

Anaesthetic Workforce Census 2025

Key Interim Findings



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1 Executive summary

Interim headline findings

- There are an estimated 9,640 consultants and 2,234 Specialist, Associate Specialist, and Specialty (SAS) doctors currently working in anaesthesia in the UK.
- UK consultant numbers have risen by an estimated 14%, and SAS doctors by 37%, compared with the last RCoA Census conducted in 2020.
- There are an estimated 4,999 Anaesthetists in Training (AiTs) and 2,150 Locally Employed Doctors (LEDs) in the UK.
- The UK has 1,571 too few consultants and 576 too few SAS doctors in order to meet current levels of demand. The combined shortfall comes to 2,147 anaesthetists, leaving numbers 15% below what is needed.
- This shortfall has grown from 1,483 in 2020 (13% below what was needed), underlining the growing scale of the workforce challenge.
- There are currently an estimated 232 qualified anaesthesia associates (AAs) in post in the UK. There are 28 Student AAs, all in their second year and close to graduation. There are no first year AAs.
- Hospitals report an overall capacity to train an extra 1,358 AiTs. Broken down to a per-year intake figure, there is space for 384 additional AiTs per year (178 at CT1-3 level and 206 at ST4-7+ level) – if government funding were made available.
- Four in ten (43%) clinical leaders said elective surgery is delayed on a daily or weekly basis because of anaesthetic workforce shortages and only 11% report no delays.
- Boosting the number of anaesthetists is the single most common factor identified by clinical leaders that could increase the rate of elective surgery, cited by 68% of respondents. This is above physical factors such as ward space (50%) and number of operating theatres (42%), and other staffing groups such as Operating Department Practitioners (55%), scrub staff (32%) and surgeons (10%).
- Based on the wider anaesthetic workforce survey, the level of wellbeing among anaesthetic staff is 7 out of 10 on a 0-10 life satisfaction scale recognised by the Office for National Statistics. This is lower than the UK population average of 7.5. Among anaesthetic staff the lowest levels are found among LEDs, who score 6.1 out of 10.
- The biggest areas of dissatisfaction identified in the working lives of anaesthetic staff were pension taxation, with 59% of respondents in the wider anaesthetic workforce survey expressing dissatisfaction, and IT systems, with 61% dissatisfied.

2 Introduction

Royal College of Anaesthetists

The Royal College of Anaesthetists (RCoA) sets the standards for anaesthesia, intensive care, and pain medicine across the UK, safeguarding patient care while supporting its members. With more than 27,000 active memberships across the College and its Faculties, the RCoA acts as a voice for its specialties, delivering education, examinations, and professional development.

Background

Anaesthetists are a highly skilled group of doctors who provide essential expertise in a range of hospital settings, including operating theatres, intensive care units, maternity wards, and perioperative care services. As such, their numbers are critical to the functioning of health services across the UK.

This report presents advanced sight of key emerging findings from the Royal College of Anaesthetists' 2025 Census. It was thought the publication of these interim results was both necessary and appropriate given:

- The development of the NHS 10 Year Workforce Plan in England
- The drafting of party manifestos for the forthcoming elections in Scotland and Wales
- The ongoing discussions around medical workforce numbers in Northern Ireland

The bulk of the data presented in this report is based on interim workforce figures from the Royal College of Anaesthetists' two ongoing workforce Census surveys. The first of these goes to clinical leaders who run anaesthetic departments, the second goes to college tutors who are responsible for the education and training of new anaesthetists. As such, the Census builds up a comprehensive picture of the anaesthetic workforce.

This is augmented with data from a third survey of the wider anaesthetic workforce.

The data from these surveys provides a key indication, with reasonable certainty, of:

- The current state of anaesthetic staffing numbers in the UK
- The shortfalls provision
- The capacity of hospitals to train more anaesthetists
- The impact of shortfalls on hospital services
- The levels of wellbeing among anaesthetic staff
- The biggest areas of dissatisfaction in the working lives of anaesthetic staff

Final figures related to these headings, and many more, will be confirmed following the close of fieldwork, data cleaning and validation of responses.

3 Methodology

Clinical leaders' and college tutors' surveys

The interim headcount, shortfall and training capacity figures in this report are drawn from data submitted to date for the RCoA Census 2025 by clinical leaders and college tutors from NHS hospitals across the UK.

- The clinical leaders' survey collects counts of anaesthetists broken down by consultants, SAS doctors, Locally Employed Doctors (LEDs) and anaesthesia associates (AAs), as well as numbers of funded vacancies and estimates of workforce shortfalls to meet demand.
- The college tutors' survey gathers information on numbers of anaesthetists in training (AiTs) and LEDs, training capacity and related educational roles.

Both surveys are being conducted online, with participants invited by email and sent weekly reminder emails to encourage completion.

As of 16 October 2025, responses had been received from approximately 86.5% of sites across the UK to the clinical leaders' survey and 95.5% to the college tutors' survey, with response rates varying across the four UK nations:

Figure 1 – Response rate for each survey by nation

Nation	Clinical leader survey	College tutor Survey
Overall	86.5%	95.5%
England	84.6%	95.0%
Scotland	96.4%	100%
Wales	83.3%	100%
Northern Ireland	90.0%	85.7%

To provide indicative national totals, reported figures have been scaled up separately for each survey and each UK nation, based on the proportion of sites in that nation that responses have been submitted for. This approach assumes that non-responding sites within each nation are broadly similar in size and staffing composition to those that have submitted data.

The following calculation was applied for each nation within each survey:

$$\text{Estimated total} = \frac{\text{Number reported so far}}{\text{Response coverage (decimal)}}$$

Wider anaesthetic workforce survey

A wider survey of the anaesthetic workforce was conducted online between 24 March and 5 May 2025, as part of the RCoA Workforce Census 2025. Email invitations and reminders were sent to all RCoA members and anaesthesia associates (AAs) who had provided their email address to the College and opted in to receiving relevant survey work. In total, 2,797 responses were received to the survey, representing a **15% response rate**.

The survey adopted a self-selecting approach, meaning participants opted in voluntarily. As such, findings should be interpreted with this mind.

Interpreting the findings

Clinical leaders' and college tutors' surveys

The findings from the clinical leaders' and college tutors' surveys are based on high response rates (86.5% from clinical leaders and 95.5% from college tutors) but are nonetheless incomplete. Scaling for headcount, shortfalls and training capacity has been used to estimate totals, but this relies on the assumption that non-responding sites are similar to those that have responded, which may not be the case. There is a slightly higher degree of uncertainty around the clinical leaders' survey figures for Wales, and for the clinical leaders' and college tutors' survey figures for Northern Ireland. Due to the smaller number of hospitals compared with England and Scotland, there is a greater chance that disproportionately large or small outliers - either included or omitted - could skew the results. Figures shown in this report should largely be treated as indicative and provisional, except in the cases where they are based on 100% complete results (e.g. the college tutors' results for Scotland and Wales). More expansive and exact figures will follow in the full census reports.

Wider anaesthetic workforce survey

Findings from the wider anaesthetic workforce survey are shown as unweighted. Therefore, figures from that survey should also be treated as indicative and provisional.

Percentages in figures

This report contains various tables and charts. In some instances, the responses may not add up to 100%. There are several reasons why this might happen:

- Only the most common responses may be shown in the table or chart.
- A question may have allowed each respondent to give more than one answer.
- Individual percentages are rounded to the nearest whole number so the total may come to 99% or 101%.
- A response of less than 0.5% will be shown as 0%.

All figures in this report have been rounded to the nearest whole number.

Base sizes in figures

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

Subgroup analysis

Subgroup analysis has been undertaken to explore the results provided by different groups, such as staff group/role, UK devolved nation, and key demographics, such as age group and gender. This analysis has only been carried out where the sample size is seen to be sufficient for comment, as smaller base sizes tend to produce less reliable results due to a wider margin of error. Where sample sizes were not large enough, subgroups have been combined to create larger groups if possible. In charts, subgroup results are not shown where the base size is fewer than 10, to avoid misinterpretation of unreliable data.

This analysis is only shown in the report where statistically significant differences between subgroups have been found at the 95% level of confidence according to the z-test. This means that we can be confident that if we repeated the same survey, 95 times out of 100, we would get similar findings.

4 Headcount numbers

Consultant and SAS doctor headcount by nation

Consultants are the most senior grade of hospital doctor in the UK and comprise the largest single group of anaesthetists. Their jobs incorporate a mix of direct clinical care provision to patients; the supervision of other grades of anaesthetists, including those in training; and a range of other tasks such as management and governance. They work on standard, nationally negotiated contracts.

Other senior anaesthetists work on Specialty, Associate Specialist, and Specialist (SAS) contracts. The more experienced in this group provide clinical care and make non-clinical contributions in a similar way to consultants. Less experienced SAS anaesthetists may typically be more focussed on clinical care and may need a degree of supervision and development. SAS contracts are also nationally negotiated.

Based on the interim Census 2025 findings, it is estimated that there are 9,640 consultants and 2,234 SAS doctors working in anaesthesia in the UK. It is interesting to note that although Scotland has more consultants than Wales, Wales has a greater number of SAS doctors than Scotland.

Figure 2 – Estimated headcount numbers of consultants and SAS doctors by nation*

Group	UK	England	Scotland	Wales	Northern Ireland
Consultants	9,640	8,161	800	478	201
SAS doctors	2,234	1,820	96	267	51
Total	11,874	9,981	896	745	252

*Figures are interim estimates based on partial responses and are subject to change following the close of the surveys.

Consultant and SAS doctor headcount growth

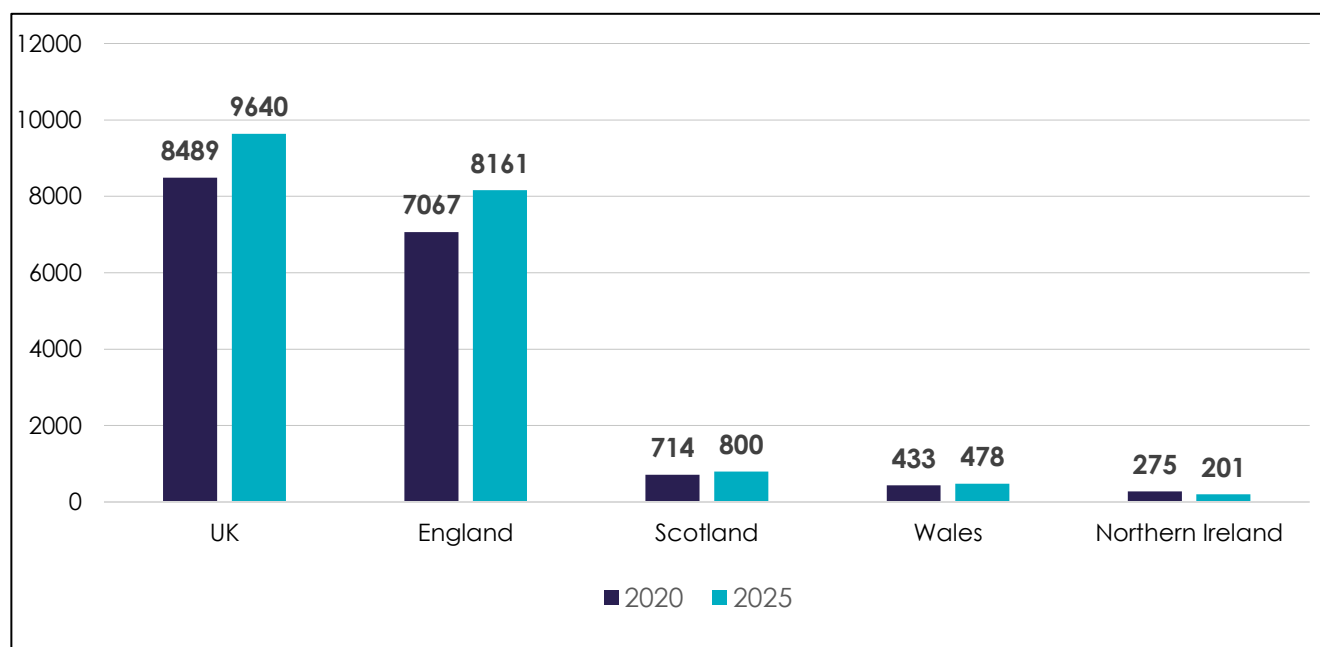
Since the last RCoA Census in 2020, it is estimated that the number of consultants working in anaesthesia has grown from 8,489 to 9,640, a growth of 14%, and the number of SAS doctors has grown from 1,635 to 2,234, a growth of 37%.

Figure 3 – Estimated headcounts of anaesthetic consultants and SAS doctors in the UK by year and nation*

Group	UK	England	Scotland	Wales	Northern Ireland
Consultants 2020	8,489	7,067	714	433	275
SAS doctors 2020	1,635	1,370	92	133	40
Combined 2020	10,124	8,437	806	566	315
Consultants 2025	9,640	8,161	800	478	201
Consultant % change	14%	15%	12%	10%	-27%
SAS doctors 2025	2,234	1,820	96	267	51
SAS % change	37%	33%	4%	101%	28%
Combined 2025	11,874	9,981	896	745	252
Combined % change	17%	18%	11%	32%	-20%

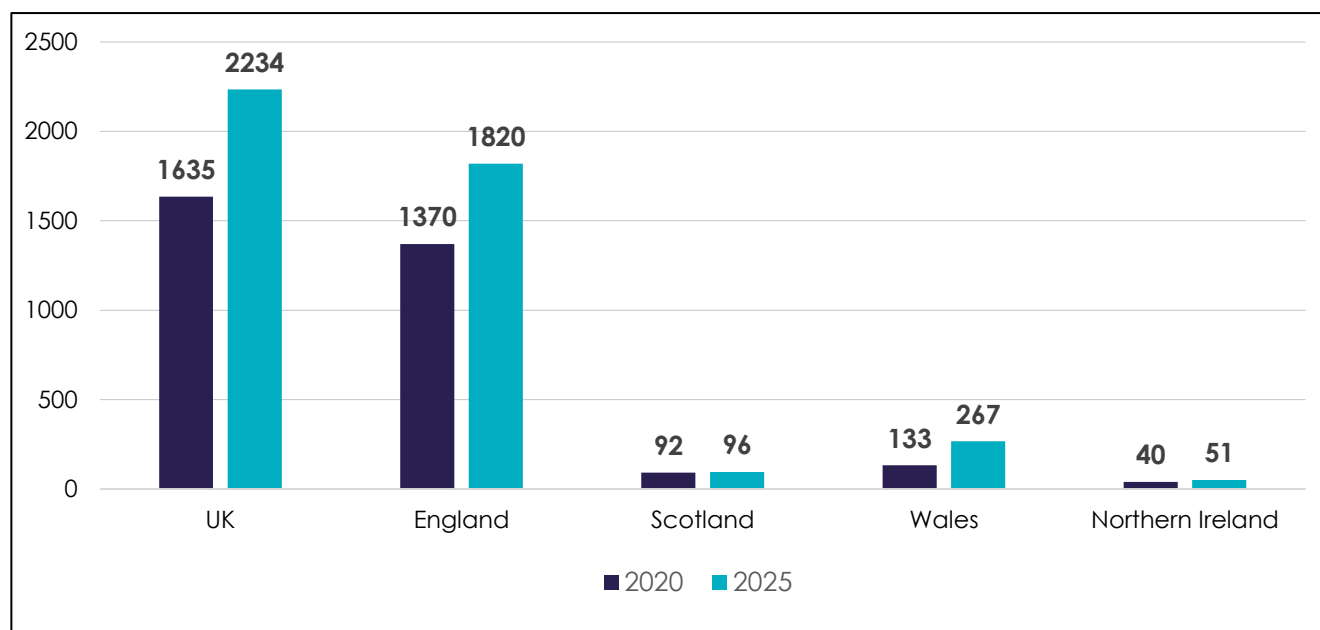
*2025 figures are interim estimates based on partial responses and are subject to change following the close of the surveys.

Figure 4 – Estimated headcounts of anaesthetic consultants in the UK by year and nation*



*2025 figures are interim estimates based on partial responses and are subject to change following the close of the surveys.

Figure 5 – Estimated headcounts of anaesthetic SAS doctors in the UK by year and nation*



*2025 figures are interim estimates based on partial responses and are subject to change following the close of the surveys.

AiT headcount by nation

Two other large groups of anaesthetists are Anaesthetists in Training (AiTs) and Locally Employed Doctors (LEDs).

The current UK medical training system involves around five years at a university medical school, followed by two years of general foundation training, followed by an application to an area of specialty training. Specialty training may be in a field such as anaesthesia, surgery, or general practice. In anaesthesia, the most common training pathway for AiTs involves three years of core or "stage 1" training (years CT1-3), followed by four years of higher training (years ST4-5, which can be referred to as "stage 2", and years ST6-7+, which can be referred to as "stage 3"). However, there are alternative routes, such as the Acute Care Common Stem (ACCS) pathway. Some AiT posts are also 'dual programme' where anaesthetic training is combined with that of another specialty, such as intensive care medicine.

Despite their name, AiTs are not merely trainees. They usually have at least seven years of medical training under their belt before they start their posts and provide a considerable amount of service provision to patients, particularly at night – often while remotely supervised by a consultant.

AiTs are almost always on national training programmes with a defined curriculum and work on nationally negotiated contracts.

Based on Census figures, across the UK, there are an estimated 4,999 AiTs in total, which comprise:

- 1,341 CT1-3 AiTs
- 1,560 ST4-5 AiTs
- 1,219 ST6-7+ AiTs
- 746 ACCS-anaesthesia AiTs
- 133 other AiTs

In most groups, numbers are greater in Scotland than Wales, as would be expected given Scotland's larger population. However, the number of ACCS-anaesthesia AiTs was higher in Wales than Scotland.

Amongst ST4-5 and ST6-7+ AiTs, there were greater numbers on single programmes than dual.

Figure 6 – Estimated headcount numbers of AiTs by nation*^

Group	UK	England	Scotland	Wales	Northern Ireland
CT1-3	1,341	1,064	145	79	53
ST4-5 single programme	1,390	1,127	131	92	40
ST4-5 dual programme	170	145	17	7	1
ST4-5 total	1,560	1,272	148	99	41
ST6-7+ single programme	1,066	863	113	55	35
ST6-7+ dual programme	153	126	19	2	6
ST6-7+ total	1,219	989	132	57	41
ACCS-anaesthesia	746	655	41	45	5
Other AiTs	133	112	19	2	0
Total AiTs	4,999	4,092	485	282	140

*Figures are interim estimates based on partial responses and are subject to change following the close of the surveys.

^Comparisons with the 2020 data are not presented here due to: a) significant changes in training programme structures since 2020, e.g. the duration of core training (CT) has increased by one year, and the duration of higher speciality training (ST) has decreased by one year since the 2020 Census; and b) increases in less-than-full-time working, which renders like-for-like comparison difficult.

LED headcount by nation

LEDs are a very diverse group of doctors in terms of job focus and experience. They are defined merely by working outside of the nationally negotiated contracts that consultants, SAS doctors, and AiTs work on. Instead, they work on local contracts which may vary hospital by hospital.

Some LEDs work at a relatively junior level, having only completed foundation training, while others work at more senior levels. They are often highly involved in direct clinical care.

LED numbers have grown substantially over the past few years. A key driver of this has been the emergence of severe bottlenecks in the medical training system. There are currently far more post-foundation doctors than there are specialty training places for them to progress to. This pressure is further compounded by the growing number of non-UK medical graduates entering the LED workforce.

Based on Census figures, there are an estimated 2,150 LEDs in the UK. It is interesting to note that there are more LEDs in Wales than in Scotland, given the population size difference between the two nations.

Figure 7 – Estimated headcount numbers of LEDs by nation*

Group	UK	England	Scotland	Wales	Northern Ireland
LEDs^	2,150	1,981	45	105	19

*Figures are interim estimates based on partial responses and are subject to change following the close of the surveys.

^This figure combines the number of LEDs who report to the clinical lead and those who report to the college tutor.

AA headcount

Anaesthesia associates (AAs) work as part of the anaesthetic team providing patient care alongside consultants, SAS, A&T, and LED doctors. AAs are not doctors and they work under supervision, with one consultant or autonomously practising anaesthetist supervising either one or two AAs. AA training is shorter and narrower than that of an anaesthetist, typically taking two years.

There has been considerable debate over the role of AAs in anaesthetic teams, and in February 2024 the RCoA requested that clinical leaders pause the recruitment of new student AAs. The pause does not apply to student AAs who, at the time of the request to clinical leaders, were enrolled on courses or already training, or to qualified AAs. The RCoA remains committed to supporting current student and qualified AAs who provide a valuable contribution to the anaesthetic team and to patient care.

In July 2025, the Government-commissioned 'Leng Review' was published, which explored the role of Medical Associate Professionals (MAPs), including AAs. The RCoA is currently considering its position in light of this review.

It is estimated that there are 232 qualified AAs and 28 student AAs in the UK. All of the student AAs are currently in their second year and approaching graduation. There appear to have been no new student AAs starting courses since the RCoA requested a pause on recruitment.

Figure 8 – Estimated headcount of qualified and student AAs across the UK

Group	UK
Qualified AAs*	232
First year student AAs	0
Second year student AAs	28
Total	260

*Figures are interim estimates based on partial responses and are subject to change following the close of the surveys.

5 Shortfalls

Consultant and SAS doctor shortfall by nation

Clinical leaders were asked to quantify how many additional anaesthetic staff they needed (if any) to meet the demand their hospitals currently face.

Across the UK there is an estimated overall shortfall of 1,571 consultants and 576 SAS doctors, creating a combined shortfall of 2,147. This means current workforce numbers are 15% below what is needed.

Figure 9 – Estimated shortfall numbers for consultants and SAS doctors by nation*

Group	UK	England	Scotland	Wales	Northern Ireland
Consultants	1,571	1,326	116	91	38
SAS doctors	576	440	55	55	26
Total	2,147	1,766	171	146	64

*Figures are interim estimates based on partial responses and are subject to change following the close of the surveys.

Consultant and SAS doctor shortfall growth

Since the last Census, there has been an estimated increase in the shortfall of consultants and SAS doctors in the UK from 1,483 in 2020 to 2,147 this year, which is 15% below what is needed.

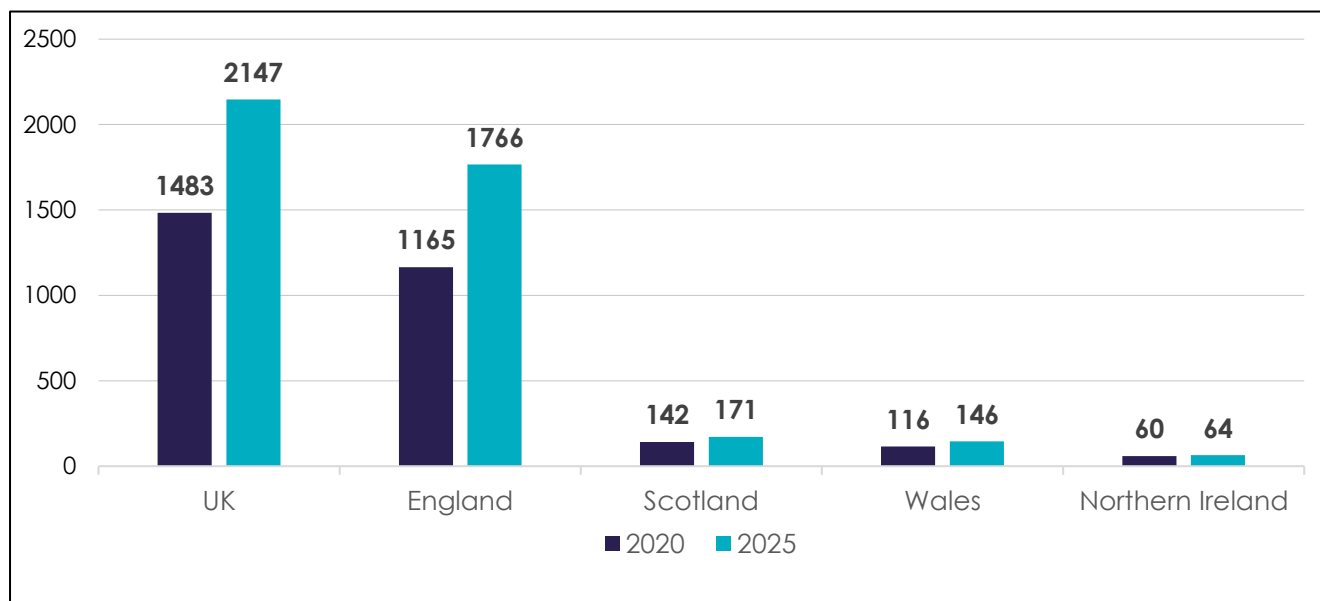
There was an increase in shortfall growth in each nation – largest for England (52%) and smallest for Northern Ireland (7%).

Figure 10 – Estimated shortfalls of anaesthetic consultants and SAS doctors by year and nation*

Group	UK	England	Scotland	Wales	Northern Ireland
Consultants 2020	1,121	901	94	97	29
SAS 2020	362	264	48	19	31
Combined 2020	1,483	1,165	142	116	60
% below what was needed in 2020	13%	12%	15%	17%	16%
Consultants 2025	1,571	1,326	116	91	38
Consultant % change	40%	47%	23%	-6%	31%
SAS 2025	576	440	55	55	26
SAS % change	59%	67%	15%	189%	-16%
Combined 2025	2,147	1,766	171	146	64
Combined % change	45%	52%	20%	26%	7%
% below what is needed in 2025	15%	15%	16%	16%	20%

*2025 figures are interim estimates based on partial responses and are subject to change following the close of the surveys.

Figure 11 – Estimated shortfalls of anaesthetic consultants and SAS doctors by year and nation*



*2025 figures are interim estimates based on partial responses and are subject to change following the close of the surveys.

6 Additional training capacity

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

Across the UK there is an estimated capacity for 534 AiTs at CT1-3 (stage 1) and 824 at ST4-7+ (stage 2 & 3) levels.

Given stage 1 training typically lasts 3 years and stage 2 & 3 training (taken together) typically lasts 4 years, dividing the aforementioned figures by three and four respectively gives a figure for the maximum additional yearly intake. This means that 178 extra CT1-3s could be recruited each year, and 206 AiTs at ST4-7+ level.

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

Figure 12 – Estimated training capacity per year for AiTs by nation*

Group	UK	England	Scotland	Wales	Northern Ireland
CT1-3 (stage 1)	178	147	20	6	5
ST4-7+ (stage 2 & 3)	206	171	22	6	7
Total	384	318	42	12	12

*Figures are interim estimates based on partial responses and are subject to change following the close of the surveys. These figures have been calculated by totalling capacity across each response and dividing by the number of years covered by each stage (i.e. by three for Stage 1 and by four for Stage 2 and 3).

7 Impact of shortages

Delays to elective surgery

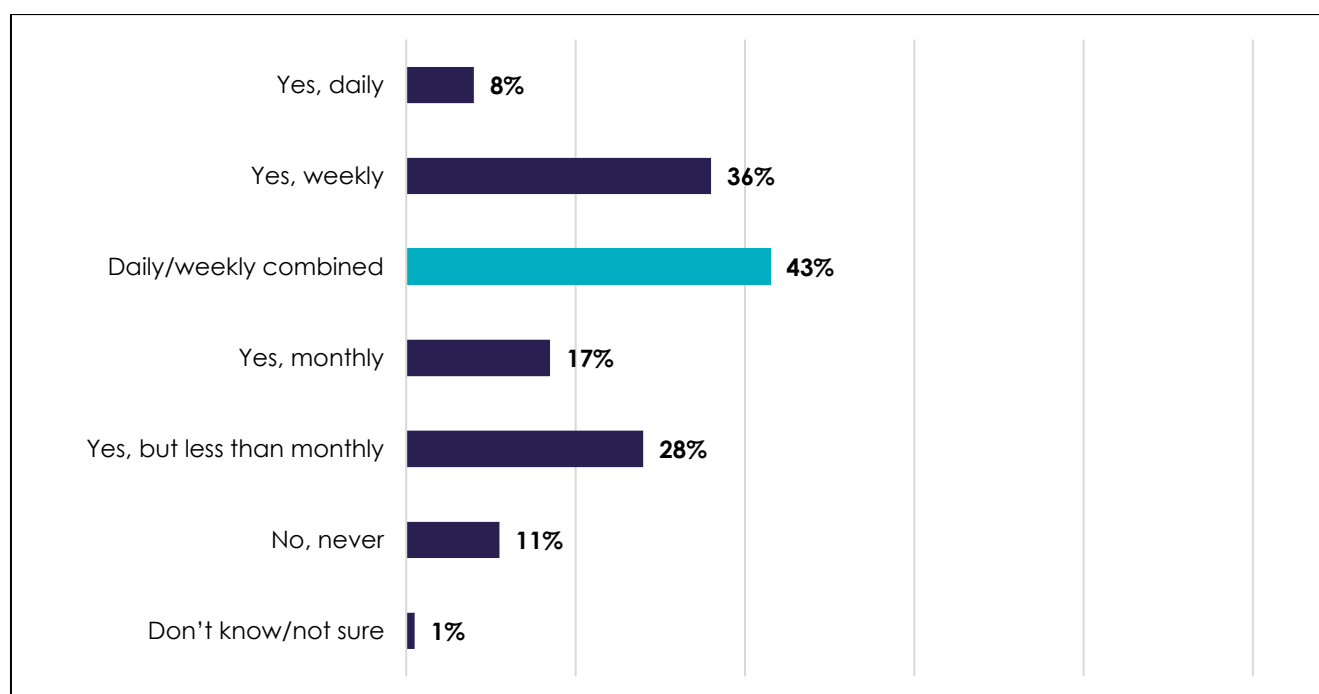
When asked if a lack of anaesthetic staff ever delayed elective surgery, 8% of clinical leaders said delays occurred daily due to this reason and 36% on a weekly basis, resulting in 43% experiencing delays because of workforce shortages at least on a weekly basis.

A further 17% said elective surgery was delayed monthly because of a lack of anaesthetic staff and 28% said it did occur, but less than monthly.

Only 11% said there were never any delays to elective surgery due to anaesthetic staff shortages.

Figure 13 – In the hospital(s) you are responding on behalf of, is elective surgery ever delayed or postponed due to a lack of anaesthetic staff?*

Base: Clinical leaders (143)



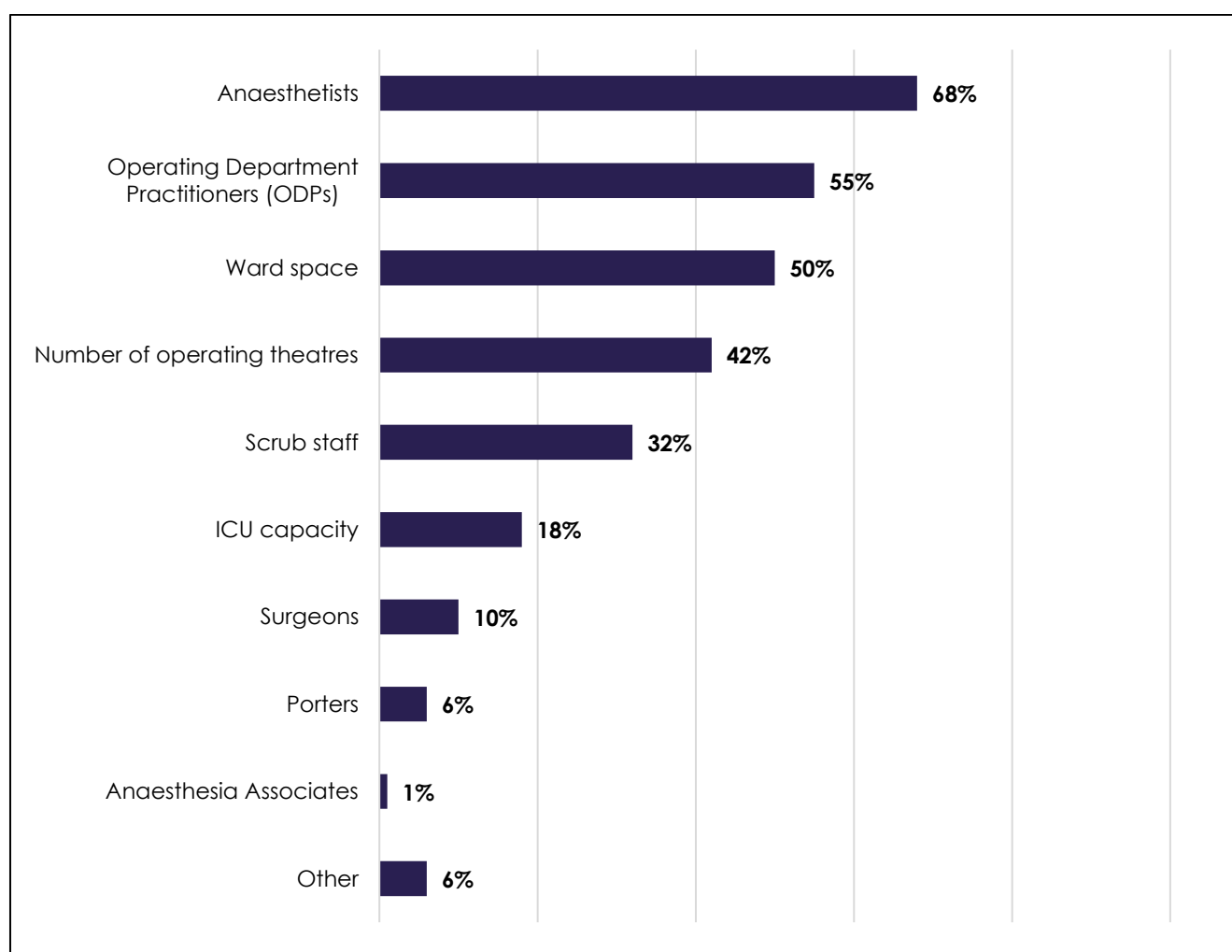
*Figures are interim based on responses to date, are unweighted, and are subject to change following the close of the surveys.

Factors holding back elective surgery

When asked about the top three factors that are most important to increase in order to boost the rate of elective activity, *anaesthetists* was the most common response, selected by almost seven in ten clinical leaders (68%). This was above physical factors such as ward space (50%) and the number of operating theatres (42%), and other staffing groups such as Operating Department Practitioners (55%), scrub staff (32%), and surgeons (10%).

Figure 14 – In the hospital(s) you are responding on behalf of, which three of the following factors would you say are the most important to increase in order to boost the rate of elective activity?*

Base: Clinical leaders (143)



*Figures are interim based on responses to date, are unweighted, and are subject to change following the close of the surveys.

8 Wellbeing

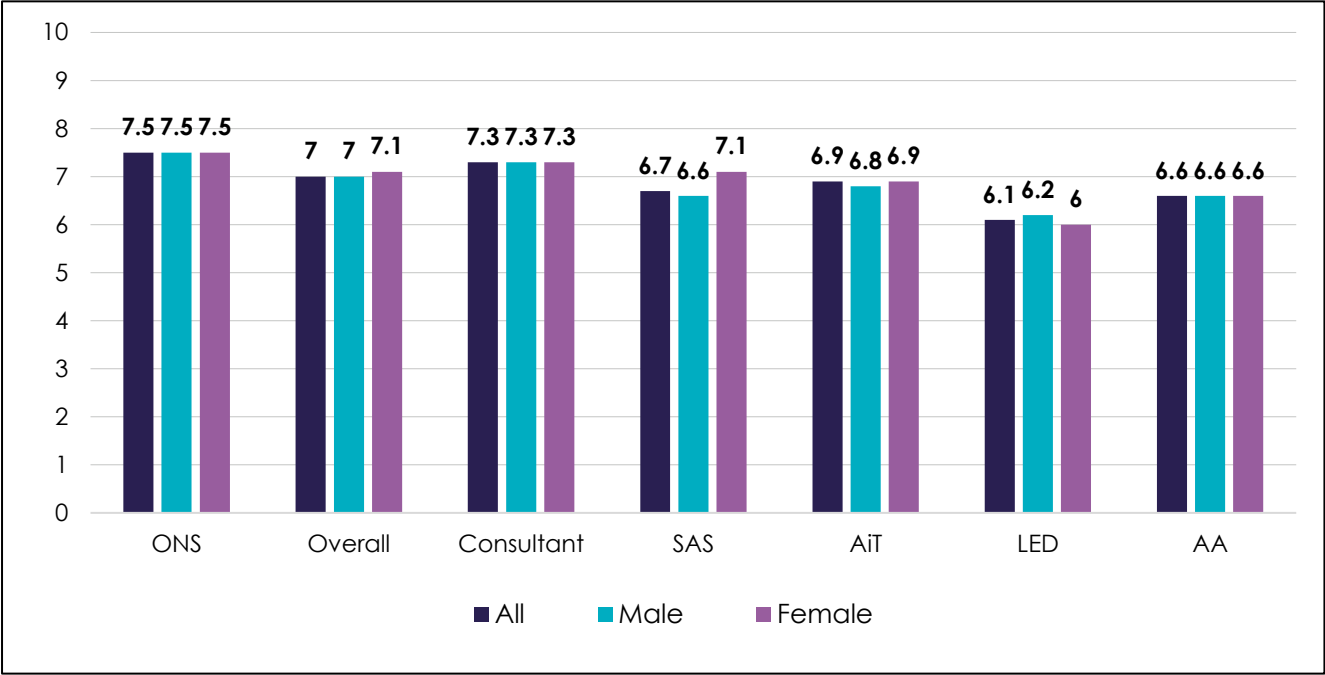
An important aim of the Census was to explore the wellbeing of anaesthetic staff and assess how it compares to national averages reported by the Office for National Statistics (ONS). One key wellbeing metric used by the ONS is 'life satisfaction'.

In the survey of the wider anaesthetic workforce, the average life satisfaction score across all respondents was 7.0, on a scale from 0 (not at all) to 10 (completely). This was below the UK population average of 7.5, according to ONS figures¹.

At an overall level, there was little difference between males (7.0) and females (7.1), but there were differences seen by staff group. Consultants recorded the highest overall mean score for life satisfaction (7.3), whereas the mean score amongst LEDs was 6.1.

For most staff groups, there was little difference between males' and females' mean scores, with the exception of SAS doctors, where females scored more highly (7.1) than males (6.6).

Figure 15 – Life satisfaction mean scores by staff group and gender*
Base: All member and AA respondents (2,797)



*Figures are unweighted.

¹ ONS Quarterly personal well-being estimates: Q4 October to December 2024

9 Satisfaction with aspects of working life

As part of the Workforce Census, the RCoA sought to quantify concerns frequently raised anecdotally by anaesthetic staff about aspects of their working lives in the NHS. These concerns span a broad range of issues, including pay, pensions, and progression opportunities, and practical matters such as parking. The Census aimed to provide a clearer picture of how widespread such concerns are across the workforce.

In the survey of the wider anaesthetic workforce, satisfaction levels with various aspects of working life among anaesthetic staff who worked in the NHS were mixed, with notable variation depending on the issue in question. Overall, 61% of respondents on average reported being satisfied (either 'very' or 'mostly') with the factors listed, while 30% expressed dissatisfaction on average.

Facilities and amenities drew some of the lowest satisfaction scores. Fewer than half of respondents were satisfied with rest facilities (47%) or the availability/proximity and affordability of parking (48% and 35% respectively), while dissatisfaction was high (44% for rest facilities, 47% for parking affordability, and 41% for the availability/proximity of parking facilities).

Food and drink access was another area of concern, with just 50% satisfied and 46% dissatisfied. In contrast, access to **staff toilet facilities** was viewed more positively (78% satisfied), one of the highest satisfaction scores.

Access to mental health support saw relatively low satisfaction (31%), though over half (52%) said this was not applicable, they didn't know or they preferred not to say, suggesting some uncertainty or low awareness.

Professional issues such as career progression, hours worked, fairness, and team support fared better. Satisfaction with the ability to progress was 68%, and 78% were satisfied with the number of hours worked and their rotas. Most (75%) were satisfied that they were treated fairly, and support from the immediate team received a particularly high satisfaction rate (87%). Workload (79%) and management/supervision (71%) also scored well overall.

Work/life balance was an area of concern for a sizeable minority, with around three in ten (29%) dissatisfied and 68% satisfied.

Pay and pensions seemed more contentious. Only 60% were satisfied with their pay, and more than a third (37%) were dissatisfied. The pension taxation regime attracted the highest dissatisfaction of all issues, with 59% expressing dissatisfaction and only 16% saying they were satisfied.

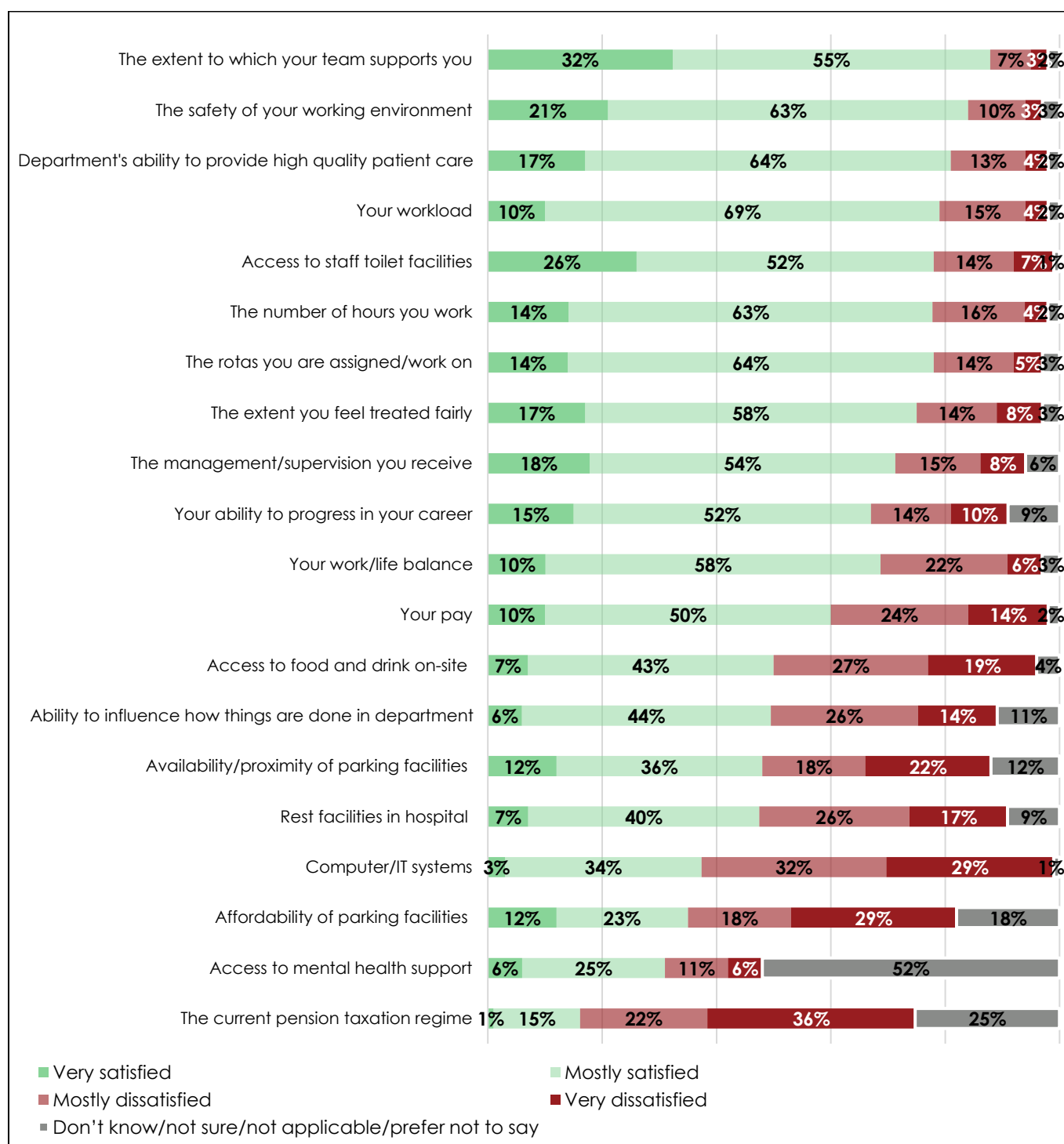
IT systems also stood out for negative feedback, with just 37% satisfied and 61% dissatisfied. This makes IT systems the most negatively rated operational issue in the list.

Safety and patient care were positive points. 84% were satisfied with the safety of their working environment, and 81% were satisfied with their department's ability to deliver high quality patient care, which were among the highest scores overall.

Influence over departmental matters was more mixed. Just half (50%) were satisfied with their ability to influence how things are done in their department, and 40% were dissatisfied, highlighting an area where staff may feel disempowered.

Figure 16 – Levels of satisfaction with factors of working life*

Base: All member and AA respondents (2,797)



*Figures are unweighted.

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