vital that the pledge of these extra posts be resurrected as soon as possible – and that the funding offer behind them is sufficient to turn them into reality.

This report

Given these issues, we have written this report to provide policy-makers with the key summary information that they need to understand the current state of the anaesthetic workforce, the challenges that it faces, the consequences for the NHS and how those challenges can be addressed.

Where the data come from

Most of the figures cited in this report come from the RCoA's Anaesthetic Workforce Census 2025, which was conducted by the RCoA and Enventure Research. This involved three surveys which went to different groups:

1. A survey of **clinical leaders** in anaesthesia. Clinical leaders run anaesthetic departments and can provide insight into: the numbers of consultant, SAS and locally employed anaesthetists in their hospitals; the staffing shortfalls that their hospitals face; and levels of highest service pressure. A 97% response rate was achieved across all NHS trusts and boards in the UK, providing a high level of confidence in the data. Small corrections have been made to account for the missing 3% of the data.
2. A survey of **college tutors**. College tutors lead on the education and training of new anaesthetists and provided detailed information on the number of anaesthetists in training and an assessment of spare training capacity. A response rate covering 100% of NHS hospitals where anaesthetic training takes place was achieved, providing a very high level of confidence in the data.
3. A survey of the **wider anaesthetic workforce**, which went 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. This survey received 2,797 complete responses, constituting a 15% response of the population to whom it was sent.

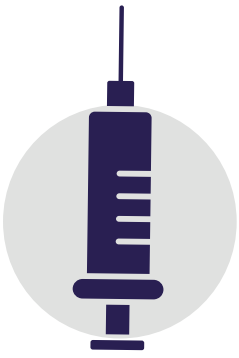
In a few places in this report, external data are used, such as those from the Office for National Statistics (ONS), the General Medical Council (GMC), and academic publications. In such cases, the source of the data will be clearly attributed. We also reference some statistics that will be more fully set out in an impending report that we intend to publish shortly on patients' experience of the waiting list.

Anaesthetists' role in direct clinical care

Anaesthetists undertake a wide range of hospital duties.

General and specialty surgery

The most fundamental role of the anaesthetist is to deliver safe anaesthesia and effective pain relief during operations – a complex and finely balanced task. They assess patients before surgery, considering the effects of both the procedure and the anaesthetic, as well as each patient's individual health, existing condition, and medications.



During surgery, the anaesthetist keeps the patient stable and safe. They continuously monitor vital signs – breathing, heart rate, blood pressure, and oxygen levels – and respond immediately to any changes. When needed, they support vital functions such as breathing, assist in managing blood loss, and help ensure timely delivery of treatments like antibiotics to reduce the risk of infection.

After the surgery, they provide additional pain relief and manage the immediate postoperative complications of general anaesthesia.

Intensive care

Anaesthetists frequently work in intensive care settings alongside others, including intensivists (doctors who specialise in intensive care medicine). In this environment, they care for patients who are critically ill, often after major surgery or severe illness.

Their role involves the provision of multi-organ support, which often includes managing breathing through advanced airway management and mechanical ventilation, supporting heart function and blood pressure with medications, and carefully controlling fluid levels and electrolytes in the body. They continuously monitor patients and make rapid, informed decisions to prevent complications such as lung failure, heart problems, or kidney injury.

In addition, they are central to effective pain management strategies and facilitate early mobilisation, which is essential in reducing the risk of complications of clots in the legs.

Maternity units

In maternity services, anaesthetists work around the clock alongside other healthcare professionals such as midwives and obstetricians. Most women giving birth on maternity wards require some kind of anaesthetic input[11] – this includes providing pain relief for women going through childbirth by inserting an epidural and providing anaesthesia for caesarean sections, which are now the mode of delivery for 45% of births.

Anaesthetists are present before, during, and after the birth. They are team leaders if complications in childbirth occur, such as haemorrhage or the need for resuscitation, ensuring the best outcomes for both mother and baby. They also deliver postoperative pain relief to help women have a smooth, comfortable recovery.

Pain services

All anaesthetists diagnose and manage pain conditions to a degree, including treating pain after surgery. Some anaesthetists specialise in pain medicine in particular. This involves diagnosing and managing complex or chronic pain, such as treating pain resulting from cancer or cancer treatment, joint pain, or neuropathic pain.

To do this they have a thorough grounding in the complex biology of pain, knowing how pain medicines may affect the body and delivering targeted treatments for certain conditions, such as pain-relief injections.

Some pain services are located in hospitals, but others are based in community settings.

Perioperative care

Anaesthetists take a leading role in delivering and managing 'perioperative care'. This refers to all the care that patients receive before and after their operation, from the moment that surgery is first considered through to complete recovery.

Examples include running early screening and optimisation services for surgical patients. These are important because many patients arrive for surgery in poor health due to either negative health behaviours, such as smoking or poor diet, or unmanaged comorbidities, such as anaemia or diabetes. If unaddressed, these factors increase the risk that an operation will have to be postponed or, if it does go ahead, raise the likelihood of surgical complications and poor recovery, leading to extended hospital stays and additional strain on services.

By screening patients for their health behaviours and comorbidities, and taking active steps to address any issues found, health services can run more efficiently, and patient outcomes can be improved.

Anaesthetists provide these interventions alongside other healthcare professionals, including surgeons, physicians, GPs, paediatricians, nurses, physiotherapists and more.

More information on this is provided in Chapter 9.

General support across the hospital

Anaesthetists are needed throughout the hospital to look after very sick patients, including in cases where their blood pressure drops, their oxygen saturation falls or they can't breathe. Their expertise in helping patients breathe and life support makes them indispensable in such situations – and means that they are among the first called to hospital emergencies such as cardiac arrests.

Other clinical roles

Anaesthetists also work in other areas, such as psychiatry, out-of-hospital and emergency care, gastroenterology, radiology, dentistry and much more.

Anaesthetists' wider roles

Anaesthetists also have wider duties supporting hospital functioning and include the following.

Training and supervision

Anaesthetists play a key role in educating, training and supervising the next generation of the workforce. This includes medical students and anaesthetists in training (AiTs) – but also others, including nurses, midwives, and paramedics in matters related to anaesthesia.

Anaesthetists also train and educate a variety of healthcare staff across the hospital to ensure that they recognise when to call an anaesthetist, for example, when resuscitation is needed.

Examinations

Senior anaesthetists may take on roles as examiners, where they assess AiTs undertaking postgraduate examinations. Their role is to ensure that candidates meet the required standards of knowledge, clinical reasoning, professionalism, and patient safety expected of an anaesthetist at that stage of training.

Governance and leadership

Many anaesthetists take on leadership roles in hospitals. This can be within anaesthetic departments such as roles of 'clinical lead' and 'clinical director', who manage anaesthetic teams. Some hold even more senior positions, such as 'medical director' roles. Medical directors in England, for example, sit on the boards of NHS trusts as an executive director and provide strategic, professional, and operational leadership for all medical staff.

More generally, anaesthetists are involved in ensuring that clinical guidelines are produced, updated, and maintained to support safe and high-quality patient care.

Research

Anaesthetists of all grades are involved in educational quality improvement and lead academic projects. Many AiTs pursue research qualifications and can achieve recognition in their field even before completing their training.

Types of anaesthetic staff

Anaesthetists in training (AiTs)

AiTs are anaesthetists who are currently being trained as part of defined national training programmes and are employed on nationally agreed contracts. They benefit from a defined curriculum, clear funding streams, educational supervision, and structured exams.

AiTs are already doctors and part of a group known as 'resident doctors', which also includes those training in other areas, such as surgery or general practice.

Before these doctors even start anaesthetics training, they already have considerable medical experience under their belt. This includes having completed an undergraduate medical degree (a 'primary medical qualification' [PMQ]), which typically takes 5 years if completed in the UK, and then NHS foundation training, which typically takes a further 2 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 in what area of medicine they may wish to specialise.

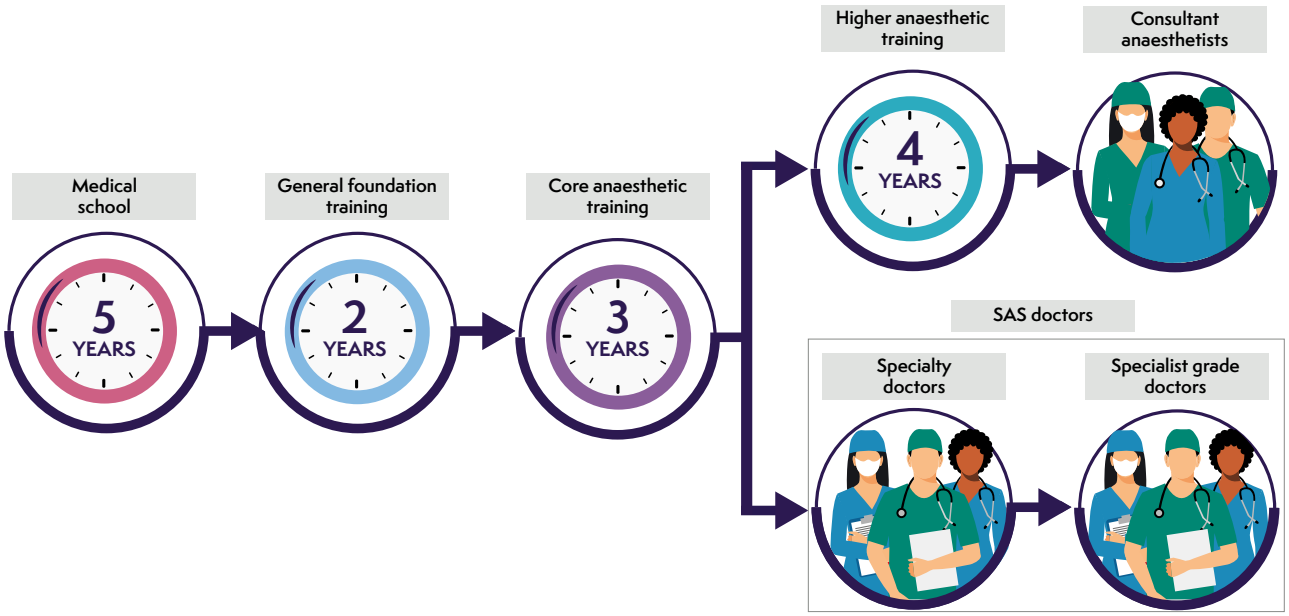
Anaesthetics training pathways

Those who wish to specialise in anaesthesia then apply to one of the follow pathways:

The standard anaesthetic training pathway. This comprises three stages. 'Core' or 'stage 1' anaesthetics training usually lasts 3 years (years CT1, CT2 and CT3). On completion of core training, a doctor may apply to become an SAS doctor – initially on the 'specialty' contract.

However, most wish to continue their training. If they successfully apply, they can progress to 'higher' training, which usually lasts ≥4 years. This is subdivided into 'stage 2', which usually lasts 2 years (years ST4 and ST5), followed by 'stage 3', which lasts ≥2 years (ST6–ST7+).

Most in these posts will be doing 'single programme' training in anaesthesia. However, at higher levels, there are also some who are in a 'dual programme' post, which involves studying an additional specialty, such as intensive care medicine.



Acute care common stem (ACCS) anaesthesia. As an alternative to the standard pathway, post-foundation doctors may enter the ACCS scheme. This is a 4-year programme where resident doctors rotate around a number of acute specialties for the first 2 years – emergency medicine, intensive care medicine and anaesthetics – before specialising. If they choose to specialise in anaesthetics, they will then complete 2 years of specialty training (equivalent to core training) in anaesthetics before applying for higher training (ST4) places.

Other AiTs. There are also other categories of AiT, such as those participating in the Medical Training Initiative (MTI) scheme. The MTI scheme permitted doctors who gained their primary medical qualification from a low- or middle-income country to train within the NHS for up to 2 years. Although a number of doctors remain on this scheme, the Government closed it to new applicants at the end of March 2026. Another category of AiTs is those on the RCoA Global Fellowship Scheme. This provides an opportunity for anaesthetists, intensivists and pain medicine doctors who work and train in high-income countries to undertake a period of subspecialty training within the NHS.

Clinical contribution

It is important to note that AiTs do not just learn; they also provide direct clinical care to patients during normal working hours and, after their assessment of competence at 3–6 months, cover night-time or weekend shifts under the supervision of an on-call consultant or autonomously practising SAS doctor.

Locally employed doctors (LEDs)

LEDs are employed on locally agreed contracts rather than nationally agreed contracts like AiTs, SAS doctors and consultants. LEDs also vary considerably in their levels of prior experience and work at a range of levels. Their contracts, by their very nature, are hugely varied, as are their job titles – although 'clinical fellow' is a common term.

LEDs can be roughly subdivided by their prior level of training:

Post-foundation doctors: these have finished foundation training but have either been unsuccessful at applying for a core training post or, in some cases, do not wish to start one. That may be because either they wish to gain experience before applying or their particular contract suits their current life circumstances, wishes and interests.

Post-core doctors: these have, as a minimum, finished core anaesthetics training (or international equivalent) but have been unsuccessful at applying for a higher training post or a specialty doctor post – or, in some cases, do not wish to start either. Again, this may be because either they wish to gain experience before applying or their particular contract suits their current life circumstances, wishes and interests.

Post-CCT fellows: these have finished higher training and are qualified to take up a role as a consultant but either wish to engage in a particular area of further study or, in some cases, find that there is no vacant consultant post due to recruitment freezes.

LEDs often wish to progress to more senior anaesthetic grades, but find themselves stuck in system bottlenecks, unable to secure the training or a consultant post that they wish to obtain. They are often heavily involved in direct service provision.

SAS doctors

Many doctors work on SAS (specialty, associate specialist and specialist) contracts.

These doctors have completed core anaesthetics training (or international equivalent) but will usually not have completed higher training. Nevertheless, they may have years of experience working as an anaesthetist. Some doctors prefer to work on SAS contracts because they may offer better work–life balance than consultant roles, whereas others find themselves in such roles through circumstances.

SAS doctors can work autonomously or non-autonomously. Non-autonomous SAS doctors require some level of supervision from senior colleagues. Autonomous SAS doctors work independently, manage patients without supervision, and sometimes supervise other doctors. This can involve working at levels similar to a consultant.

There are different grades of SAS doctor:

Specialty doctors. These have completed medical school, foundation training and core anaesthetics training – or their international equivalents. More junior specialty doctors work under supervision, although after years of experience they may become autonomously practising.

Specialist doctors. This is a relatively new senior SAS grade introduced in 2021. Anaesthetists wishing to work on the specialist contract must have at least 12 years of medical experience since obtaining a primary medical qualification, including at least 6 years in anaesthetics. Autonomous practice is an intrinsic part of the specialist doctor's role.

Associate specialist. This is an historic senior SAS grade which closed to new entrants in 2008; however, many are still working on this contract.

Consultant anaesthetists

Consultant anaesthetists are the most senior grade of anaesthetist. They have usually completed at least 14 years of medical training, including 7 years of specialist training in anaesthetics, before starting their role.

Consultants are critically important because they provide senior level decision-making and can work across all levels of cases, including extremely complex cases that other grades of anaesthetist may be unable to manage.

A key part of their role is supervising others. When AiTs, non-autonomous SAS doctors, LEDs or PAAs work on cases, consultants are there to provide advice, training and guidance. If necessary, they also step in when problems occur.

In addition to clinical care, consultant anaesthetists often have managerial and educational duties and they have overall responsibility for a patient's anaesthetic care.

Physician assistants in anaesthesia (PAAs)

PAAs (formerly known as anaesthesia associates), introduced in 2004, are trained, skilled practitioners who work within the anaesthetic team under the supervision of a consultant or autonomously practising SAS doctor.

Unlike anaesthetists, PAAs are not doctors and their training is shorter and narrower. As a result, their scope of practice is more limited.[12]

All qualified PAAs undertake a 2-year postgraduate qualification, on top of background as either a registered healthcare professional or a graduate in biological or biomedical sciences. The role of the PAA is to assist with the overall service requirements of a department, as additional members of the team.

2. Numbers of anaesthetists have grown, but not by enough

Key messages

- Although numbers of non-training grade anaesthetists in the UK rose from around 10,150 in 2020 to around 12,050 in 2025, demand has increased further.
- Numbers are 16% lower than what is needed, with a shortfall of around 2,250 anaesthetists across the UK.
- The biggest part of the shortfall is in consultants – the most senior grade of anaesthetist. The consultant shortfall is around 1,640 or 73% of the total shortfall.

Staffing numbers

A key aspect of understanding the anaesthetic workforce is to quantify the numbers currently in post and how those numbers have changed over time. Across all grades of anaesthetist – including AiTs, LEDs, SAS doctors, and consultants – there are currently around 19,000 in post.

Consultants and SAS doctors

Between 2020 and 2025, there was moderate growth across non-training grades of anaesthetists, that is, the consultant and SAS workforce. The number of consultant anaesthetists rose from 8,489 to 9,858, an increase of 16%, and the number of SAS anaesthetists rose from 1,635 to 2,182, an increase of 33%. The combined total of consultants and SAS anaesthetists rose from 10,124 to 12,040, an increase of 19%.

Beneath the UK headline figures, there is national and regional variation. For example, Northern Ireland saw a decrease in consultant numbers, but an increase in SAS numbers, whereas the other three UK nations experienced either a small or moderate rise in both consultants and SAS doctors.

Figure 1: Consultant and SAS anaesthetist numbers by nation and region, 2020 and 2025

	Consultants			SAS doctors			Combined numbers		
	2020	**2025**	**% change**	**2020**	**2025**	**% change**	**2020**	**2025**	**% change**
East of England	616	735	19	140	238	70	756	973	29
West Midlands	739	850	15	124	161	30	863	1,011	17
South East	707	992	40	175	274	57	882	1,266	44
North East	445	492	11	71	75	6	516	567	10
South West	957	1,106	16	209	254	22	1,166	1,360	17
Yorkshire and the Humber	682	810	19	124	195	57	806	1,005	25
London	1,382	1,526	10	163	243	49	1,545	1,769	15
East Midlands	517	661	28	136	217	60	653	878	35
North West	1,022	1,198	17	228	262	15	1,250	1,460	17
Northern Ireland	275	253	-8	40	45	13	315	298	-5
Scotland	714	808	13	92	92	0	806	900	12
Wales	433	465	7	133	148	11	566	613	8
England	7,067	8,332	18	1,370	1,897	38	8,437	10,229	21
UK	8,489	9,858	16	1,635	2,182	33	10,124	12,040	19

LEDs

The use of LEDs across the UK varies in each nation. In England, for example, there are 2,127 LEDs across the country, compared with only 49 in Scotland, where these kinds of contracts are not frequently used.

Figure 2: LED numbers by nation and region, 2025

	Number of LEDs
East of England	197
West Midlands	265
South East	336
North East	69
South West	77
Yorkshire and the Humber	107
London	608
East Midlands	141
North West	294
Northern Ireland	16
Scotland	47
Wales	114
England	2,096
UK	2,272

Note: the figures for the regions in England don't add up to the final England figure due to rounding.

Although full historic data for LEDs are unavailable due to differences in data collection methods between censuses, their numbers have almost certainly risen in recent years. This is probably due to bottlenecks in the medical training system (see Chapter 4) which prevent many anaesthetists from progressing through traditional training routes.

AiTs

Between 2020 and 2025, the headcount of AiTs across the UK rose from 4,479 to 4,923, an increase of 11%. However, this headline figure hides dramatic variation across national levels. In Northern Ireland and Wales for example, there was a decrease in the overall number of AiTs.

Also, large numbers of AiTs now work less than full time. This means that rises in headcount do not necessarily translate to large increases in whole-time equivalent (WTE) posts.

Figure 3: Number of AiTs across the UK, 2020 and 2025

	Northern Ireland	Scotland	Wales	England	UK
Core (stage 1)					
2020	39	99	97	737	972
2025	52	145	79	1,054	1,330
Higher (stages 2 and 3)					
2020	97	257	144	2,064	2,562
2025	77	280	156	2,207	2,720
ACCS anaesthesia					
2020	3	26	18	328	375
2025	5	41	45	642	733

Continued	Northern Ireland	Scotland	Wales	England	UK
Other AiTs					
2020	0	16	13	139	168
2025	3	19	2	116	140
Total AiTs					
2020	147	417	297	3,618	4,479
2025	137	485	282	4,019	4,923

Note 1*: there is a greater number of higher AiTs than core AiTs because higher training is slightly longer and a greater proportion of higher AiTs work less than full time, resulting in more individuals in the system*

Note 2*: the structure of the training curriculum has changed between 2020 and 2025. In 2020, AiTs completed 2 years of core training followed by 5 years of higher training. This has now shifted to 3 years of core training (referred to as stage 1) and 4 years of higher training (split into stages 2 and 3). Therefore, the real percentage change in the number of higher AiTs could be greater than is shown in these figures.*

PAAs

The number of qualified physicians' assistants in anaesthesia (PAAs) has increased modestly, from 182 in 2023 to 242 in 2025. However, the number of student PAAs has decreased considerably from 114 in 2023 to just 28 in 2025 and 3 in 2026 – all of whom were in the second year and nearing the end of their training. There are no PAAs in their first year of training.

Figure 4: Number of qualified PAAs, 2023 and 2025

Qualified PAAs			
	2023	**2025**	**% change**
Northern Ireland	3	2	-33
Scotland	15	31	107
Wales	12	10	-17
England	152	199	31
UK	182	242	33

Figure 5: Number of student PAAs, 2023-2026

Student PAAs		
2023	**2025**	**2026**
114	28	3

These changes occurred in the context of a motion about PAA recruitment passed at an Extraordinary General Meeting (EGM) of the College in October 2023.[13] In response to this, in February 2024, the RCoA wrote to clinical leaders to request a pause in the recruitment of new student PAAs.[14]

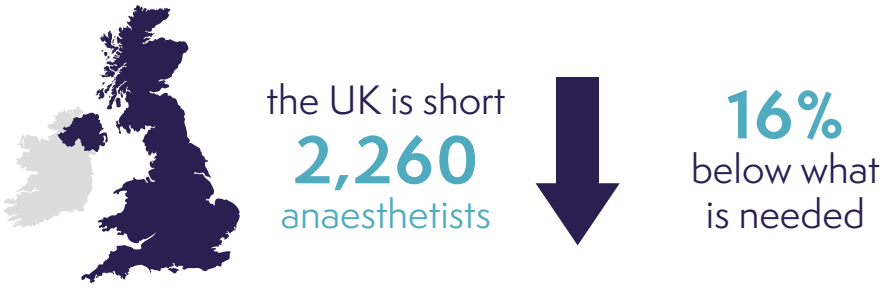
In February 2026, the RCoA wrote to clinical leaders again to recommend that they 'resume autonomy' for decision-making.[15] However, it also added: '... the College does not support, and sees no justification for, rapid expansion of the role. Any future requirement for PAA training posts should be determined locally, based on a Clinical Leader's intention to employ PAAs after training and in line with the Scope of Practice'.[15]

Shortfalls

As we have seen in this chapter so far, the anaesthetic workforce has grown – including that of non-training grades (consultant and SAS anaesthetists). Unfortunately, the numbers are still way below what are needed.

As part of the census, clinical leaders were asked to estimate how many additional anaesthetists (if any) their hospitals needed to meet the levels of demand that they were facing. These figures show a UK-wide shortfall of around 2,260, 16% below what is needed. This is a dramatic rise from 2020, where the gap was around 1,480.

The current shortfall breaks down as around 1,640 consultant anaesthetists (73%) of the total – suggesting a high demand for senior staff – and around 620 SAS doctors.



Looking at the numbers in the table below, we see some variation in the gaps across regions and nations; however, the central message is that, in every area of the UK, there is a shortfall of both consultant and SAS anaesthetic doctors.

Figure 6: Consultant and SAS doctor shortfalls, 2025

	Consultant gaps		SAS doctor gaps		Combined numbers	
	2025	% lower than what is needed	2025	% lower than what is needed	2025	% lower than what is needed
East of England	205	22	60	20	265	21
West Midlands	151	15	56	26	207	17
South East	158	14	67	20	225	15
North East	37	7	15	17	52	8
South West	141	11	46	15	187	12
Yorkshire and the Humber	173	18	64	25	237	19
London	255	14	62	20	317	15
East Midlands	96	13	32	13	128	13
North West	183	13	82	24	265	15
Northern Ireland	44	15	25	36	69	19
Scotland	114	12	54	37	168	16
Wales	85	15	53	26	138	18
England	1,398	14	483	20	1,881	16
UK	1,641	14	615	22	2,256	16

Note: figures are subject to rounding, which may lead to small differences in totals.

Efforts must be made to fill these gaps if anaesthesia is to be put on a sustainable footing and the stated aims of UK Governments around reducing record-breaking elective backlogs are to be achieved. We discuss the consequences of the shortfall in Chapter 3, and the solutions in Chapters 4 and 5.

3. Anaesthetic workforce shortages severely impact NHS performance

Key messages

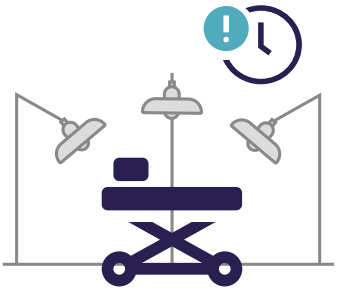
- Of clinical leaders, 88% report surgery being postponed due to lack of anaesthetists, with 43% reporting this happening on a daily or weekly basis.
- Long waiting lists for surgery are bad for patients – 31% reported a decline in their mental health while waiting, and 36% reported a decline in physical health.
- Long waiting times are associated with the following: additional use of healthcare services; increased likelihood that patients will seek financial compensation; and a greater risk that patients' health deteriorates to the point where they can no longer work. These issues are expensive for the NHS and the economy.
- 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 followed by 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%).
- Addressing the current anaesthetic workforce shortages could enable up to 1.5 million extra operations and procedures per year.
- Anaesthetist shortages also have impacts on women's access to pain relief during childbirth, pandemic preparedness, and increased use of expensive external/agency locums.

The consequences of anaesthetic workforce shortages are profound. Given that most operations cannot take place without an anaesthetist, any shortfall puts an intolerable restriction on the ability of the NHS to perform surgery and get waiting lists down.

In our census, 88% of clinical leaders reported that surgery was being postponed in their hospitals due to shortages of anaesthetists. Worryingly, 43% reported that this was occurring on a daily or weekly basis.

Quantifying this in a different way, if we take the shortfall that we noted in Chapter 6 of 2,256 anaesthetists, and multiply this by the average number of cases that an anaesthetist manages (680), we can calculate that up to 1.5 million operations and procedures are unable to take place each year due to the current anaesthetic workforce shortage.

1.5 million operations and procedures unable to take place due to anaesthetic workforce shortages



It is, of course, the case that anaesthetist shortages are not the only restraint on the NHS's capacity to perform surgery – so in our census we attempted to weigh these factors against each other.

We asked clinical leaders what factors would be the most important to increase to boost the rate of elective surgery. Increasing anaesthetist numbers emerged as the very top factor – identified by almost 7 in 10 (68%) clinical leaders. 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%).

Another key area impacted by anaesthetic workforce shortages is maternity care. Of clinical leaders, 53% reported that women in labour were sometimes delayed from getting pain relief due to lack of anaesthetists, with 11% reporting this happening on a daily or weekly basis.

Deterioration in physical and mental health of people on the waiting list

Long waiting lists are more than just worrying statistics on paper; each number represents a human story – one that may feature worry, pain, and deterioration, sometimes to the point of no longer being able to work. One way to illustrate this is by looking at the impact of delays on people's physical and mental health.

In summer 2025, we conducted a survey of surgical patients, which we will publish soon alongside the Centre for Perioperative Care (CPOC) in a further report. The results show that, among patients who have already had surgery, 31% reported that their mental health worsened while they were on waiting lists, and 36% reported that their physical health worsened.

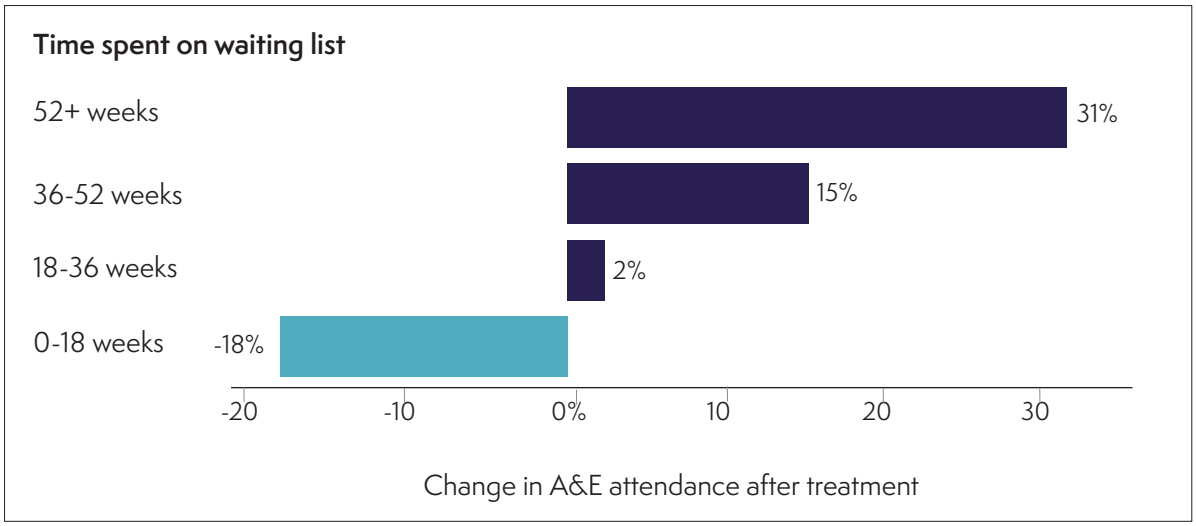
This is bad for individuals, bad for employers, and bad for the health service itself.

Increases in healthcare usage

Patients who have to endure long waits often require more healthcare support after their treatment than those who have shorter waits. Part of the explanation for this may be that patients' declining health leads them to have additional healthcare needs which may interfere with speedy recovery.

Analysis from the Health Foundation helps to illustrate this. They found that patients who were treated within the Government's 18-week target were far less likely to attend A&E in the months following their procedure compared with those who experienced longer waits.[16]

Figure 7: Change in weekly A&E attendances by time on waiting list (based on data from North West London)



A similar trend was also found in primary care. Patients who waited more than 36 weeks were more likely to require primary care services such as GP appointments after treatment.[16]

This suggests that prolonged waits may increase healthcare utilisation long term. This is probably bad for patients, expensive for the system, and consumes valuable hospital and GP time.

Compensation costs from delays in NHS care

Long waits are also costly for the NHS in terms of compensation claims and litigation related to delays in care.

Analysis of NHS Resolution data by the *Sunday Times* estimated that, since 2010, there have been almost 40,000 compensation claims for injury and deaths caused by delays in care, costing the NHS more than £8.3 billion.[16] This represents another drain on funding that could otherwise be used to improve services and strengthen patient care.

Since 2020 compensation claims have cost the NHS

£8.3 billion

Consequences for employment and the wider economy

Beyond the costs that long waiting lists impose on the NHS, there are also costs for employers and the wider public finances.

A 2025 economic analysis was conducted by the Office for National Statistics (ONS) and NHS England. This suggested that, if the Government were to meet the NHS standard of 92% of patients in England waiting no longer than 18 weeks for elective treatment, it would result in £2.7 billion additional cumulative pay by 2030–31. It also expected a cumulative gain to the Treasury of more than £1 billion.[17]

It does, however, note that these figures are probably underestimates and the true economic gains would be greater.

Pandemic preparedness

During the Covid-19 pandemic, anaesthetists treated huge numbers of patients. A key part of their contribution involved their redeployment from operating theatres to intensive care units (ICUs), also known as critical care units. In ICUs they utilised their skills to assist their intensivist (intensive care doctor) colleagues by, for example, ensuring that patients could breathe.

The importance of anaesthetists was acknowledged by the UK Covid-19 Inquiry , which noted in its 'Module 3' report that '... the UK entered the Covid-19 pandemic with a low number of hospital beds and high bed occupancy, as well as significant shortages of healthcare workers to care for the patients in those beds. This included intensive care (also referred to as critical care)'.[18]

It went on to say, 'Some healthcare workers, for example anaesthetists, had more easily transferable skills and so were better suited to assist patients needing critical care'.

However, 'Redeployment of staff bolstered the number of people working in critical care but at the expense of other areas of healthcare', in particular, 'The redeployment of anaesthetists and other operating theatre staff affected the restoration of elective surgery, cardiac care and maternity services.'[18]

Ultimately, the shortage of anaesthetists, combined with their transfer from operating theatres to ICUs, were key reasons why waiting lists for elective surgery shot up during the pandemic.

If we are to go into any future pandemic better prepared, then numbers of anaesthetists need to be increased so that ICUs can rapidly increase capacity and elective surgery can continue. This is on top of direct increases in ICU capacity, such as numbers of intensivists, critical care nurses, and bed numbers.

Locum use

Shortages in contracted staff can increase the need for expensive external/agency locums. Across the UK, clinical leaders reported 197 external/agency locum consultants and SAS doctors in anaesthesia at the time of the census.

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.

Overall

The shortage of anaesthetists is hindering progress towards addressing surgical waiting lists. In fact, based on data from clinical leads, the anaesthetic workforce shortage may be the single biggest factor at play. This has detrimental consequences for patients' physical and mental health, probably increases NHS costs, and impacts the wider economy.

Anaesthetist numbers also have consequences for maternity services, pandemic preparedness, and use of expensive external/agency locum staff.

Boosting anaesthetist numbers is, therefore, vital for patients, the NHS, and the country as a whole.

4. Anaesthetic workforce shortages are driven by a lack of funded training places

Key messages

- The UK-wide anaesthetic workforce shortfall has been worsening by an average amount of 155 anaesthetists per year.
- The first logical step to address this is to train more.
- In the UK, the training pathway for doctors involves completing 5 years of medical school, then 2 years of general NHS foundation training. After that doctors specialise. Specialty anaesthetics training involves 'core' and 'higher' levels – progression through both is required to be a consultant anaesthetist.
- Unfortunately, there are huge bottlenecks in the medical training system: in 2025 there were 6,770 applicants for just 539 core anaesthetics training places.
- As of 2025, NHS hospitals across the UK had the capacity to take on around 380 extra training posts per year, including around 180 at core level and 200 at higher level.
- If the aforementioned posts were fully funded and filled, the workforce shortfall would finally start to close.
- In England, 312 extra posts should be created, including around 145 at core level and 167 at higher level.
- The funding arrangements behind these posts must be sufficiently generous to enable and incentivise NHS trusts to take them on.
- In Scotland, 24 extra posts should be created, 12 at core level and 12 at higher level.
- Scottish funding rules for AiTs must be reformed to allow departments to reinvest unused funds – such as when AiTs reduce their hours – into creating additional anaesthetic training posts.
- In Wales, six extra training posts should be created – with precise allocation between levels to be determined.
- In Northern Ireland, eight extra posts should be created, including four at core level and four at higher level.

As set out in Chapter 2, the consultant and SAS anaesthetist workforce has grown from around 10,150 in 2020 to around 12,050 in 2025. This implies a net average yearly increase of around 380 anaesthetists. This net increase is a result of new entries to the workforce, which are discussed in this chapter, and exits from the workforce, discussed in Chapter 5.

Unfortunately, despite this growth, the anaesthetic workforce shortfall has also increased from around 1,480 in 2020 to 2,260 in 2025, implying a widening of the shortfall of around 155 per year. This means that, if the net increase in anaesthetists was boosted by 155 per year to 535, the current shortfall would stabilise. If the increases were beyond 155 per year, then the gap would actually start to close.

Doing this would put the NHS on a pathway to cutting waiting lists and providing patients with the high-quality anaesthetic services that they deserve. The greater the scale of the increase beyond 155, the faster this would happen.

The first logical step to address this is to train more.

National training programmes

Overall, the most common entry route into the anaesthetic workforce is via national training programmes. To recap from Chapter 1, medical training typically involves 5 years at medical school, 2 years of general NHS foundation training, followed by training in a specialty area such as 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 3 years (CT1, CT2 and CT3). As an alternative, there is also a 4-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–ST5) and stage 3 (years ST6–ST7+). These stages typically take 2 years each, or 4 years in total.

Throughout doctors' time on training programmes, they do not just train, they also make essential contributions to the NHS service. Examples include providing anaesthetic support during operations, epidurals to women in labour, and cover at night to deal with emergencies and admissions to critical care.

Training posts

Unfortunately, in terms of entry-level anaesthetics training posts (CT1 or ACCS), numbers have not increased but actually declined. In 2016, the numbers of available posts stood at 603 but declined by 64 to just 539 in 2025.[19] Entries to higher training, currently ST4 level but previously ST3 level, have increased from 374 in 2016 to 423 in 2025 – an increase of 49.[20]

Figure 8: Number of available CT1/ACCS and ST3/4 training posts available, 2016-2025

Year	CT1 anaesthesia/ACCS posts available	ST3–ST4 posts available
2016	603	374
2017	601	398
2018	581	392
2019	568	377
2020	569	353
2021	566	396
2022	558	N/A due to curriculum change
2023	545	399
2024	542	391
2025	539	423

Note: in 2022 the anaesthetics curriculum changed. Core training increased from 2 to 3 years; this means that an entry cohort to higher training was skipped.
N/A, not available.

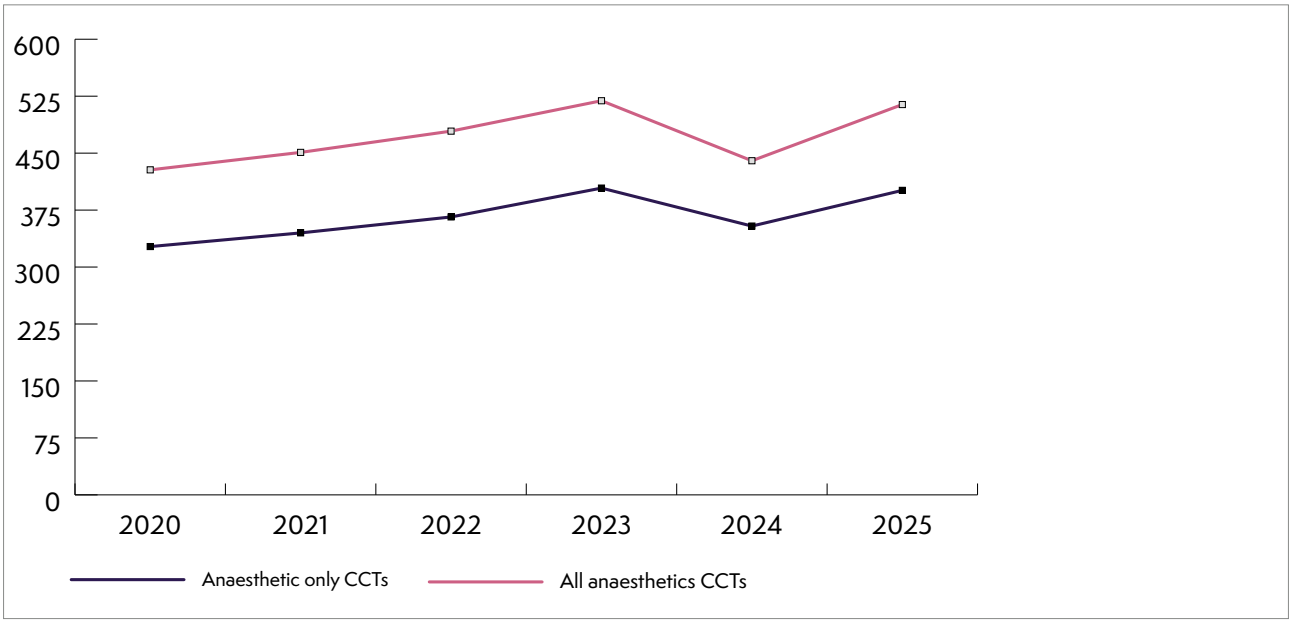
In addition to posts available to apply for, it is also useful to look at the number who gain their certificate of completion of training (CCT), which is received after successful completion of stage 3 training. Often doctors train only in anaesthetics; however, some complete dual or joint CCTs, for example, with intensive care medicine (ICM) or pre-hospital emergency medicine (PHEM).

Figure 9: Number of anaesthetists receiving Certificates of Completion of Training (CCT), 2020-2025

	2020		2021		2022		2023		2024		2025	
	Anaesthetic only	All anaesthetics	Anaesthetic only	All anaesthetics	Anaesthetic only	All anaesthetics	Anaesthetic only	All anaesthetics	Anaesthetic only	All anaesthetics	Anaesthetic only	All anaesthetics
Northern Ireland	11	14	11	13	13	20	11	13	11	16	19	23
Scotland	33	39	37	50	29	40	33	47	32	38	46	58
Wales	10	13	20	23	17	23	19	23	14	18	18	25
England	272	359	275	362	306	394	341	436	297	367	318	408
UK	327	428	345	451	366	479	404	519	354	440	401	514

As can be seen, across the UK, 401 doctors gained CCTs in anaesthesia exclusively in 2025, up from 327 in 2020. If doctors on joint programmes are included, the numbers have risen from 428 in 2020 to 514 in 2025.

Figure 10: All anaesthetic and anaesthetic only CCTs over time, 2020-2025



Portfolio pathway

As an alternative to the defined training routes outlined above, there is also the portfolio pathway (previously known as the Certificate of Eligibility for Specialist Registration or CESR). This allows doctors to build and submit a portfolio of evidence to demonstrate that they have acquired the knowledge, skills, and experience necessary to practise as an anaesthetic consultant in the UK.

The portfolio pathway route is commonly used for anaesthetists who trained abroad. It is also used by some domestically trained SAS doctors and LEDs who wish to become consultants, but have been unable to secure a place on a national training programme, or who, for whatever reason, do not wish to follow that path.

Figure 11: Numbers of portfolio pathway applications assessed by the RCoA, total and successful, 2021-2025

	Number of portfolio pathway applications assessed by the RCoA	Number of successful applications for the portfolio pathway
2021	47	33
2022	76	59
2023	119	78
2024	120	72
2025	103	57

Anaesthetists from outside the UK

In terms of recruitment, each year around 250 doctors from outside the UK start working in anaesthesia in the UK, accounting for a large part of anaesthetic workforce growth. This is probably a key reason why the workforce has expanded, despite relatively modest increases in training places.

Overall, about 35% of anaesthetists gained their primary medical qualification (PMQ) outside the UK. These doctors are particularly concentrated in SAS roles, where they constitute 59% of the workforce, and LED roles, where they constitute 44%.

Training capacity

Fortunately, there is capacity in the system to accommodate more anaesthetic training posts. As part of our 2025 Census, we asked college tutors across the UK how many additional AiTs their hospital had the capacity to take on. This revealed space for around 180 extra core training places a year across the UK, and 200 extra higher places each year.

Figure 12: Estimated numbers of extra AiTs that could be taken on per year, by nation

	UK	England	Scotland	Wales	Northern Ireland
CT1–CT3	175	145	20	6	4
ST4–ST7+	201	167	22	6	6
Total	376	312	42	12	10

Training bottlenecks

Unlike in the early 2000s, there is no longer a shortage of doctors wanting to choose a career in anaesthesia. These days, there are more than enough willing and able applicants who want to start anaesthetic training. In fact, across the board, there are far more applicants for specialty medical training than places available. This bottleneck has grown year on year and emerged due to a number of factors:

1. The lifting of visa restrictions in 2020 led to large increases in applications from international medical graduates – from 6,913 in 2021 to 20,807 in 2025.[21]
2. Increase in graduates coming from UK medical schools, which rose from 7,356 in 2021 to 9,734 in 2025.[21]
3. Low growth in training places for these doctors to go to.

In 2025, across all medical specialties, approximately 42,000 individual applicants applied for just 13,000 specialty training posts, leaving 29,000 unable to progress.[21]

Figure 13: Individual applicants and posts available across all medical specialties, 2021-2025

	2021	2022	2023	2024	2025
Individual applicants	22,858	23,715	26,208	32,623	41,727
Posts available	11,579	12,105	12,680	12,743	12,833

In anaesthesia specifically, in 2025 there were 6,770 applicants for just 539 places at core level – a competition ratio of >12:1. At the ST4 level, there were 699 applicants for 423 posts – a competition ratio of 1.65:1.[22]

Figure 14: Individual applicants and posts available in anaesthesia, 2021-2025

	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

Note: 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.
N/A, not available.

These bottlenecks, particularly at core level, are hugely problematic for doctors who have probably already dedicated at least 7 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.

LEDs

As mentioned in Chapter 2, there are currently 2,306 LEDs working in anaesthesia in the UK. Of these, 44% had applied for anaesthetic training places, but lost out due to the aforementioned bottlenecks. A further 23% were taking time to build experience before applying – perhaps because bottlenecks were intimidatingly high.

This is another potential source of recruits for anaesthetic training posts. The advantage of this group is that the NHS is already paying their salaries, which means that a large part of the cost of training (which involves salary costs and training/education costs) is already paid for. As we set out in Chapter 8, the desire for progression among this group is also very high.

Argument in summary

Overall, it is clear that more anaesthetic training places are needed. Fortunately, there is capacity in the system to train more. There are also more than enough applicants to fill training places if they were created – as evidenced by competition ratios and the large pool of LEDS. As such, expansion is both desperately needed and eminently achievable. The only thing missing is Government funding to cover both the training and the salary costs.

The payoff from increasing the number of training places could be rapid, because AiTs can start making meaningful contributions to NHS service in 3–6 months after beginning their training.

Government actions on training numbers

In 2022, 70 extra higher anaesthetics training posts were granted in England. Following that, in 2025, the *10 Year Health Plan for England* announced that 1,000 extra additional medical training places (across all medical specialties) would be created.[5] In early 2026, we were told that 200 of these would be allocated to anaesthesia, mainly at core level. It was intended that these would involve converting existing LED posts into training posts, which is in line with the argument that we have made in this chapter and many times in the past.

Unfortunately, the offer of these posts was withdrawn in April 2026.[10] This withdrawal is likely to have severe negative consequences for the NHS in England and the patients whom it serves.

The Government linked the withdrawal of posts to the ongoing industrial action by resident doctors ;[10] however, we believe that the two issues must be considered separately. As we have already abundantly demonstrated in this report, the NHS and patients need more anaesthetists, which requires an increase in training numbers.

However, even before the posts were withdrawn, the Government was finding it difficult to fill the posts that it had pledged. This was not due to lack of applicants, but an insufficient funding model which meant that NHS trusts were unwilling to take the new posts on. Additional details of the historic and proposed funding arrangements are set out in Appendix B.

We believe that previous offers of extra places must be resurrected and, indeed, expanded upon. Our data show that around 320 extra training posts could be accommodated in England, including around 150 at CT1 level and 170 at ST4 level. This must be backed with more generous funding to actually enable and incentivise NHS trusts to take them on.

In the devolved nations, additional training posts are also needed. In Scotland, we believe that 24 extra posts need to be created, including 12 at core level and 12 at higher level. There also needs to be changes to the currently rigid funding rules for posts. Currently, if an AiT in Scotland decides to work part-time instead of full-time, the unused portion of their salary cannot be re-used by the hospital, for example, to take on another AiT. This differs from other nations, such as England, where hospitals can reallocate funding when an AiT goes part-time, enabling them to bring in more support.

As such we believe that reform is needed to allow departments to reinvest unused funds – such as when AiTs reduce their hours – into creating additional training posts.

We also believe that six extra posts need to be created in Wales (with precise allocation between levels to be determined) and eight in Northern Ireland (four at core level and four at higher level).

Recommendations

- In England, 312 extra posts should be created, including 145 at core level and 167 at higher level.
- The funding arrangements behind these posts must be sufficiently generous to enable and incentivise NHS trusts to take them on.
- In Scotland, 24 extra posts should be created, 12 at core level and 12 at higher level.
- Scottish funding rules for AiTs must be reformed to allow departments to reinvest unused funds – such as when AiTs reduce their hours – into creating additional training posts.
- In Wales, six extra training posts should be created – with precise allocation between levels to be determined.
- In Northern Ireland, eight extra posts should be created, including four at core level and four at higher level.

5. Retention of existing staff is essential

Key messages

- Almost one in five anaesthetic staff (19%) expects to leave the NHS in the next 5 years.
- Boosting retention involves a number of factors, including engaging with doctors constructively on pay issues and addressing ongoing issues with the current pension taxation rules.

As outlined in Chapter 4, it is important to increase the supply of new anaesthetists by increasing the number of anaesthetic training places. However, it is also extremely important to retain existing staff.

Unfortunately, when it comes to anaesthetists, it appears that the NHS faces a large retention challenge. Our data show that almost one in five members of anaesthetic staff (19%) does not expect to be working in the NHS in 5 years' time – and a further 22% are unsure if they will be doing so.

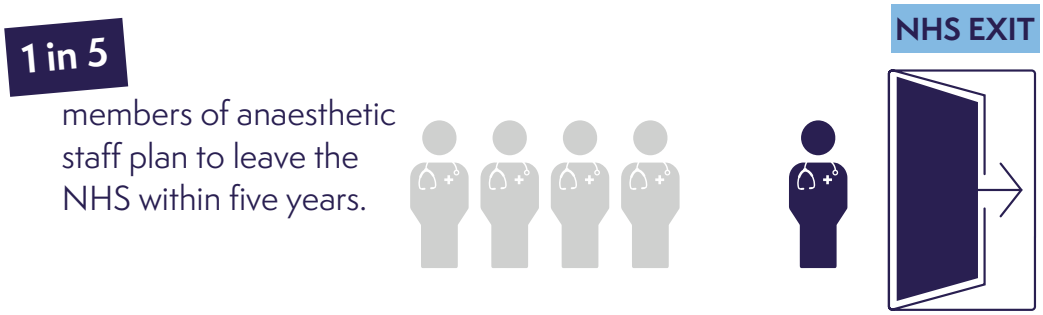
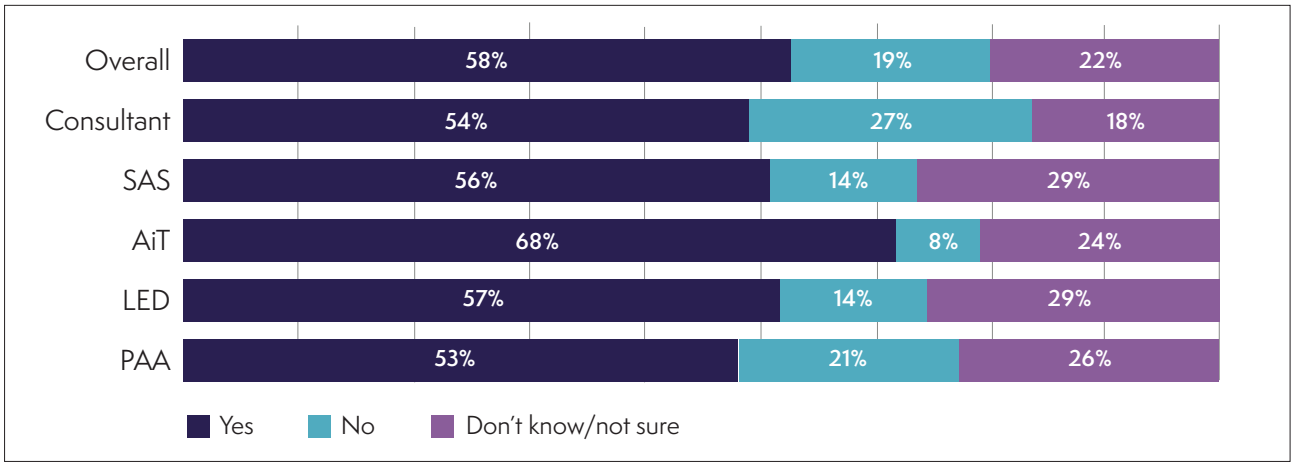


Figure 15: Intention to still be working in the NHS in the next five years by staff group



Census data show that consultants, who tend to be older than other staff groups, were the most likely to say that they will not be working in the NHS in 5 years: 27% indicated this and a further 18% were unsure. Perhaps even more worrying is that 8% of AiTs, who are near the start of their careers, are also expecting to leave and a further 24% are unsure.

Age profiles and retirement

The most common reason why anaesthetists expect to leave the NHS in the next 5 years is due to retirement, accounting for 62% of the total.

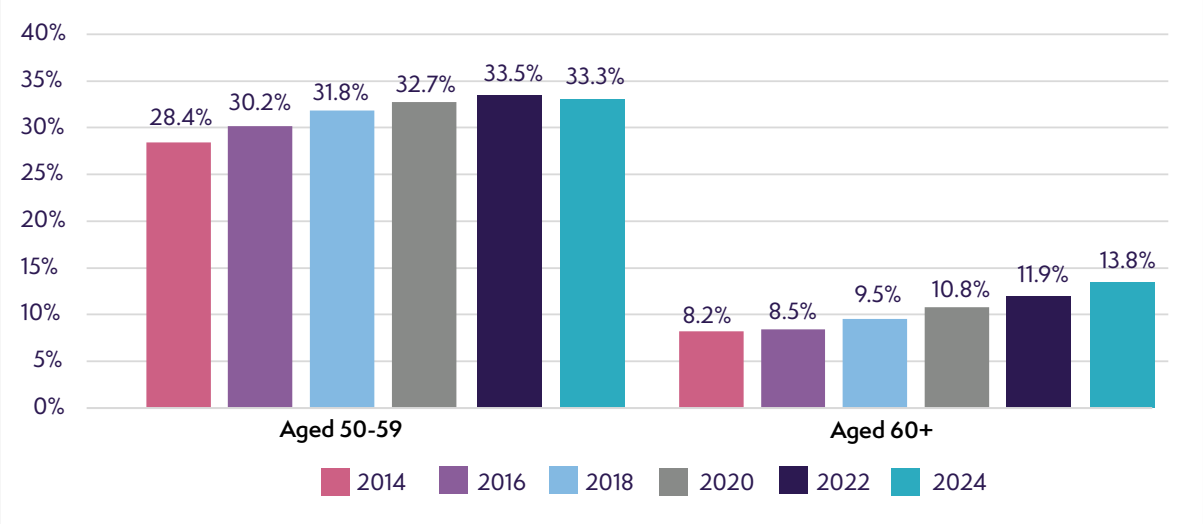
This is probably a reflection of the age profiles. The best data on age profiles of anaesthetists come from the General Medical Council, albeit with the caveat that their data are combined with intensivists – a closely related specialty.[23]

According to these data, 13.8% of consultant anaesthetists and intensivists are now aged >60 and a further 33.3% are 50–59, meaning that 47.1% are aged >50. This is up from 8.2% aged >60 in 2014 and 36.6% aged >50.[23]

Figure 16: Percentage of anaesthetists aged 50-59 and 60+, 2014-2024

	2014	2016	2018	2020	2022	2024
Age 50–59 years (%)	28.4	30.2	31.8	32.7	33.5	33.3
Age 60+ years (%)	8.2	8.5	9.5	10.8	11.9	13.8

Figure 17: Percentage of anaesthetists aged 50-59 and 60+, 2014-2024



Exits due to retirement increase the need to create more anaesthetic training places to replace those who will leave.

Non-retirement reasons

Retirement is not the only reason why anaesthetic staff plan to leave the NHS. Over a third of anaesthetic staff (36%) cited other reasons.

Intentions to leave are associated with low wellbeing. As set out more fully in Chapter 7, among respondents planning to leave for reasons other than retirement, 58% recorded low life-satisfaction scores. Recommendations for improving wellbeing are set out in Chapter 7.

However, the census also directly asked those who indicated that they would or might leave the NHS for reasons other than retirement, what factors would encourage them to stay.

Figure 18: Factors that would encourage expected/potential NHS leavers to stay (excluding those leaving to retire)

	Percentage
Increased pay	66
Improved ability to progress in your career/training	34
More flexible working hours/rotas	27
Changes to pension taxation regulations	24
Being treated more fairly	19
Reduced working hours	18
Reduction in workload	14

Overall, the biggest factor is 'increased pay', selected by 66% of the aforementioned group. In fact, pay came out as one of the top two factors across all grades of anaesthetist. It was cited by 59% of consultants (number 1 factor), 56% of SAS doctors (number 2 factor), 74% of AiTs (number 1 factor) and 74% of LEDs (number 1 factor). This suggests a continued need for UK Governments to engage constructively with doctors (including anaesthetists) on pay issues.

For consultants, the second biggest factor that would encourage them to stay is reform of the current pension taxation rules. As we show in Chapter 7, the current pension taxation rules are also a big source of job dissatisfaction and, as we show in Chapter 9 (where the matter is discussed in detail), it is a major constraint on NHS capacity.

Pension taxation is determined by the Treasury and is uniform across all UK nations. As such, it is extremely important that the Westminster Government re-examine this issue and make any appropriate and sensible reforms.

For SAS doctors, the biggest factor that would encourage them to stay is improved ability to progress in their career or training, cited by 60%. It is also the second largest factor for LEDs, cited by 59%. These issues are explored in detail in Chapter 8; however, in short, these findings add to the reasons why extra places on national training programmes are needed. It is also important that, where possible, access to training should be expanded outside of these programmes.

For AiTs, the second biggest factor was more flexible working hours/rotas. Working arrangements for AiTs are something that the RCoA has tried to tackle. In 2024, we published guidance on 'Minimising the impact of rotational training'.[24] However, some issues are related to staffing levels. If a hospital is understaffed, for example, it may lead to AiTs having to work out of hours more frequently.

For physician assistants in anaesthesia (PAAs), the number 1 identified factor was their ability to progress in their career/training (71%), followed by being treated more fairly (62%). Despite seeing no case for the rapid expansion of this role, the RCoA believes that those PAAs currently training or working in the NHS must be supported. The welfare of PAAs is important and it is vital that they are treated with respect in all anaesthetic departments. This includes tackling bullying where it occurs and ensuring that they are supported with continued professional development (CPD).

Recommendations

- UK Governments must engage constructively with doctors (including anaesthetists) on pay issues.
- The Westminster Government should re-examine the impact of the current pension taxation rules on NHS capacity and make any appropriate and sensible reforms.
- As per Chapter 4, anaesthetic training places must be expanded across all UK nations to meet the shortfall in anaesthetic provision both now and in the future.
- PAAs should be treated with respect in all anaesthetic departments. This includes tackling bullying where it occurs and ensuring that they are supported with continued professional development (CPD).

6. Open and transparent workforce planning is urgently required

Key messages

- There has been no open and transparent modelling of the current and future needs of the NHS workforce for around a decade – and the last modelling that took place for anaesthesia, specifically, was in 2015. UK Governments need to urgently commission and publish such work.
- UK Governments should work collaboratively with the RCoA to make this happen, as recommended by the Leng Review. This involves utilising our extensive workforce data on headcounts, shortfalls and training capacity.

As outlined in Chapter 2, although the number of consultant and SAS anaesthetists grew from 10,150 in 2020 to around 12,300 in 2025, the staffing shortfall has actually widened. This stood at 1,483 across the UK in 2020 (14% below what was needed) and is now 2,257 (16% below what is needed). The simple message is that demand for anaesthetists has risen faster than supply.

Drivers of demand

Rising demand is driven by factors such as a growing and aging population; more conditions becoming amenable to surgery; and the expanding role of anaesthetists into perioperative care. It is important that these factors are properly and transparently modelled to allow for detailed, evidence-based workforce planning to take place

The UK's growing and aging population

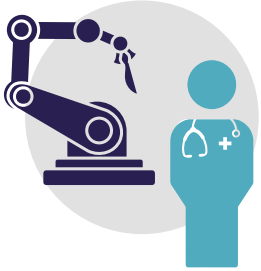
The UK population is projected to grow to 72.4 million by 2032, an increase of 4.8 million since 2022. At the same time, the population is ageing, with the number of people at state pension age expected to increase by 1.7 million, from 12 million in 2022 to 13.7 million by 2032.[25]

Population **to grow** to
72.4 million
by 2032

A larger population, by default, requires a larger health workforce to provide treatment. An aging population exacerbates this. Older people tend to have a greater prevalence of complex, long-term health conditions, for example, the number of people living with major illnesses is projected to rise by 37% between 2023 and 2040. This is predicted to drive healthcare demand in two ways: (1) more people requiring NHS services such as surgery and (2) patients being more likely to experience complications or adverse outcomes, leading to additional treatment needs.[26]

More conditions amenable to surgery

Medical, scientific, and technological advances continue to be made – and these often serve to expand what surgery can do and the kind of patients on whom it can be performed. A growing range of interventions – such as minimally invasive surgery – is now widely available. Minimally invasive surgery has progressed rapidly due to recent developments in video and robotic technology, enabling surgeons to operate through smaller and fewer incisions than traditional open surgery. This reduces trauma, shortens hospital stay and speeds up recovery.



As a result, surgery has become an option for patients who previously may not have been suitable. This means that more patients can now benefit from surgical procedures, and a bigger range of patients can undergo surgery safely.

Although this is a positive development, it has also increased demand for clinical staff, including anaesthetists – and will probably continue to increase in the future.

Expansion of the anaesthetist's role

Anaesthetists provide essential care across a wide range of services and are playing an increasingly central role in the delivery of perioperative care. As outlined more fully in Chapter 9, perioperative care refers to all the care that patients receive before, during and after their operation, from the moment that surgery is first considered through to complete recovery.

Providing better perioperative care can deliver significant productivity and efficiency gains for the NHS; however, it also increases the demand for anaesthetists. This makes expansion of the anaesthetic workforce even more critical.

Projections work

In 2011, the Government-funded Centre for Workforce Intelligence (CfWI) was founded. It conducted detailed modelling of the future needs of the health workforce. In 2015, this included modelling for anaesthesia.[27] Unfortunately, the CfWI ceased operations in 2016 and, since then, no publicly funded, transparent anaesthetic workforce modelling has been published.

To fill the gap in public provision, in 2021 the RCoA funded the York Health Economics Consortium (YHEC) to project future supply and demand of anaesthetists in the UK.[28]

Although the YHEC was unable to replicate every aspect of the CfWI's prior modelling work, it gave a stark indication of the increasing demand for anaesthetists. It also showed that supply would probably prove inadequate to meet that demand if historic rates of workforce growth continued.

However, RCoA's resources do not allow us to fund, on a regular and recurring basis, the continued modelling that health services really need to plan for the future. Furthermore, it is likely that health service planners will take their own projections seriously, compared with those produced externally. For these reasons, ideally, we believe that health workforce modelling should be a public function that bodies like RCoA support, rather than one on which we lead alone.

As such we recommend that the UK Governments ensure that a public body produces and publishes detailed and transparent workforce modelling for future healthcare workforce needs – along the lines of those produced by the former CfWI. The RCoA would be very happy to support this by providing our extensive workforce data, including on factors such as headcounts, shortfalls, and training capacity.

Recommendations

- Each of the four UK Governments should commission a public body to produce and publish detailed and transparent workforce modelling for future healthcare workforce needs – along the lines of those produced by the former CfWI.
- Those aforementioned public bodies should work collaboratively with the RCoA to make this happen. This involves utilising our extensive workforce data on headcounts, shortfalls, and training capacity.

7. Workforce wellbeing needs to be improved

Key messages

- The wellbeing of the anaesthetic workforce is lower than the average for the UK population.
- Of anaesthetists, 56% report being at least 'somewhat' burnt out.
- This is bad for the staff affected and bad for the system. Each year, 184,000 working hours are lost due to sick leave related to stress, burnout, anxiety, or depression – preventing up to 60,000 operations and procedures from taking place.
- The biggest sources of dissatisfaction in the working lives of anaesthetic staff revealed by survey work are poor IT systems and current pension taxation rules.
- Other key sources of dissatisfaction are hospital staff parking charges, and a lack of rest and refreshment facilities. Cancellation of lists is also cited as a major source of frustration.
- All these issues can and should be addressed.

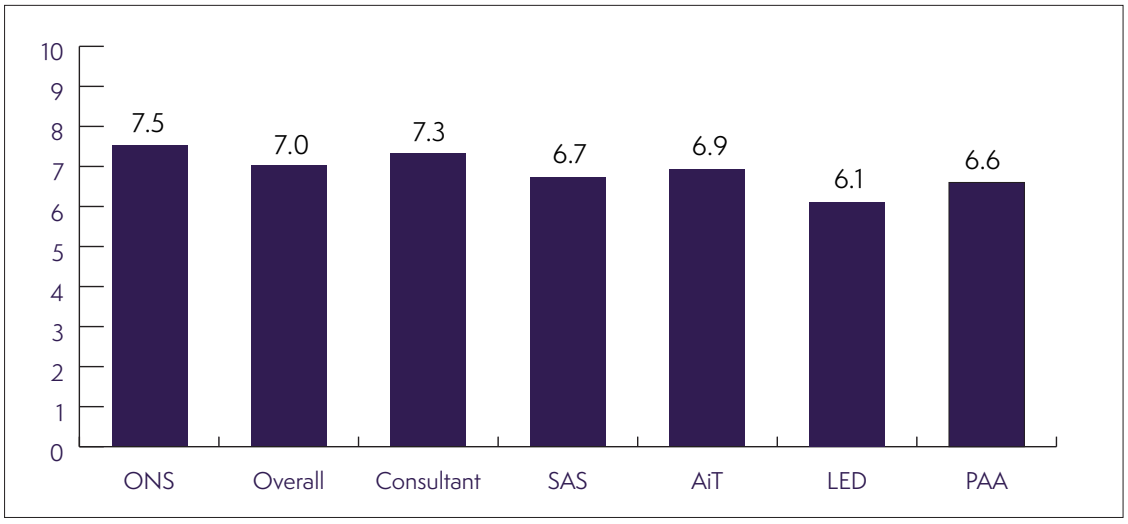
The wellbeing of the anaesthetic workforce must be supported and protected. Wellbeing is not only important for anaesthetists in their own lives but also for maintaining a stable and effective workforce. Anaesthetists with high wellbeing are more likely to want to remain in the profession longer, take fewer sick days for stress, and are at reduced risk of burnout. To deliver the highest quality care, clinicians must first be supported. Patients are best served when the staff caring for them are cared for themselves.

In the Census, we explored the wellbeing of anaesthetic staff. This complements the more general findings of the NHS staff survey and burnout data collected by the General Medical Council (GMC).

Life satisfaction

On average, anaesthetists report slightly lower levels of life satisfaction than the UK population as a whole, rating their satisfaction at 7.0 out of 10, which is lower than the UK population average of 7.5.

Figure 19: Life satisfaction mean scores by staff group



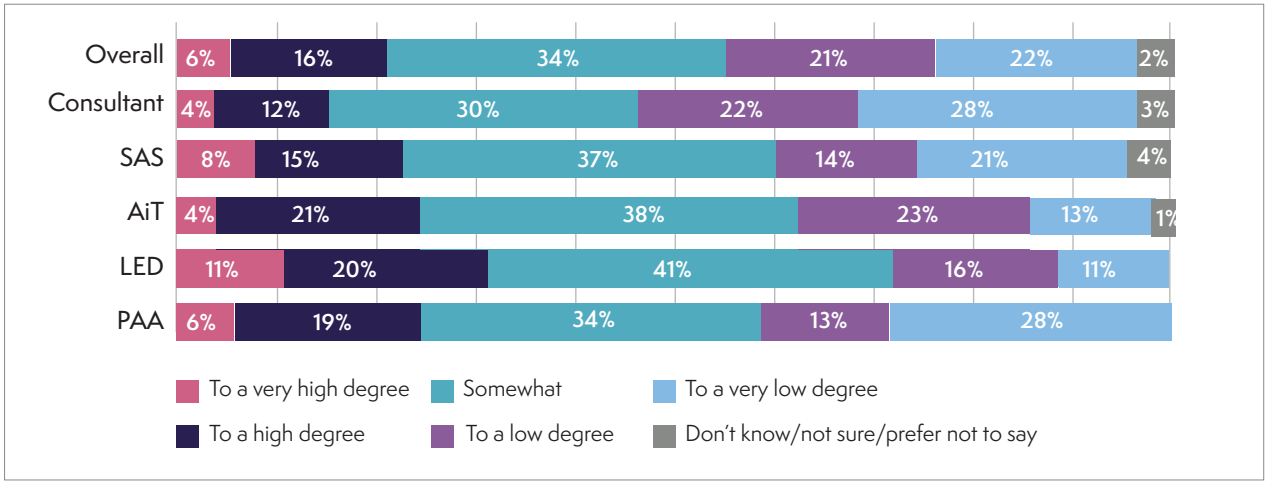
Comparing between staff groups, consultant anaesthetists reported the highest levels of life satisfaction, with an average score of 7.3 out of 10. In contrast, LEDs consistently reported the lowest levels at 6.1 out of 10 – suggesting that efforts to support their wellbeing require particular focus. This is discussed in detail in Chapter 8.

Burnout

With regard to burnout, our 2025 census found that it is widespread across the anaesthetic workforce. More than half the workforce (56%) reported being at least somewhat burnt out. This breaks down as 6% saying that they felt burnt out to a very high degree, 16% to a high degree, and a further 34% somewhat burnt out.

Unfortunately, GMC data suggest that doctors in other medical specialties are faring even worse, particularly in obstetrics and gynaecology and emergency medicine.[29]

Figure 20: Burnout levels by staff group



Among anaesthetic staff, LEDs again fare the worst. Overall, 72% of LEDs described themselves as being at least 'somewhat' burnt out, compared with (a still substantial) 46% of consultants, 60% of SAS doctors, 63% of AiTs, and 59% of PAAs.

Consequences of low workforce wellbeing for the NHS

Low levels of wellbeing and high levels of burnout are not just problems for the individuals who experience them. They may also create challenges for the health system as a whole.

On average, anaesthetists take 5.6 days of sick leave per year, with at least 1.3 days (23% of the total) of these taken due to stress, burnout, anxiety, or depression. With approximately 19,600 anaesthetists in the workforce, we estimate that this results in >23,000 days lost each year due to these factors. Making a conservative assumption of the average day being 2 programmed activities (PAs), or 8 hours, 184,000 working hours are lost due to sick leave related to stress, burnout, anxiety, or depression – preventing up to 60,000 operations and procedures from taking place.

184,000

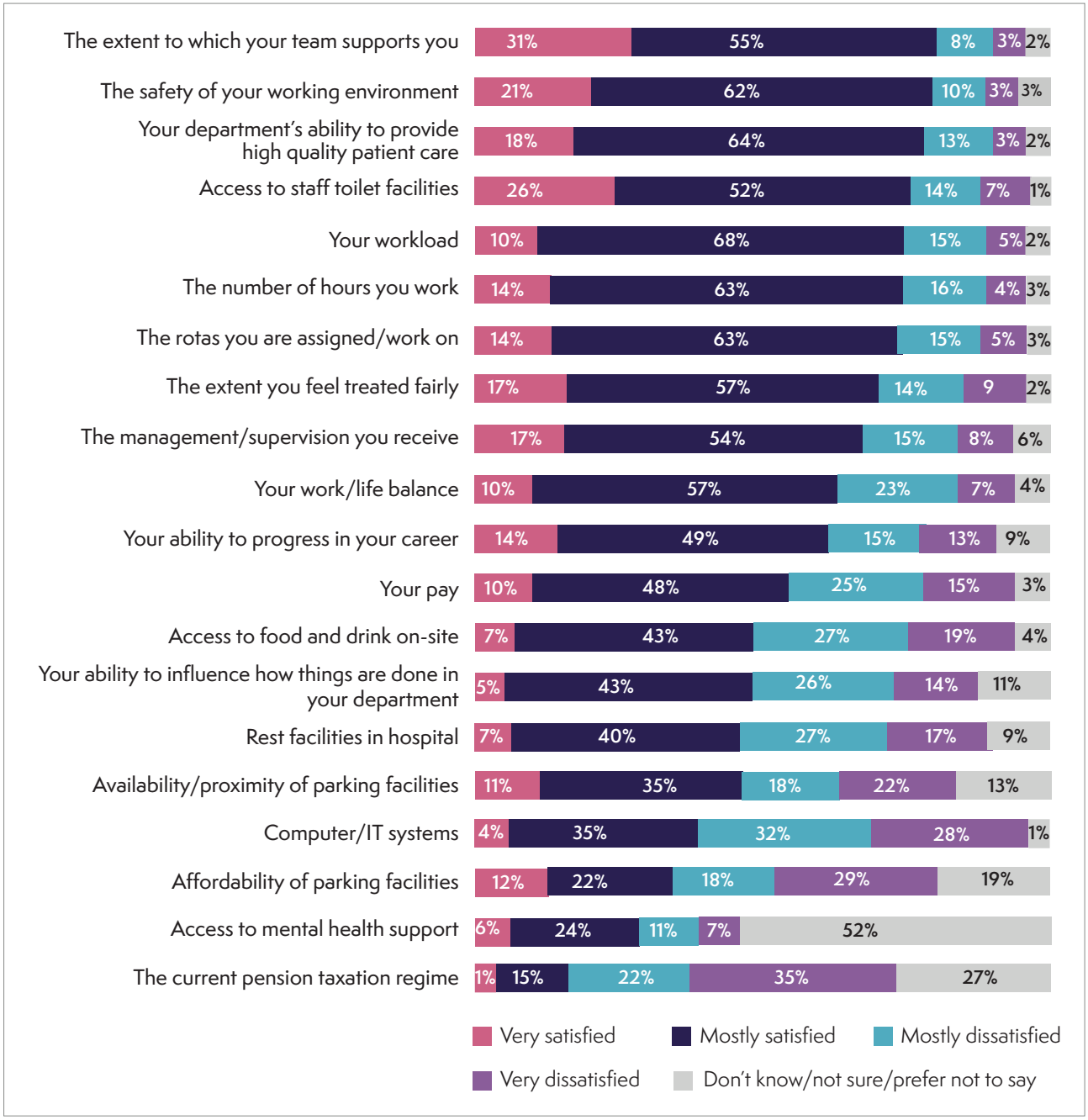
working hours lost due to low wellbeing – preventing up to 60,000 operations and procedures from taking place.

Promoting wellbeing may also help with staff retention. Of those who reported low life satisfaction, 58% expected to leave the NHS in the next 5 years compared with only 7% of those with very high life satisfaction.

Areas of dissatisfaction

Poor wellbeing and burnout may relate to a range of factors in hospitals. As part of the census, anaesthetic staff were asked to rate their satisfaction, or lack thereof, with various aspects of their working lives.

Figure 21: The satisfaction and dissatisfaction of anaesthetic staff with aspects of working life



Areas where respondents reported the greatest satisfaction were in the extent to which their team supported them (86% very or mostly satisfied), the safety of their working environment (83%), and their department's ability to provide high-quality patient care (82%).

There were, however, areas with which respondents were far less satisfied. The biggest problem area was their hospital's computer and IT systems – where 60% reported being mostly or very dissatisfied (discussed in more detail in Chapter 9).

The current pension taxation rules were also identified as a major issue of concern, with 57% reporting that they were mostly or very dissatisfied with the current regime (also discussed in more detail in Chapter 9).

Other major sources of dissatisfaction were the following:

- Affordability of parking services, with 47% mostly or very dissatisfied. This issue varies by nation. Hospital parking charges were abolished in Wales in 2008 and Scotland in 2009 but remain in England and Northern Ireland.[30]
- Access to food and drink onsite, with 46% mostly or very dissatisfied. At some hospitals, access to *any* food and drink is poor, whereas at others only unhealthy options are available. The *10 Year Health Plan for England* promised a new set of staff standards that will cover, among other things, access to nutritious food and drink at work.[5] The impact of this remains to be seen, but it is vital that the promised positive changes are delivered.
- Access to rest facilities, with 44% mostly or very dissatisfied. This is particularly a problem for doctors who work nights.

Ensuring that these basic provisions help clinicians to feel valued are important in supporting clinicians to perform at their best.

Recommendations

- The Westminster Government should re-examine the impact of the current pension taxation rules on NHS capacity and make any appropriate and sensible reforms.
- UK Governments and health services should work to improve IT systems by upgrading slow and outdated computers and modernising digital platforms to make clinicians' working lives easier and enable efficient, integrated patient care.
- Parking charges for staff at hospitals in England and Northern Ireland should be reduced or abolished as per Scotland and Wales.
- Around-the-clock access to good quality food, drink and rest facilities in hospitals must be improved.

8. SAS and locally employed doctors (LEDs) need better support

Key messages

Anaesthetists on specialty, associate specialist and specialist (SAS) contracts, and locally employed doctor (LED) contracts are growing in number and face unique challenges in their working lives.

SAS doctors

- Lack of opportunity for career progression is the single biggest source of dissatisfaction in SAS doctors' working lives, cited by 55% of all SAS respondents.
- Within SAS categories, specialty doctors who meet the criteria for the more senior specialist contract must be allowed to progress to it.
- Lack of fair treatment is a concern for 28% of SAS doctors.
- Greater use of SAS advocates, including SAS staff in clinical governance meetings, and providing sufficient supporting professional activities (SPA) time, could help provide greater fairness.

LEDs

- LEDs have lower wellbeing and higher burnout than any other staff group.
- As with SAS doctors, desire for progression is high – only 5% want to remain in their posts indefinitely.
- The vast majority of LEDs (81%) work on fixed-term contracts. This gives this group of staff far less job security than other groups.
- To help rectify this, LEDs should be given assured transition to the specialty doctor contract after a maximum of 2 years in the role.

For both groups

- NHS trusts and boards should promote progression opportunities – and national Governments should expand training places (as per Chapter 4).

SAS and LED overview

SAS doctors and LEDs are large and growing sections of the anaesthetic workforce. They perform many vital tasks, working alongside consultants in operating theatres, emergency departments, labour wards, intensive care units and a wide range of other clinical settings. They may also face unique challenges in their working lives.

In the census, a deep dive was taken into these doctor groups with a view to producing recommendations that address their needs.

SAS doctors

As set out in Chapter 1, SAS doctors work on three different contracts: specialty, specialist and associate specialist. SAS doctors have usually, as a minimum, completed core specialty training in the UK or an equivalent level abroad. However, many have much more experience, and some work at a similar level to consultant anaesthetists.

Numbers of SAS doctors

As also mentioned in Chapter 1, the number of SAS doctors rose from 1,635 in 2020 to 2,182 in 2025, an increase of 33%. However, despite the growth in the supply of SAS doctors, there has been an even greater increase in demand. The shortfall of SAS doctors grew from 363 (18% below what is needed) in 2020 to 616 (22% below what is needed) in 2025.

In addition to the headline data presented in Chapter 1, we have broken down the number of SAS doctors by contract in Figure 22. As can be seen, the largest group of SAS doctors is specialty doctors, with 1,624 in post – 74% of the workforce. Numbers of specialist and associate specialist doctors are lower, with 361 (17%) and 197 (9%) in post, respectively.

Figure 22: Numbers of SAS doctors by contract and nation, 2025

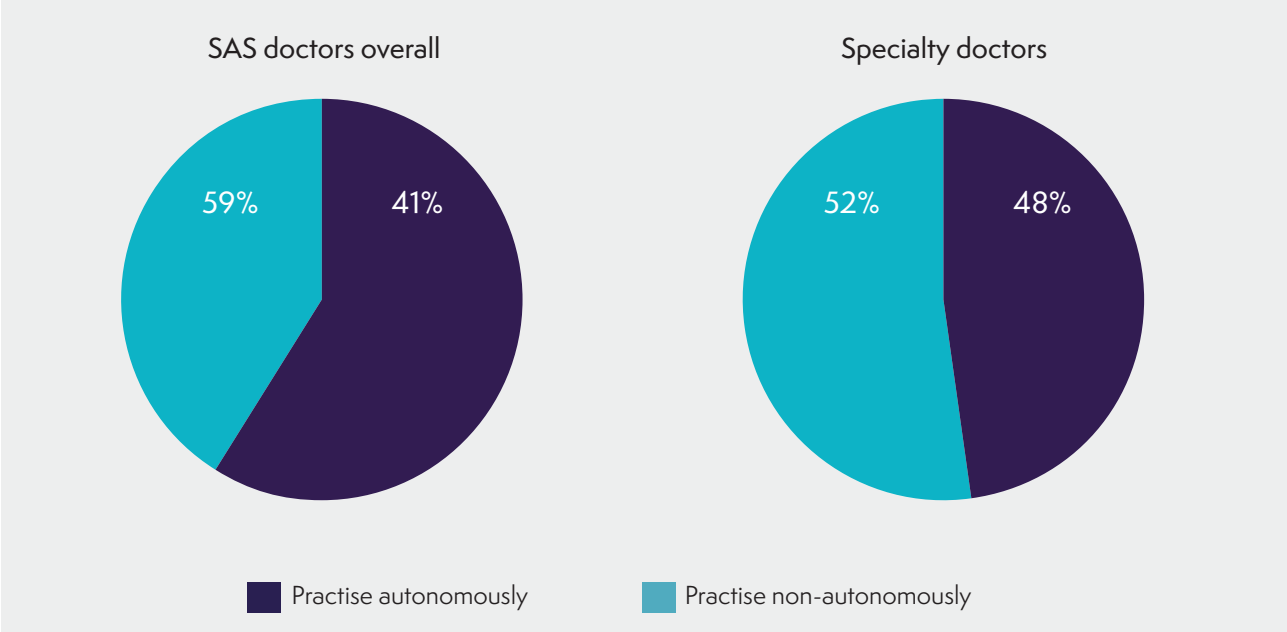
	Headcount by nation and respective percentages of the SAS				
Group	**UK***	**England**	**Wales**	**Scotland**	**Northern Ireland**
Specialty	1,624 (74)	1,403 (74)	108 (73)	72 (78)	41 (91)
Specialist	361 (17)	323 (17)	21 (14)	16 (18)	1 (2)
Associate specialist	197 (9)	171 (9)	19 (13)	4 (4)	3 (7)
SAS doctors overall	2,182 (100)	1,897 (100)	148 (100)	92 (100)	45 (100)

Note: percentages may not sum to 100 due to rounding.

Levels of autonomy

SAS doctors work at varying levels of responsibility and autonomy, depending on their experience, training and the needs of their department. Overall, 59% report practising autonomously, while the remaining 41% work under some level of supervision. Among specialty doctors, 48% practise autonomously compared with 52% who practise non-autonomously. All specialist and associate specialist doctors report working autonomously.

Figure 23: Percentage of SAS doctors overall and specialty doctors practicing autonomously



Where SAS doctors are coming from

A total of 59% of SAS doctors completed their primary medical qualification (PMQ) outside the UK. This is higher than all other groups of anaesthetists and compares to 44% of LEDs, 20% of consultants, and 7% of AiTs.

Desirability of SAS doctor role

Overall, 43% of SAS doctors report being in their role through choice. Of those doctors choosing the role, the perception of better work–life balance was by far the single most common motivator for choosing it – cited by 79%. Other factors included more direct clinical care (cited by 45%), reduced governance responsibilities (34%) and lower stress (33%).

Figure 24: Factors that attracted SAS doctors to the role by contract (SAS doctors who stated they were in their role by choice)

Response	Overall SAS	Specialty	Specialist	Associate specialist
Better work–life balance (%)	79	78	81	82
More direct clinical care (%)	45	47	44	45
Lower stress (%)	33	38	19	18
Fewer governance responsibilities (%)	34	40	31	9
Fewer complex cases (%)	5	5	–	9
Other (%)	22	24	25	9

It is clear that, for a substantial number of SAS doctors, entering into the role is a positive choice. However, others enter the role through circumstances. This can include difficulties securing a training post, not passing required exams, or not having compiled a sufficient portfolio of work to progress via the portfolio pathway – at least not yet.

Areas of concern

In the census, the most common source of dissatisfaction for SAS doctors was their ability to progress with their careers – cited by 55% of SAS respondents.

Furthermore, of SAS doctors who identified themselves as potential leavers, the single most common factor that they reported would encourage them to stay was, again, improved ability to progress in their career/ training – cited by 60%.

Another way of looking at this is to consider the number of SAS doctors who wish to remain in their posts indefinitely without taking active steps to access a more senior role. Only 24% fell in this category; however, there were substantial differences between SAS grades. Only 6% of specialty doctors wished to remain in their post indefinitely, compared with a much higher 52% of specialist doctors, and an even higher 71% of associate specialist doctors.

It appears, therefore, that, among SAS doctors, especially specialty doctors, a desire for progression is very high. On the flip side, the lack of opportunity for progression is the prime driver of SAS doctor dissatisfaction and their intentions to leave the NHS. We therefore focus on these factors in this chapter.
The second most common source of dissatisfaction in SAS doctors' working lives was their hospitals' IT systems. This also happened to be the most common source of dissatisfaction when averaging across all anaesthetic staff – and has large consequences for workforce productivity. As such we cover this separately in Chapter 9.

The second most common concern identified that would encourage potential SAS leavers to stay was increased pay. As per Chapter 5, we encourage UK Governments to engage with doctors on pay issues.

It is also worth mentioning that 28% of SAS doctors reported dissatisfaction with the fairness with which they were treated at work. Of potential leavers, 25% also cited 'being treated more fairly' as a factor that would encourage them to stay.

Progression for SAS doctors

SAS doctors may pursue progression via more than one route and have more than one potential end goal in mind. Doctors on the specialty contract may wish to progress within the SAS category to the more senior specialist contract.

Also, doctors on any SAS contract may wish to become consultants. This could be achieved via the portfolio pathway, accessing national training programmes or studying and training outside those programmes and taking the relevant exams.

Progression from specialty to specialist contracts

Specialty doctors can, at least in theory, move on to the specialist doctor contract after gaining at least 12 years of medical experience since obtaining a primary medical qualification (PMQ), including 6 years in anaesthetics. This contract is more senior, offering higher pay and intrinsic autonomous practice. In Scotland and Wales, there are policies in place to ensure that progression of appropriately qualified applicants actually occurs [31,32] – but this is not the case in England and Northern Ireland.

Across the UK, most specialty doctors (72%) expressed a desire to move on to the specialist contract. This broke down as 23% who had not been in post long enough to qualify. However, the other 49% said that they had been in post long enough but had still not yet been able to access it.

49% of specialty doctors
qualify for the specialist contract,
but have been unable to access it.

Among specialty doctors who wished to move to the specialist contract but had been unable to do so, >6 in 10 (62%) of specialty doctors said that it was not available in their hospital.

It is unfair that so many specialty doctors are unable to access a contract for which they qualify. As such, the RCoA urges trusts and boards across the UK to make the specialist contract available and make provision for appropriately qualified candidates to transition to it. To assist with this, the RCoA has produced guidance on autonomy and progression for SAS doctors.[33]

Progression to consultant contracts

SAS doctors may also wish to become consultants. This can be via the portfolio pathway, gaining a post on a national training programme or studying/training outside of such programmes and entering the requisite exams.

Over a third (38%) of SAS doctors reported in the census that they were already studying, training, or building a portfolio to support progression, and a further 30% intend to do so.

Despite this, SAS doctors may not always receive the support that they desire. College tutors reported that 14% of SAS doctors actually had an educational supervisor and 11% were actually attending teaching sessions. This may be because SAS doctors lack time in their job plans for these things or the hospital is unable to prioritise (or has not prioritised) the funding or resources to provide such support.

The RCoA believes that SAS doctors should be supported in their professional development, including by having a personal development plan agreed at their annual appraisal, and being given the same study leave entitlements and budgets as consultants. Their training should also be supported to allow them to sit the fellowship examination or collect evidence for a portfolio pathway.

As per Chapter 4, extra posts on national training programmes are required, which would also provide progression opportunities. Where possible, support with education and training should also be provided outside such programmes. The RCoA has produced guidance for educational support for SAS, LED and MTI doctors, setting out best practice for how this can be done.[34]

Fair treatment

Fair treatment for SAS doctors is important – and lack of it appears to be a factor that drives SAS doctors away from the profession.

One example of fair treatment is via allocation of sufficient 'supporting professional activities' (SPA) time. Such time is earmarked for things like for job planning, appraisal, revalidation, teaching, research, and clinical management. Currently, the 'specialty doctor' contract stipulates at least one programmed activity (PA; usually equivalent to 4 hours) of SPA per week.

The good news from the census was that SAS doctors, on average, actually reported 1.6 PAs. However, this is still less than the average for consultants of 2.6 PAs.

Another example is involvement in clinical governance meetings. We believe that SAS doctors should be integral to the work of anaesthetic departments and that their skills, views and expertise should be valued and respected. As part of this, SAS doctors should be able to attend clinical governance meetings in the same manner as consultants and AiTs. Cover for any emergency lists taking place at the same time should be shared equitably.

In 2021 the role of the 'SAS advocate' was introduced. This position was designed to strengthen support for the SAS workforce. These advocates, based within local NHS trusts, provide career development advice, mentorship to SAS doctors, and a formal channel through which SAS doctors' interests can be represented.

However, our 2025 Census revealed that only around half of SAS doctors (51%) were aware of having an SAS advocate in their trust or board, 35% were unaware of the role altogether, and 14% reported that there was no advocate in place. For SAS doctors to feel better supported and their concerns properly heard, the SAS advocate role must be consistently established, and effectively signposted, across all trusts and boards.

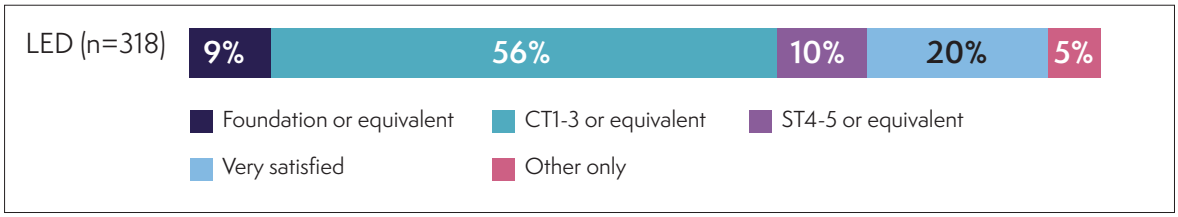
Locally employed doctors

LEDs are a very diverse group with various job titles. A common one, however, is 'clinical fellow', or some variant thereof. The key distinguishing feature of LEDs is that they are employed on bespoke local contracts rather than standard ones that have been negotiated and agreed at national levels. Hence, they may not benefit from the collective bargaining efforts of trade unions to the same extent as other groups.

Numbers of LEDs and training backgrounds

As set out in Chapter 2, there are 2,278 LEDs working in the UK. However, their levels of training vary considerably: 9% have only foundation level training. A much larger number (56%) have completed core anaesthetics training, a further 10% have completed ST4–ST5 level training, and 20% have completed ST6–ST7+ training. This implies a very broad range of experience.

Figure 25: LEDs' highest level of training

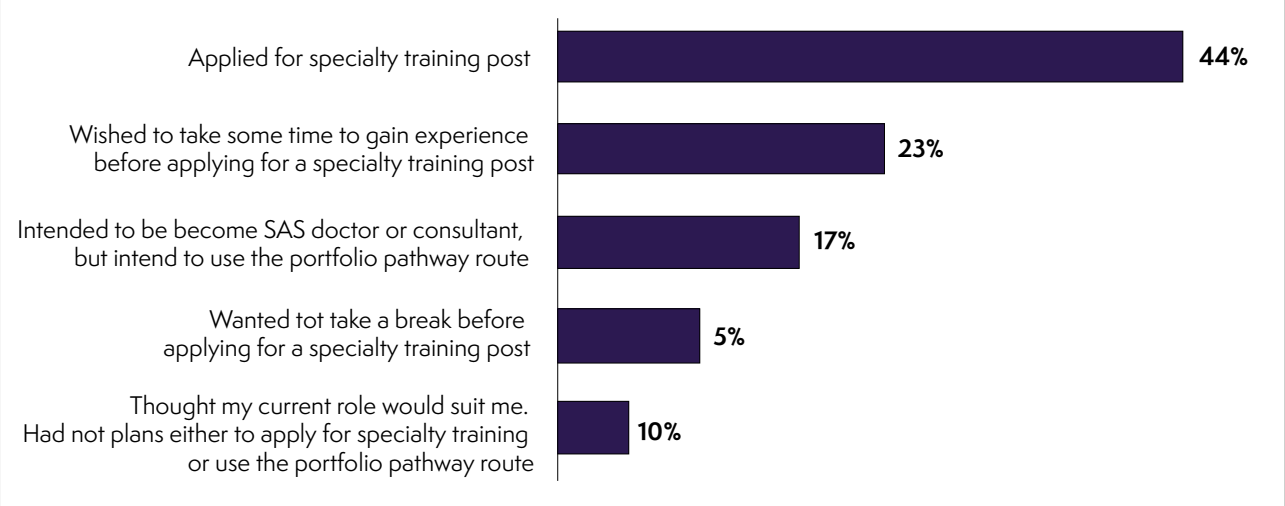


LEDs rarely wish to remain in their role long term – if, indeed, they wish to be in the role at all. It appears that only a very small minority (5%) actually thought that their current role would suit them long term.

The most common reasons for being in LED roles were that they had applied for a post on a national training programme, but been unable to secure one (44%) – or that they wished to take some time to gain experience before making such an application (23%).

It seems likely that the bottlenecks in training identified in Chapter 4 are an important contributing factor. Most LEDs seem to want to progress via national training programmes, but have lost out on a place or, having seen high competition ratios, attempt to improve their chances of success in the future by gaining experience before applying.

Figure 26: LEDs intentions for being in LED roles



Progression activity

Most LEDs hope to progress by securing a specialty training post or engaging with the portfolio pathway. At the time of the census, 39% of LEDs had a current active application for a specialty training post and a further 29% intended to submit an application for one in the next 2 years.

The portfolio pathway also appears to be a route that many LEDs view as a route to progression. Over a third (36%) reported that they were actively building a portfolio, with a further 8% intending to do so in the future.

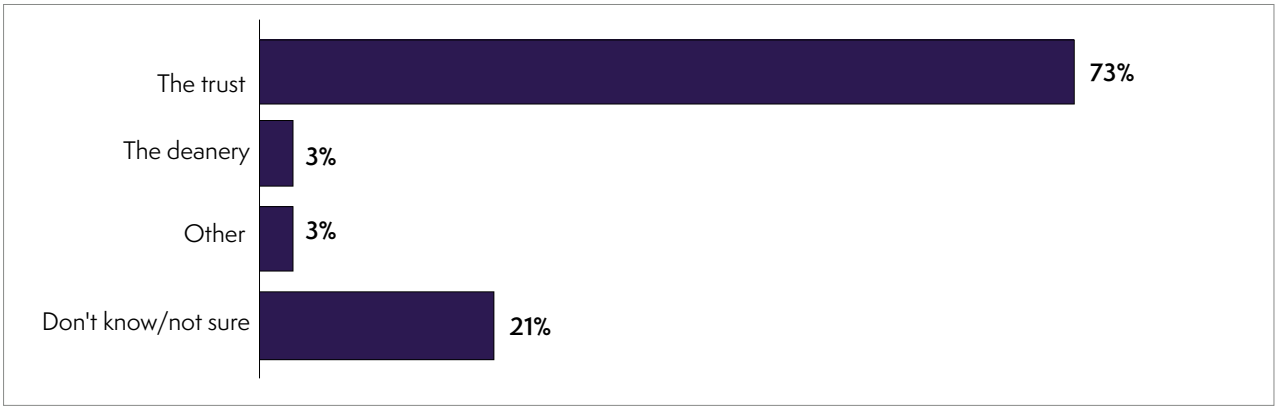
Despite these desires to progress, the educational and training support available to this group is limited. Based on reports from college tutors, only 26% of LEDs actually have an allocated educational supervisor (a person who oversees and coordinates their training) and 22% attend teaching sessions.

36%

reported that they were actively building a portfolio **with a further 8% intending to do so in the future**.

This may, in large part, relate to funding. As outlined in Appendix A, funding for training posts usually comes from the deanery (a regional body responsible for coordinating, delivering, and assuring the quality of postgraduate medical and dental training). However, deanery funding is limited by national Governments or an intermediary body (like NHS England). Only 3% of college tutors report that educational support provided to LEDs is funded via deaneries. Far more (73%) comes direct from the NHS trust (or board).

Figure 27: Sources of funding for LEDs educational support



Given the parlous, overstretched funding of NHS trusts and boards, it seems unlikely that much more support can be drawn from such sources. To give an example, in England, NHS trusts and integrated care boards were projected to have a £2.2 billion deficit in 2025–26.[35]

Areas of concern

The widespread desire of LEDs to progress, combined with restricted opportunities to do so, seem likely to be driving dissatisfaction and low levels of wellbeing:

- LEDs score 6.1 out of 10 on life satisfaction – the lowest of any anaesthetic staff group – compared with the overall average of 7.
- Of LEDs, 72% report being at least somewhat burnt out – the highest of any anaesthetic staff group, compared with the overall average of 56%.
- LEDs score 5.4 out of 10 on job satisfaction – the second lowest of any anaesthetic staff group after PAAs – compared with the overall average of 6.3.

When asked about specific areas of dissatisfaction with their working lives, 65% expressed dissatisfaction with their ability to progress with their careers. This dissatisfaction was greater than any other factor in LEDs' working lives.

Of LEDs, 14% stated that they did not expect to be working in the NHS in 5 years' time and a further 29% were unsure. Of this group, when asked about what would encourage them to stay, 59% reported 'Improved ability to progress in your career/training' – their second highest factor.

Although LEDs are a diverse group, it appears that they are faring badly compared to other anaesthetic staff groups, and improved progression opportunities would go a long way to helping them.

The best way of achieving this would be to increase the number of specialty training posts. This should be backed with Government funding. These posts should be both at core level and augmented by additional posts at higher level. As shown in Figure x, 86% of LEDs working in anaesthesia have already, as a minimum, completed core training – so higher training posts are also required.

In the absence of funded training places, NHS trusts and boards should do what they can to ensure that LEDs can access education and training, including receiving support to progress via the portfolio pathway.

It is also important to note, however, that pay featured the very highest in the list of factors that would encourage LEDs to stay – cited by 74% of those expecting to leave or unsure if they would do so. This is perhaps unsurprising, because LED rates of pay are lower than any other group of anaesthetic doctors.

LEDs have not featured prominently in pay discussions between trade unions and Government – but there is a strong case for a greater emphasis on this group.

Temporary contracts

Unlike other members of anaesthetic staff, the vast majority of LEDs (81%) work on fixed-term contracts. The compares with 4.8% of consultants, 10.2% of SAS doctors, and 2% of PAAs. This gives this group of staff far less job security than other groups.

81%
of LEDs work on fixed term contracts

LEDs' ability to access the SAS specialty contract

The RCoA has endorsed the SAS Six campaign, led by the SAS Collective, which outlines a series of actions to improve the experience, recognition and progression of SAS doctors and LEDs. One ask of the campaign is that LEDs should be able to access the SAS specialty contract after 2 years of service.[36]

In our survey of college tutors, 27% reported that LEDs could access the contract after 2 years in post in their hospitals, and a further 16% said that this was possible after more than 2 years. However, 11% said such a policy was not available and almost half (47%) did not know.

These results demonstrate that access to the specialty contract is far from universal – and that lack of awareness may be a further problem.

Therefore, where the policy does exist, employers should be actively promoting and signposting the opportunity to ensure that LEDs are fully aware of their options. Where it does not, organisations should adopt it to support LED transition into more stable SAS roles.

Recommendations

SAS doctors

- Specialty doctors who meet the criteria for the more senior specialist contract must be allowed to progress to it.
- NHS trusts and boards should ensure that SAS advocates are in place.
- SAS staff should be included in clinical governance meetings, and provided with sufficient SPA time.

LEDs

- LED roles should not be indefinite. After 2 years of service, LEDs should be able to gain the security of the nationally agreed specialty contract. This involves creating such policies locally, where they do not already exist, and raising awareness of those policies where they do.
- Rates of pay for LEDs should factor in to pay discussions between trade unions and national governments.

For both groups

- NHS trusts and boards should promote progression opportunities – and national governments should expand training places (as per Chapter 4).
- NHS trusts and boards should adhere to the RCoA's best practice for educational support for SAS, LED and MTI doctors.

9. Anaesthetists drive NHS productivity, but are being held back

Key messages

- Optimising the surgical pathway: anaesthetists are proven innovators and leaders when it comes to developing and embedding interventions that improve NHS productivity. These interventions can reduce the number of operations that need to be postponed, prevent surgical complications that keep patients in hospital for prolonged periods, and facilitate fast recovery. UK Governments must support these efforts.
- IT systems: unfortunately, NHS IT systems are often slow, waste time, and do not give clinicians quick and easy access to critical patient information. Of anaesthetic staff, 89% say that their productivity would increase if systems were improved.
- Pension taxation: 26% of consultant and SAS anaesthetists report reducing their hours due to current pension taxation rules – which must be urgently reviewed. The current rules result in up to 1.5 million hours of lost clinical anaesthetic time per year, which could allow up to 460,000 extra patients to be seen.

Overview

Anaesthetists are innovators and have developed several ways in which the surgical pathway could deliver greater efficiency for the health service and better outcomes for patients. These innovations need support and implementation.

However, anaesthetists are also held back, including by IT systems that slow them down and factors such as the current pension taxation rules, which cause them to reduce their working hours at a time when the NHS really needs their skills. If UK Governments want to achieve their goals for NHS productivity, they need to support anaesthetists' evidence-based initiatives, and tackle the factors holding them back.

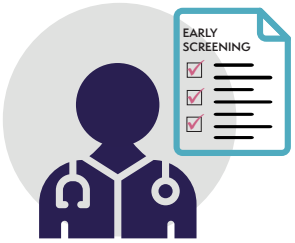
Optimising the surgical pathway

Anaesthetists play a central role in optimising the surgical pathway, with responsibilities extending far beyond their traditional expertise in anaesthesia and pain management. Modern anaesthetists often play leading roles in 'multidisciplinary' teams made up of various staff groups, including nurses and physiotherapists, to deliver high-quality perioperative care. Perioperative care refers to all the care that patients receive before and after their operation, from the moment that surgery is first considered through to complete recovery.

By driving simple but effective interventions throughout the surgical pathway, anaesthetists can help reduce avoidable inefficiencies in health services and improve outcomes for patients. These interventions also support wider system priorities, such as those outlined in the *10 Year Health Plan for England* and devolved nation equivalents – including embedding prevention, shifting care into the community, and accelerating digital transformation. Key interventions include the following.

Turning waiting lists into 'preparation lists'

Many patients arrive for surgery in a poor state of health due to either negative health behaviours, such as smoking or poor diet, or unmanaged comorbidities, such as anaemia or diabetes. If unaddressed, these factors increase the risk that an operation will have to be postponed or, if it does go ahead, raise the likelihood that complications will occur during surgery. In the case of postponements, this can lead to operating theatres standing idle, especially if the postponement occurs at short notice. In the case of complications, this can lead to extended hospital stays and additional strains on health services.



To address this, anaesthetists are driving new ways of working, such as introducing early screening services. In many hospitals perioperative teams, often led by anaesthetists, assess patients' health and modifiable risks shortly after they have been referred for surgery. When issues are identified, relevant patients are offered support. This may involve:

- advice on how to prepare for surgery
- 'prehabilitation' programmes that actively provide support services such as smoking cessation, dietary guidance and exercise support
- medical optimisation services to tackle comorbidities such as anaemia or diabetes.

Such preparation and support can reduce surgical complications by up to 50% and shorten length of hospital stay by 1–2 days.[37] Hence, screening and optimisation can help minimise the time that a patient needs to spend in hospital and promotes speedy transfer back to the community. Furthermore, many prehabilitation services can be delivered in the community itself, such as in leisure centres, further supporting the Government's 'hospital to community' shift.

Anaesthetists also conduct 'preoperative assessments' of patients, often days or weeks ahead of surgery to check that they are in a fit state for surgery. Where applicable, this can include checking to see whether prehabilitation or medical optimisation has succeeded.

It is important to note that referral for surgery also creates a valuable 'teachable moment' where patients are highly motivated to improve their health and in contact with health professionals who can deliver credible health messages. This can have major payoffs in terms of embedding the Government's shift of 'sickness to prevention' because 48–75% of patients who participate in prehabilitation programmes report lasting positive lifestyle changes.[38]

SICKNESS ✗ PREVENTION ✓

All of the aforementioned services benefit from good digital systems. If an anaesthetist can quickly and easily access relevant information about a patient's health – including information from primary care – they can make better treatment decisions, and make them faster. This can include data on the medications that a patient is taking, their allergies, their body mass index, their latest blood test results, and more.

There are examples of good systems, such as the ECS (Electronic Care Summary) in Scotland. There are also examples developed by anaesthetists themselves, for example, Guys and St Thomas's NHS Foundation Trust anaesthetists have developed a digital system that allows patient information to be easily inputted and integrated. This allows risks to be identified earlier and supports more efficient triage and care planning.

Shared decision making

Patients are not always fully involved in decisions about their care, which can undermine their satisfaction with their treatment and increase the rate at which operations of questionable value occur. Around 14% of patients report surgical regret and may have opted against surgery if they had been fully aware of the potential consequences. [39]

To address this, anaesthetists are promoting shared decision-making in the surgical pathway, using structured approaches such as the BRAN framework, where the Benefits, Risks, Alternatives and option of No treatment are all discussed. These conversations ensure that patients have a clear understanding of their condition and treatment, and that clinical decisions reflect their goals and preferences. Higher-quality shared decision making not only improves patient satisfaction, but also results in around 10% of patients deciding not to have surgery,[40] saving valuable NHS resources. In addition, patients who feel involved in decisions are around 80% less likely to pursue litigation, producing further cost savings for health services.[41]

Day case surgery

Day case surgery is an increasingly important way of reducing surgical waiting lists. By enabling patients to be admitted, treated, and discharged within the same day, it dramatically reduces length of hospital stay and improves productivity.

Perioperative teams led by anaesthetists have been instrumental in expanding these pathways. For example, procedures like laparoscopic cholecystectomy (surgery to remove the gallbladder) were previously associated with 2–3 days in hospital, but now can be delivered as a day case.[42] Technological and technical advances in both anaesthesia (such as regional anaesthesia) and surgery (such as minimally invasive surgical techniques) have enabled this shift, supported by updated guidance and resources designed to improve practice.

Enhanced recovery programmes

Anaesthetists are also key to improving postoperative care and rapid recovery. A key intervention involves supporting patients to Drink, Eat, and Mobilise (DrEaM) as soon as possible after surgery, where clinically appropriate. In general, supporting patients to do this within the first 24 hours of surgery can reduce the length of hospital stay by 37.5%,[43] contributing to better patient outcomes, more efficient use of hospital resources, and a swifter return to the community.

Discharge planning

Delayed discharge remains a significant challenge across the health service. Poor planning contributes to longer hospital stays, poor patient experience, and disrupted patient flow.

However, anaesthetists lead perioperative teams in planning for discharge well before surgery takes place, supporting patients to organise transport arrangements, liaise with community services, and provide clear recovery instructions. Effective planning helps patients leave hospital safely on time, supporting recovery and reducing readmission rates by 11.5%.[44]

Enhanced care services

In many hospitals the choice for where to look after post-surgical patients is binary. If their needs are relatively typical, they may go to a regular ward bed. If, however, they need greater care than provided on a typical ward bed, then the only other choice is to go to intensive care.

Intensive care, as per its name, is intensive. Intensive care beds have very high levels of staffing and are supported by high-end monitoring equipment that is in limited supply. As such, intensive care beds are expensive and few in number. However, not all patients who have greater needs than provided on a ward bed really need full levels of intensive care support.

Anaesthetists, and their intensivist colleagues, have therefore pioneered intermediate 'enhanced care' units, providing a third option and allowing hospitals to provide more cost-effective care to those for whom ward care is not suitable.

Quantifying anaesthetists' involvement

Of anaesthetic staff, 78% are involved in the provision of perioperative care services like those referred to above, and 22% are involved in their supervision or management.

The most common area that anaesthetists are involved with is shared decision-making – reported by 65% of census respondents. The most common area that anaesthetists are involved with managing/supervising is enhanced recovery.

Figure 28: Percentage of anaesthetic staff involved in providing or managing/supervising different perioperative care services

Service type	Percentage of anaesthetic staff involved in providing this service	Percentage of anaesthetic staff involved in managing/supervising this service
Early assessment	15	4
Preoperative assessment days/weeks ahead of surgery	34	6
Medical optimisation	19	7
Prehabilitation	6	3
Advising patients on how to prepare for their operation	18	4
Shared decision making	65	7
Enhanced recovery services	29	9
Enhanced care services	31	7
Discharge planning	16	4
Any of the above	78	22

Conclusion

Across the surgical pathway, anaesthetists are enabling more personalised, efficient, and high-quality care via perioperative interventions.

Unfortunately, the adoption of these interventions is far from universal. As such, not all patients who could benefit from these interventions actually do so. Barriers to implementation include: insufficient staffing (including anaesthetists); poor digital systems; lack of central endorsement and support; and lack of funding for start-up costs. Insufficient incentivisation for uptake may also play a role.

Fortunately, all of these issues could be addressed. Increased staffing levels are both needed and possible. They could be boosted as per the recommendations of Chapter 4. Better digital systems, as more fully outlined in the next section, would have major benefits for the health service. The UK Governments could explicitly endorse perioperative interventions and include them in their headline health plans. Furthermore, transformation funding could be provided to get schemes off the ground. Finally, clinical quality bodies, like the Care Quality Commission (CQC) in England, and devolved nation equivalents, could include perioperative interventions and outcomes in their inspection frameworks to incentivise uptake.

IT systems

As outlined in Chapter 7, the current health service IT systems are a major source of concern among anaesthetic staff, with 59% indicating that they were very or mostly dissatisfied with them. However, IT problems do not just cause dissatisfaction, they also hamper the ability of anaesthetic staff to do their jobs and undermine their productivity.

Overall, 89% of anaesthetic staff believed that improving their IT system would improve their personal productivity, including 46% who said that it would make a 'big' improvement, and 43% who said that it would make a 'reasonable' improvement.

Figure 29: Percentage of anaesthetic staff who perceive better IT systems would improve their personal productivity

Impact	Percentage of anaesthetic staff
Big improvement	46
Reasonable improvement	43
Not very much improvement	8
No improvement at all	1
Don't know/not sure	1

To narrow down the specific sources of concern, respondents to the census were asked to rate various aspects of their hospitals' IT system. In the following table we present the percentage who selected poor or very poor.

Figure 30: Percentage of anaesthetists ranking aspects of IT systems as poor or very poor

Aspect of IT system	Percentage of 'poor' or 'very poor' ratings
Computer loading speed	59
System's ability to quickly and easily provide patient information	45
System's ability to run necessary software	43
Ability to access the hospital system from outside the organisation	42
WiFi reliability	34
WiFi speed	32

The loading speed of computers came out as the most commonly cited negative factor, with 59% rating it as poor or very poor. This matches with anecdotal reports suggesting that anaesthetic staff are forced to use outdated machines that are slow. This can be frustrating and wastes extremely valuable and expensive clinical time

The next biggest source of concern was the ability of hospitals' IT systems to quickly and easily provide patient information. This matches with anecdotal reports from anaesthetic staff that they often have to load up multiple programs, which are often incompatible, to access the relevant patient information. This is another source of frustration, wastes further time, and may even undermine patient safety.

Ideally, anaesthetic staff should be able to quickly access all the relevant health data that they need on a patient to make informed, high-quality decisions about their care. This includes getting relevant data from primary care. A patient's existing medication and health behaviours all have a big impact on whether an operation can go ahead, the risk of surgical complications, and which anaesthetic should be used.

It is possible that lessons could be learned from Northern Ireland, where the widespread use of the 'Epic' system appears to have resulted in higher satisfaction ratings with IT systems in general and a clinician's ability to access relevant data. Epic is used by some hospitals in other parts of the UK too, but it's use is not universal.

Data coding

In addition to the topics outlined above, there is also an issue with how anaesthetic interventions are recorded (or 'coded') in NHS databases. This is a particular issue in maternity services where the Professional Records Standards Body (PRSB) has recently been conducting an inquiry.[45] The discovery phase of this work highlighted significant variability in the composition of anaesthetic records across England.

Good information on anaesthetic interventions is important in identifying the proportion of varied cases with which anaesthetists are involved and allows changes to be identified over time. This can help inform research studies and workforce planning at both the local and the national levels. If, for example, the number of anaesthetic interventions in maternity services is under-recorded, then workforce planners may allocate fewer anaesthetists to those services than are truly needed. This is detrimental for patients and the NHS as a whole.

It is, therefore, very important that sufficiently detailed and accurate information is recorded.

Pension taxation

In recent years, a major factor affecting the anaesthetic workforce, especially consultants, has been the pension taxation regime. In essence, if someone puts more than a certain amount into their pension each year, they may receive a tax bill.

This is a particular problem for doctors working on the NHS. The NHS pension scheme is a rigid all-or-nothing system. Doctors cannot simply reduce the amount of money that they put into it. Also, both the scheme itself and the tax system are complex. These factors combine so that doctors may receive tax bills that are large, and very difficult to predict, and may be paid out of their current earnings/savings.

The potential scale of the bills, and their unpredictable nature, mean that they can be highly disruptive to the personal finances of doctors and their families. Many doctors find that the safest way to mitigate against the worry and uncertainty around pension tax bills is to simply limit the hours that they work. This is very bad for the NHS if it wants to reduce waiting lists.

More details of the scheme and the taxation regime are set out in Appendix C.

Recent history

In the early 2020s, the RCoA pushed strongly for the pension taxation regime to be reformed alongside others like the British Medical Association (BMA). Fortunately, in the March 2023 budget, many changes were made that lessened the impact of pension taxation problems, for at least some doctors, by raising the levels that someone needed to earn to receive bills.[46] However, anecdotally problems remained – and in the 2025 census we wished to quantify this.

Numbers reducing their hours

In the census, respondents were asked if they were reducing their hours for reasons related to the pension taxation regime: 29% of consultants and 14% of SAS doctors indicated that they were – leading to a weighted average of 26%.

26%

of anaesthetists are reducing their hours due to pension taxation

It is unclear to what extent these results are caused by actuality (that is, that doctors genuinely would receive a tax bill if they worked more hours) or perception (that is, that doctors are so confused by, or uncertain about, the complex nature of the system that they err on the side of caution – even if in actuality they could work more hours without being hit). Either way, there is a problem for the NHS.

Of those reducing their hours, we asked how many extra hours they would work if pension taxation were not an issue. We asked about this in terms of the number of extra programmed activities (PAs) that a doctor would work. A 'PA' is a standard unit of doctor's time, equating to 4 hours during normal weekday working.

The average amount was 2.3 per week for consultants and 4.0 per week for SAS doctors with a weighted average of 2.5. This translates to 9.2 and 16 hours, respectively, with a weighted average of 10 hours.

Based on 29% of consultants (equating to 2,924 individuals) and 14% SAS doctors (equating to 310 individuals), we can calculate that the total amount of extra PAs worked if the pension were not an issue would be almost 8,000 (specifically, 7,993) per week, or almost 32,000 hours. On a yearly basis (accounting for leave), this comes to almost 1.5 million hours. This is equivalent to a 5% increase in working time.

The average number of cases performed per PA is 1.3, meaning that the extra hours could translate into the NHS's ability to perform up to 10,000 extra cases per week. On a yearly basis, this equates to up to 460,000 operations and procedures.

Conclusion

It appears that, despite the changes made to the system in 2023, large numbers of doctors still have concerns about pension taxation and are still reducing their hours. This puts a large constraint on NHS capacity at a time that it really needs it.

It is right that high earners should contribute more tax than lower earners. However, where the particular nuances of pension schemes and taxation combine to negatively impact NHS capacity, something needs to change. It is surely possible to create a system of progressive taxation for pensions that doesn't involve the unpredictability and productivity disincentives that the current regime imposes on NHS doctors.

Hence, we urge the Government to look at this issue again, evaluate the impact of pension taxation on NHS capacity, and make appropriate and sensible reforms.

Recommendations

Optimising the surgical pathway

- As per the recommendations in Chapter 4, numbers of funded anaesthetic training places need expanding to ensure that there are enough anaesthetists to manage and deliver high-quality perioperative care services
- There should be explicit endorsement and support from UK Governments to roll out perioperative interventions across UK health services.
- An NHS efficiencies transformation fund should be created to provide the necessary set-up costs for implementation.
- Clinical quality bodies, like the Care Quality Commission (CQC) in England and devolved nation equivalents, could include perioperative interventions and outcomes in their inspection frameworks to incentivise uptake.

IT systems

- UK Governments and health services should rapidly work to upgrade IT systems by replacing slow and outdated computers, and facilitate the adoption of integrated data systems that allow clinicians to quickly and easily access relevant patient information.

Pension taxation

- The Westminster Government should urgently re-examine the impact of current pension taxation rules on NHS capacity and make appropriate and sensible reforms.

10. Action is needed now

Key messages

- The anaesthetic workforce gap needs to be urgently addressed.
- This involves increasing training places and retaining existing staff.
- Retention involves tackling pay issues, and the pension taxation rules, and supporting progression opportunities.
- Open and transparent workforce modelling is needed for evidence-based assessment for future workforce needs.
- Better support for the wellbeing of the anaesthetic workforce also helps improve retention, and reduces time off due to stress, anxiety, burnout or depression.
- SAS doctors and LEDs need improved progression opportunities.
- Anaesthetists' efforts to optimise the surgical pathway need support, promotion and investment.
- IT systems need improving.

It is clear from the preceding chapters that the UK is chronically short of anaesthetists – with a workforce shortfall of around 2,250. Given that most operations require an anaesthetist to take place, this has a severe impact on the NHS and the patients whom it serves. We estimate, for example, that up to 1.5 million operations and procedures are unable to take place per year due to lack of anaesthetists.

The first logical step to addressing this is to increase the number of funded anaesthetic training places. Although limited progress has been made, more places are desperately needed. As of 2025, NHS hospitals across the UK had the capacity to take on around 380 extra training posts per year, including 180 at core level and 200 at higher level. If these were funded and filled, the workforce shortfall would finally start to close. There also needs to be action to stem the flow of anaesthetists leaving the health service.

Key factors include pay, pension taxation, and opportunities for progression.

It is also important that open and transparent workforce modelling is conducted and published by a public body to get a true handle on the numbers needed in the future.

Wellbeing needs attention. Many anaesthetists are unhappy and burnt out, which further drives retention challenges and leads to valuable staff taking time off. To address this, the biggest sources of dissatisfaction need attention: poor IT systems, pension taxation (again), staff parking charges, and lack of rest and refreshment facilities.

SAS doctors and LEDs face unique challenges in their working lives and most are eager for progression. Opportunities for progression need expanding, including by creating the aforementioned additional training places.

Finally, anaesthetists drive NHS productivity in the surgical pathway and have developed several interventions that improve efficiency. These need to be supported. Unfortunately, the workforce is being held back by poor IT systems and, (yet again) pension taxation.

All of these issues can and must be tackled to create an NHS that is productive, delivers for patients, gets waiting lists down and allows UK Governments to achieve their stated health ambitions. A full list of recommendations is set out in Appendix A.

Appendix A: full list of recommendations

Training numbers

- In England, 312 extra posts should be created, including 145 at core level and 167 at higher level.
- The funding arrangements behind these posts must be sufficiently generous to enable and incentivise NHS trusts to take them on.
- In Scotland, 24 extra posts should be created, 12 at core level, and 12 at higher level.
- Scottish funding rules for AiTs must be reformed to allow departments to reinvest unused funds – such as when AiTs reduce their hours - into creating additional training posts.
- In Wales, six extra training posts should be created – with precise allocation between levels to be determined.
- In Northern Ireland, eight extra posts should be created, including four at core level and four at higher level.

Retention

- UK Governments must engage constructively with doctors (including anaesthetists) on pay issues.
- Issues like pension taxation (see the recommendations under 'Boosting productivity' below) and progression opportunities (see recommendations under 'Training numbers' above) must be addressed.
- Physician assistants in anaesthesia (PAAs) should be treated with respect in all anaesthetic departments. This includes tackling bullying where it occurs and ensuring that they are supported with continued professional development (CPD).

Open and transparent workforce planning

- Each of the four UK Governments should commission a public body to produce and publish detailed and transparent workforce modelling for future healthcare workforce needs – along the lines of those produced by the former Centre for Workplace Intelligence.
- Those aforementioned public bodies should work collaboratively with the RCoA to make this happen. This involves utilising our extensive workforce data on headcounts, shortfalls, and training capacity.

Boosting wellbeing and improving working lives

- Parking charges for staff at hospitals in England and Northern Ireland should be reduced or abolished as per Scotland and Wales.
- Around the clock, access to food, drink and rest facilities in hospitals must be improved.
- As per the recommendations under 'Boosting productivity', issues about pension taxation and IT systems must be addressed.

Addressing issues for SAS doctors and LEDs

SAS doctors

- Specialty doctors who meet the criteria for the more senior specialist contract must be allowed to progress towards this.
- NHS trusts and boards should ensure that SAS advocates are in place.
- SAS staff should be included in clinical governance meetings, and provided with sufficient supporting professional activities (SPA) time.

LEDs

- LED roles should not be indefinite. After 2 years of service, LEDs should be able to gain the security of the nationally agreed specialty contract. This involves creating such policies locally where they do not already exist, and raising awareness of those policies where they do.
- Rates of pay for LEDs should factor into pay discussions between trade unions and national Governments.

For both groups

- NHS trusts and boards should promote progression opportunities – and national Governments should expand training places (as per the recommendation under 'Training numbers').
- NHS trusts and boards should adhere to the RCoA's best practice for educational support for SAS, LEDs and MTI doctors.

Boosting productivity

Optimising the surgical pathway

- Ensuring that there are enough anaesthetists to manage and deliver high-quality perioperative care services.
- There should be explicit endorsement and support from UK Governments to roll out perioperative interventions across UK health services.
- An NHS efficiencies transformation fund should be created to provide the necessary set-up costs for implementation.
- Clinical quality bodies, like the Care Quality Commission (CQC) in England and devolved nation equivalents, could include perioperative interventions and outcomes in their inspection frameworks to incentivise uptake.

IT systems

- UK Governments and health services should rapidly work to upgrade IT systems by replacing slow and outdated computers, and facilitate the adoption of integrated data systems that allow clinicians to quickly and easily access relevant patient information.

Pension taxation

- The Westminster Government should urgently re-examine the impact of current pension taxation rules on NHS capacity and make appropriate and sensible reforms.

Appendix B: anaesthetic training post funding arrangements

Typically, in England, the cost of a funded anaesthetic training post is shared between the deanery and the employing trust – both of which receive their money via NHS England, and ultimately the Treasury.

Under the current model, the deanery covers 50% of an AiT's basic salary, with the trust contributing the remaining 50% and any overtime and out-of-hours payments. The deanery also allocates an additional £13,933 'tariff' per post for educational support costs, for example, to pay for educational supervisors and study leave. There is also an additional market forces factor to further top up this payment, depending on where in England the post is located. In London, for example, this adds a bit over 15% to the tariff to reflect additional regional costs.[47]

These funds are not tightly earmarked and usually integrated into a trust's broader financial budget. Nevertheless, they represent an incentive for trusts to take on additional AiTs.

Appendix C: how NHS pensions work and their relationship with Government pension tax rules

NHS pensions

The current NHS pension scheme in England and Wales, which started in 2015, works on a defined benefit, career average basis. Unlike some other defined benefit schemes, employee contribution percentages are tiered, so the more someone earns, the greater the percentage of their salary that they have to pay in.

In England and Wales, as of 2026, employee pension contribution rates started at 5.2% for those earning up to £13,259, rising to 12.5% for those earning £67,669 and above.[48] These rates are compulsory as part of the scheme membership.[49] This means that, unlike most people working in the private sector, doctors are locked into making an all-or-nothing decision on whether to remain in the scheme – and cannot reduce their pension contributions to a lower rate except by reducing their hours.

The employer contribution rate stands at 20.6% of pensionable pay. Of this, local NHS trusts are responsible for paying 14.38% , with the remaining 9.4% funded centrally.[50]

Slightly different rates exist in Scotland[51] and Northern Ireland.[52]

Pension tax rules

The NHS pension scheme interacts with Government pension tax rules via the annual allowance.

If the value of an individual's pension grows by more than the annual allowance in a year, they will pay tax on that amount at the same rate as their income. The allowance is currently £60,000.[53]

Furthermore, the very highest earners are subject to 'tapering'. This comes where a person's 'threshold income' and 'adjusted income' exceed certain levels. These figures are £200,000 and £260,000, respectively. Threshold income includes a person's total income from all sources minus any personal contributions entitled to tax relief at source, for example, pension contributions. The 'adjusted income' includes that figure plus pension contributions.[53]

If someone's earnings exceed both the threshold income and the adjusted income, then, for every £2 that they earn over the adjusted income, the allowance decreases by £1. This can reduce the annual allowance to a minimum of £10,000.[53]

Therefore, if the adjusted income is £260,000, the annual allowance goes down to £59,999; if someone has an adjusted income of £360,000, their tapered annual allowance goes down to £10,000 – but cannot reduce furthe.[53]

If an individual's pension grows by more than the (potentially tapered) annual allowance, then tax will be due. This can be paid either the next tax year or via 'scheme pays', which involves reducing future pension benefits.[53]

Other developments

Since October 2022, the amount of pension contributions made into the NHS scheme is mainly limited to someone's full-time salary, although there are nuances. Overtime above a full-time equivalent rate is not taxable.[54] Nor are payments from the new National Clinical Impact Award scheme (NCIAs).[55]

However, although this limits a member's pension contributions, payment for this work still counts towards someone's adjusted and threshold income, and so can still lead to their annual allowance being reduced in line with the taper.[56]

Additional mitigations

In addition to the changes outlined above, there are other ways that anaesthetists, and other doctors, have sometimes been able to mitigate the impact of pension taxation – and, in some cases, may continue to rely on this:

- Carry-forwards. If someone does not use their full annual allowance in one tax year, they can carry the unused portion forward to the next. For doctors at the start of their career, this can give temporary respite from tax bills; however, for an experienced doctor, this is not a possibility.[53]
- Opting out. Opting out of the scheme is also an option, but that often represents a de facto pay cut for doing the same work and may lead to reduced death-in-service benefits.[57]
- Retire and return. If someone reaches the threshold age for one of the NHS pension schemes that they are part of (for example, at 60 for those who were part of the 1995 scheme and state pension age for those on the 2015 scheme), they can retire, then return to work but opt out of future pension payments.[58]
- Pension recycling. Some NHS trusts have offered additional pay instead of making an employer contribution, to (partly) compensate for the loss, but this is not universal.[59]
- Scheme pays. If people exceed their annual allowance, they can ask the NHS pension scheme to pay the annual allowance tax charge on their behalf, rather than paying the bill directly to HMRC. This reduces people's future pension benefits to recover the cost. However, the complexity of the scheme has limited uptake because doctors have to estimate their pension growth and potential annual allowance charges in advance and submit applications (known as 'elections') by a strict deadline, often before the final size of their tax charge is known.[53]

References

1 NHS England. 'NHS referral to treatment (RTT) waiting times data March 2026', 14 May 2026 [online].

2 Public Health Scotland. 'Stage of treatment waiting times', 26 May 2026 [online].

3 StatsWales. 'NHS waiting lists: estimate of unique patients, March 2022 onwards,' March 2026 [online].

4 Department of Health. 'Hospital waiting times statistics' [online].

5 Department of Health and Social Care. *10 Year Health Plan for England: Fit for the future*. Department of Health and Social Care, 2025.

6 Scottish Government. *Health and Social Care Service Renewal Framework*. Scottish Government, 2025.

7 Welsh Government, *A Healthier Wales: Long term plan for health and social care*. Welsh Government, 2025.

8 Department of Health. *Health and Social Care NI – Three year plan*. NI Government, 2024.

9 K. Hobson and P. Kunzmann. *Tackling Scottish NHS Waiting Lists: The role of anaesthesia.* Royal College of Anaesthetists, 2026.

10 E. Mahase. 'Government axes 1000 new training posts in England as resident doctor dispute deepens.' *British Medical Journal*, 2026;**393**.

11 NHS England. 'NHS maternity statistics, 2024-25', 16 December 2025 [online].

12 Royal College of Anaesthetists. *Physician Assistant in Anaesthesia Scope of Practice 2025*. RCoA, 2025.

13 Royal College of Anaesthetists. 'Extraordinary general meeting (EGM) 17 October 2023 resolutions', 17 October 2023 [online].

14 Royal College of Anaesthetists. 'Letter to clinical leaders in anaesthesia network', 27 February 2024 [online].

15 Royal College of Anaesthetists. 'Letter to CLAN from RCoA president', 23 February 2026 [online].

16 T. Prendergast and H. Knight. *The Elective Care Waiting List: Insights from linked data*. The Health Foundation, 2025.

17 NHS England and ONS. Assessing the Economic Impact of Tackling Elective Waiting Times. King's Fund, 2025.

18 H. Hallett. Module 3 Report: The impact of the Covid-19 pandemic on the healthcare systems of the United Kingdom. UK Covid-19 Inquiry, 19 March 2026.

19 Specialty Applications. 'Anaesthetics (inc. ACCS anaesthetics) competition ratios', 2025 [online].

20 Specialty Applications. 'Anaesthetics ST4 competition ratios', 2025 [online].

21 Department of Health and Social Care. *Medical Training (Prioritisation) Bill: Impact statement*. GOV.UK, 2026.

22 NHS England. 'Competition ratios for 2025', 24 July 2025 [online].

23 General Medical Council. *The State of Medical Education and Practice in the UK: Workforce report 2025*. GMC, 2025.

24 J. Chambers, S. Thornton, M. Tuck, S. Jackman, D. Urwin, S. Marsden, S. Francis, H. Underhil, S. Clarke and R. Assaf. *Minimising the Impact of Rotational Training Within the Anaesthetic Training Programme*. RCoA, 2024.

25 Office for National Statistics. 'National population projections: 2022-based', 28 January 2025 [online].

26 T. Watt, A. Raymond, L. Rachet-Jacquet, A. Head, C. Kypridemos, E. Kelly and A. Charlesworth. *Health in 2040: Projected patterns of illness in England*. The Health Foundation, 2023.

27 Centre for Workforce Intelligence. *In-depth Review of the Anaesthetics and Intensive Care Medicine Workforce*. CfWI, 2015.

28 C. Collins and N. Hex. *Demand and Capacity Analysis for the UK Anaesthetic Workforce 2020–2040. York Health Economics Consortium*, 2021.

29 General Medical Council. *The State of Medical Education and Practice in the UK Workplace Experiences*. GMC, 2025.

30 P. Loft and E. Parkin. *NHS Hospital Car Parking Policies in the UK. House of Commons Library*, 2021.

31 British Medical Association. 'How specialty doctors can be regraded to specialists in NHS Scotland', 12 January 2026 [online].

32 NHS Wales. *Policy for the Management of Specialty to Specialist Career Progression – Regrading. NHS Wales,* 2025.

33 Royal College of Anaesthetists. *Autonomy for SAS Doctors and Guidance on Progression*. RCoA.

34 Royal College of Anaesthetists. *Training Update: Best practice for educational support for SAS, Locally Employed and MTI doctors*. RCoA.

35 S. Hoddinott. *Performance Tracker 2025: Hospitals. Institute for Government*, 2025.

36 SAS Collective. 'Empowering SAS doctors across the NHS', [online].

37 Centre for Perioperative Care. *Impact of Perioperative Care on Healthcare Resource Use*. CPOC, 2020.

38 L. Pearce. 'Surgery school speeds up patients' recovery.' Nursing Standard, 2020;35(8):54–56.

39 C. Snowden and M. Swart. *Anaesthesia and Perioperative Medicine: GIRFT Programme National Specialty Report.* NHS England, 2021.

40 E. Boss. '*Shared decision-making and choice for elective surgical care: A systematic review.' Otolaryngology – Head and Neck Surgery*, 2016;**154**(3):405–420.

41 NHS England. *Supporting Elective Recovery – The pivotal role of personalised care in NHS England*. NHS England, 2023.

42 D. Bunting, K. Russon and A. Wheeler. *Laparoscopic Cholecystectomy. British Association of Day Surgery*, 2024.

43 NHS England. *Commissioning for Quality and Innovation (CQUIN): 2023/24 guidance*. NHS England, 2023.

44 C. E. Jones, R. H. Hollis, T. S. Wahl, B. S. Oriel, K. M. F. Itani, M. S. Morris and M. T. Hawn. 'Transitional care interventions and hospital readmissions in surgical populations: a systematic review.' *American Journal of Surgery*, 2016;**212**(2):327–335.

45 Professional Record Standards Body. 'Obstetric anaesthetic standard', March 2026 [online].

46 HM Treasury. *Spring Budget 2023*. GOV.UK, 2023.

47 Department of Health and Social Care. *Education and Training Tariffs 2025 to 2026*. GOV.UK, 2025.

48 NHS Business Services Authority. 'NHS pensions', [online].

49 NHSBSA. 'Understanding your benefits in the 2015 scheme', 2022 [online].

50 NHS Business Services Authority. 'NHS pension scheme employer contribution rates 2025/26', [online].

51 Scottish Public Pensions Agency. *NHS Pension Schemes* 2025/07. NHS, 2025.

52 HSC Business Services Organisation. '22/23, 23/24, 24/25 & 25/26 contribution rates', April 2025 [online].

53 NHS Business Services Authority. 'Annual allowance', [online].

54 NHS Business Services Authority. 'Which payments are pensionable?'. NHS [online].

55 British Medical Association. 'National clinical impact award scheme', 23 January 2026 [online].

56 HM Revenue & Customs. 'Work out Your Reduced (Tapered) Annual Allowance', GOV.UK, 2024 [online].

57 NHS Business Services Authority. 'Leaving or taking a break from the scheme', [online].

58 NHS England. 'Retire and return' [online].

59 NHS Employers. 'Pension Tax Guidance for Employers', NHS Employers, 2026.

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