



SCPS DEI Census 2025

Workforce Analysis: Wellbeing & Inclusion

Second Installment of a Longitudinal Series

Society of Clinical Perfusion Scientists of Great Britain and Ireland

Prepared by Aswani Parmar | DEI Data collected: November 2025

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John O'Neill as author of the N+1 Survey (2023)

Noel Kelleher & James Tyrell as co-designers of the 2025 Census

Valerie Campbell & Zenia Simone for administrative support throughout the process

Executive Summary

246

Total Responses

44.8%

Response Rate

53%

Female (Perfusionists)

86%

Male (Chiefs)

The 2025 DEI Census is the second voluntary survey of perfusionists workforce practising in Great Britain and Ireland. Building on the 2022 census, the survey was live for four months, November 2025 to March 2026, and received 246 responses; a response rate of 44.8%, compared to the 33.6% achieved in 2022.

In total, 549 perfusionists were surveyed and chief perfusionists were surveyed as a distinct cohort. In total, 30 chiefs responded separately from 216 perfusionists. The census constitutes the second installment in a longitudinal series, allowing SCPS to track change over time.

Purpose and scope: This is a DEI, workforce conditions and safety report. It uses protected characteristic data to identify whether workforce pressures and experiences differ across groups, and to highlight where inclusive practice and equitable progression intersect with retention, wellbeing, and service resilience.

Key Findings at a Glance

- **Female majority with male leadership:** The practising workforce is 53% female, yet the chief perfusionist cohort is 86% male.
- **Burnout risk is real:** 25% of perfusionists report being close to burnout; 54% of women and 44% of men have considered leaving the profession at some point in their career.
- **Workforce sustainability is under pressure:** 23% of perfusionists plan to retire within 10 years and 7.4% cite stress or burnout as a reason to leave.
- **Safe staffing is not universal:** 22% report their department is only sometimes, rarely, or never safely staffed; 34% meet N+1 daytime hours only.

Executive Summary

4Data sets across
4 year span**25%**

Burnout rate

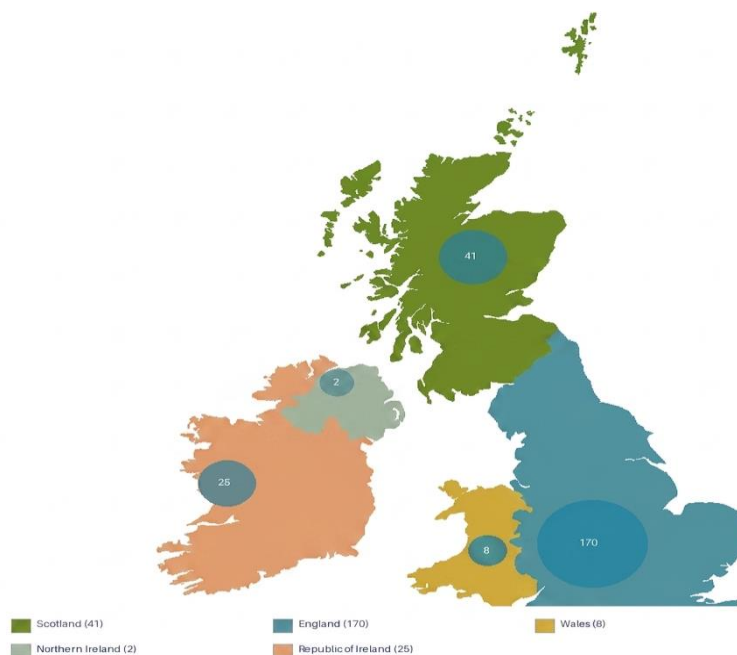
56%Are uninformed on
professional regulation**2028**

Third census

Key Findings at a Glance (cont...)

- **The profession has adapted to its own pressures:** chronically understaff departments have normalised conditions that fall below safe staffing minimums.
- **Time and resource poverty:** Only 9% always have adequate resources and only 6% always have sufficient time for CPD, research, and audit.
- **Regulation awareness gap:** 65% believe regulation will benefit the profession however 56% (121 respondents feel uninformed on what it means to be professionally regulated.
- **Respondents reported from:** England (170), Wales (8), Scotland (41), Ireland (2) and Republic of Ireland (25) with majority respondents working for the NHS (187) followed by private/locum (22) and HSE Ireland (7).

Perfusionist location (2025, n=246)



Data Quality, Limitations and a Note on Representativeness

The findings in this report are based on a 44.8% response rate from 246 respondents out of 549 surveyed. Whilst this compares well against benchmarks for voluntary professional surveys, the remaining 55.2% of the workforce did not respond. All demographic findings should be understood as estimates derived from a self-selected sample and associated bias' and as such, non-response bias cannot be ruled out; respondents to DEI-focused surveys may skew towards groups more engaged with diversity issues or dissatisfaction, which may affect the representativeness of some findings. Percentage figures throughout this report reflect the responding cohort and should be interpreted with appropriate caution.

The chief survey was distributed separately to those listed as chiefs on administrative records; however, 8 respondents self-identified as Chief within the main survey, indicating some overlap. These have been retained in the perfusionist dataset. Where margins of error are relevant, these are detailed in Section 9 Methodology and Data Quality.

This report brings together workforce conditions, wellbeing, and patient safety signals alongside diversity and inclusion metrics to inform national workforce planning.

Section 2: Key Themes

2.1 Workforce Wellbeing and Burnout

Overall work-life balance is positive for 64% of respondents. However, 25% report being close to burnout, and approximately 50% report having considered leaving the profession at some point in their career. Burnout rates are similar across genders (25% female, 25% male). Women are notably more likely to have considered leaving (54% vs 44% for men), suggesting gendered pressures beyond burnout alone; these may include on-call inflexibility, gender-based progression barriers at work and work-life friction.

It should be noted that the census question asks whether respondents have ever considered leaving, rather than whether they are actively planning to do so. Future censuses should differentiate between these two distinct states to produce a more actionable signal.

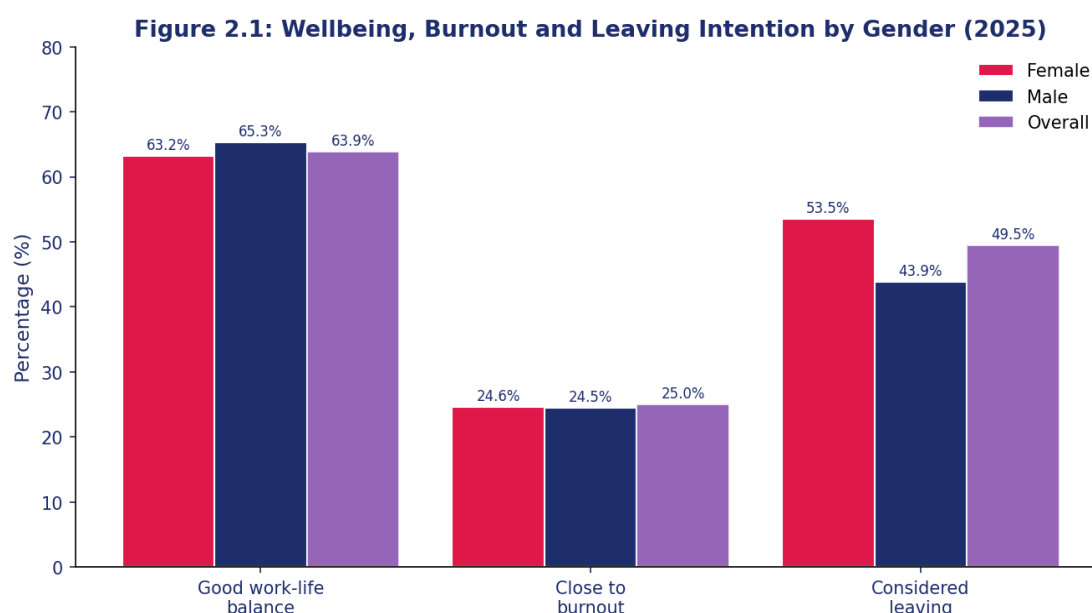


Figure 2.1: Wellbeing, Burnout and Leaving Intention by Gender (2025, n=216)

2.2 On-Call and Staffing Pressures

65% of perfusionists are on full-time on-call rotas; 28% operate pro-rata. The data does not confirm whether pro-rata on-call aligns consistently with part-time contracts, another consideration for the third census.

Of those who provided a specific on-call frequency, the most common is 1:4 (54%), followed by 1:3 (26%). A further 4% are on 1:2 or worse; a frequency widely considered unsustainable and beyond the threshold described in SCPS guidance. In accordance with the SCPS document, Recommendations for Standards of Monitoring and Safety during Cardiopulmonary Bypass (page 20): "On-call commitment should be no more frequent than 1 in 4. On-call more frequently than 1 in 3 is considered to be too onerous."

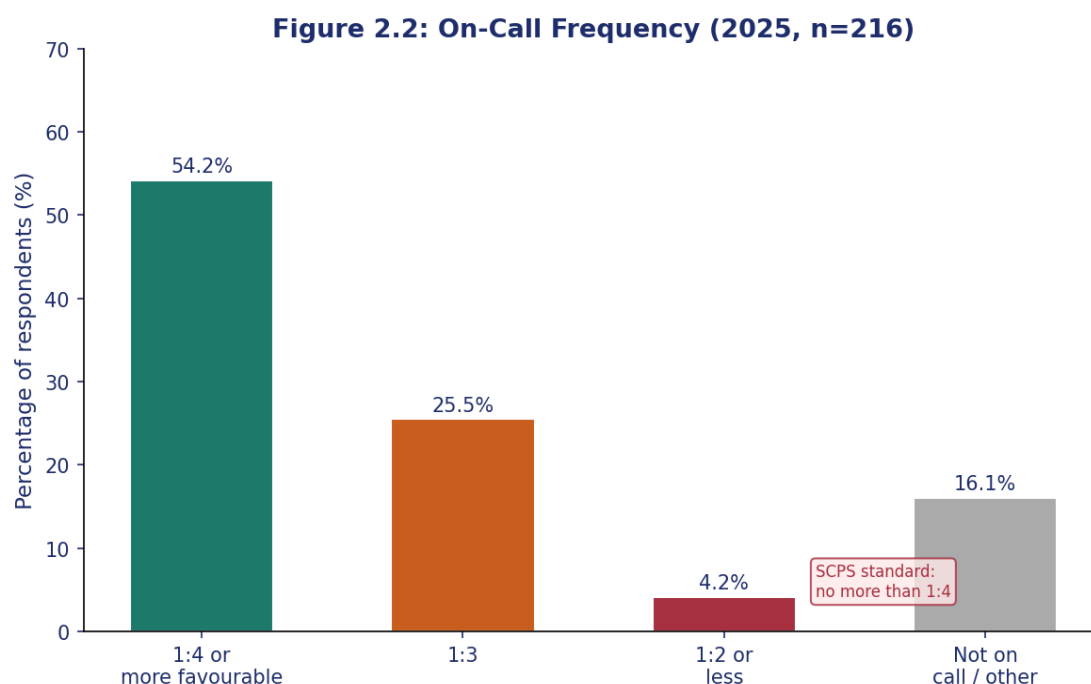


Figure 2.2: On-Call Frequency (2025, n=216)

On-Call Frequency	n	% of Respondents
1:4 or more (SCPS recommended maximum)	117	54.2%
1:3 (at threshold)	55	25.5%
1:2 or less (beyond SCPS safe standards)	9	4.2%

Table 2.2: On-Call Frequency Distribution (2025)

Free-text responses cited on-call demand 162 separate times as a key driver of burnout, poor work-life balance (64 respondents), and intent to leave (18 respondents). For female perfusionists and those with caring responsibilities, the inflexibility of on-call rotas is a particular barrier.

Where departments operate below the N+1 threshold, staff may not attain the 40 cases required annually for College accreditation. Department managers in this position are encouraged to engage with SCPS and the College to customise solutions that maintain safety, clinical competency, and appropriate use of resource for their departments.

2.3 Safe Staffing & N+1

60% of respondents report their department always runs N+1. 34% report N+1 daytime only, and 6% weekday only. Only 1 respondent reports N+1 is never met. Among chiefs, 53% report running N+1 always, 40% daytime only, and 7% during nights or weekdays only. 44% of perfusionists report their department is always safely staffed, 33% often, and a combined 22% said sometimes, rarely, or never. **Effectively, 1 in 4 perfusionist does not consider their department to be consistently safe staffed.**

Among chiefs, 40% report their department is always safely staffed, with another 40% reporting often, and 20% reporting sometimes or rarely. The consistency of findings between the two cohorts strengthens the reliability of both datasets.

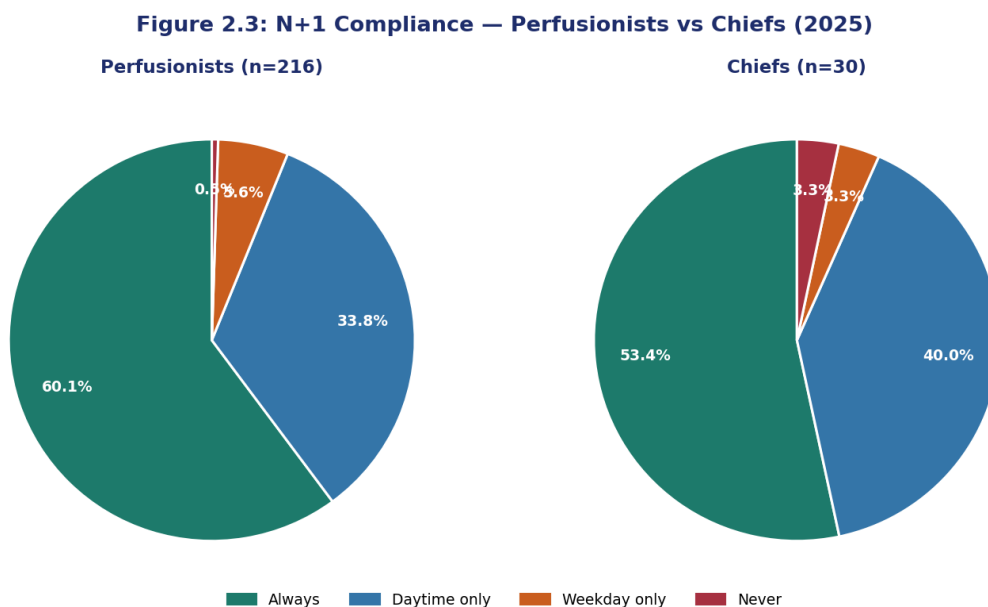


Figure 2.3: N+1 Compliance- Perfusionists vs Chiefs (2025)

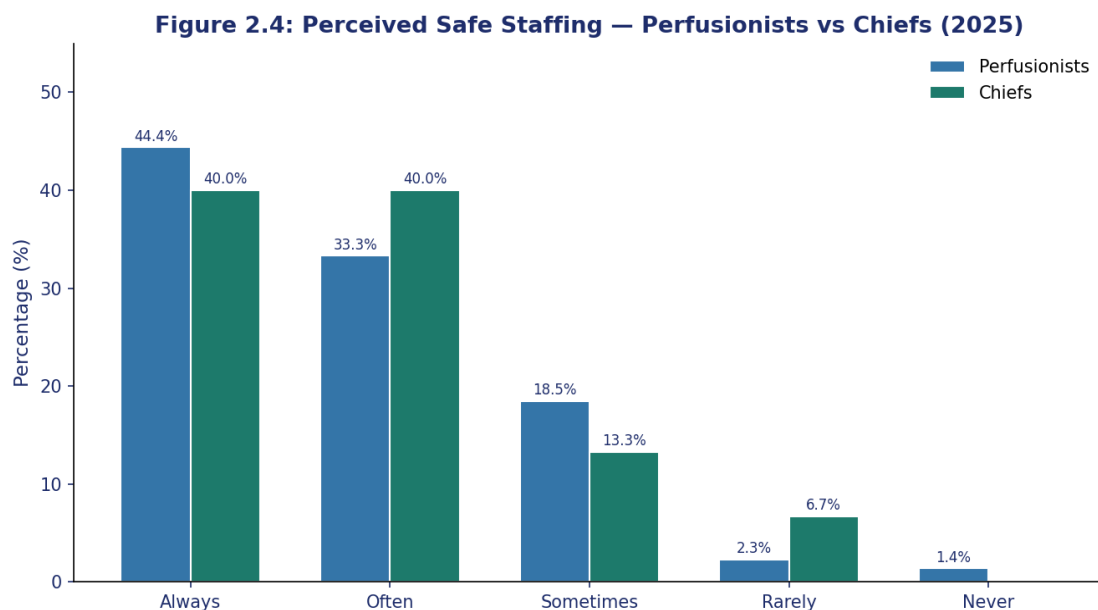


Figure 2.4: Perceived Safe Staffing (Perfusionists vs Chiefs in 2025)

2.4 Resources, Time and Professional Development

Access to both resources and time for CPD, research, audit, and administrative responsibilities is almost inaccessible. The majority report inadequate resources or sufficient time with:

- 1. 91% of perfusionists do not always have adequate resources for CPD or research.**
- 2. 94% of perfusionists do not have sufficient time for CPD or research.**

This report concludes that this is a structural under- investment undermining professional development and long-term quality of care.

The third census should consider asking how much of this work is undertaken in perfusionists' own unpaid time, to inform advocacy for protected time with job descriptions to external stakeholders. It is equally important to recognise the work that cannot be undertaken in personal time, including clinical competency.

2.5 Retirement and Workforce Sustainability

23% of perfusionists report planning to retire within 10 years. Among chiefs, 33% report planning retirement within 10 years and 63% within 15 years, with 20% expecting to retire within 5 years. Given that chiefs typically hold accumulated clinical experience and institutional knowledge, this represents a significant risk and direct implications for patient safety.

7.4% of perfusionists cite stress or burnout as a reason for planning to leave.

2.6 Professional Regulation

Support for professional regulation is largely positive: 65% support professional regulation, and 6% do not. However, a substantial proportion (56%) do not feel fully informed about regulation.

The subcommittee recommends that the SCPS executive address this gap through, written communication on progress; sustained campaigning directed at the full membership; ensuring historical information is accessible to junior and newly qualified perfusionists; outlining and updating SCPS's aspirations, red lines, and parameters for regulation; and using plain language with clear timelines.

Figure 2.6a: Support for Professional Regulation by Years of Experience (2025, n=216)

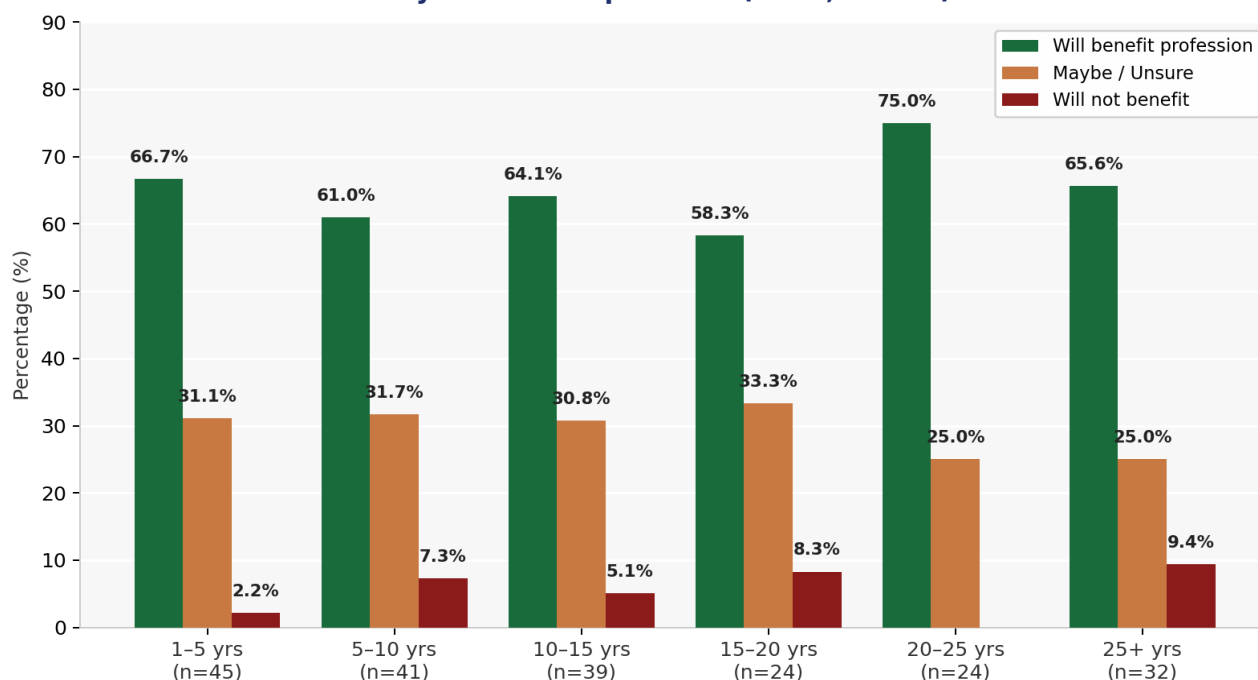


Figure 2.6b: Feeling Fully Informed About Regulation by Years of Experience (2025, n=216)

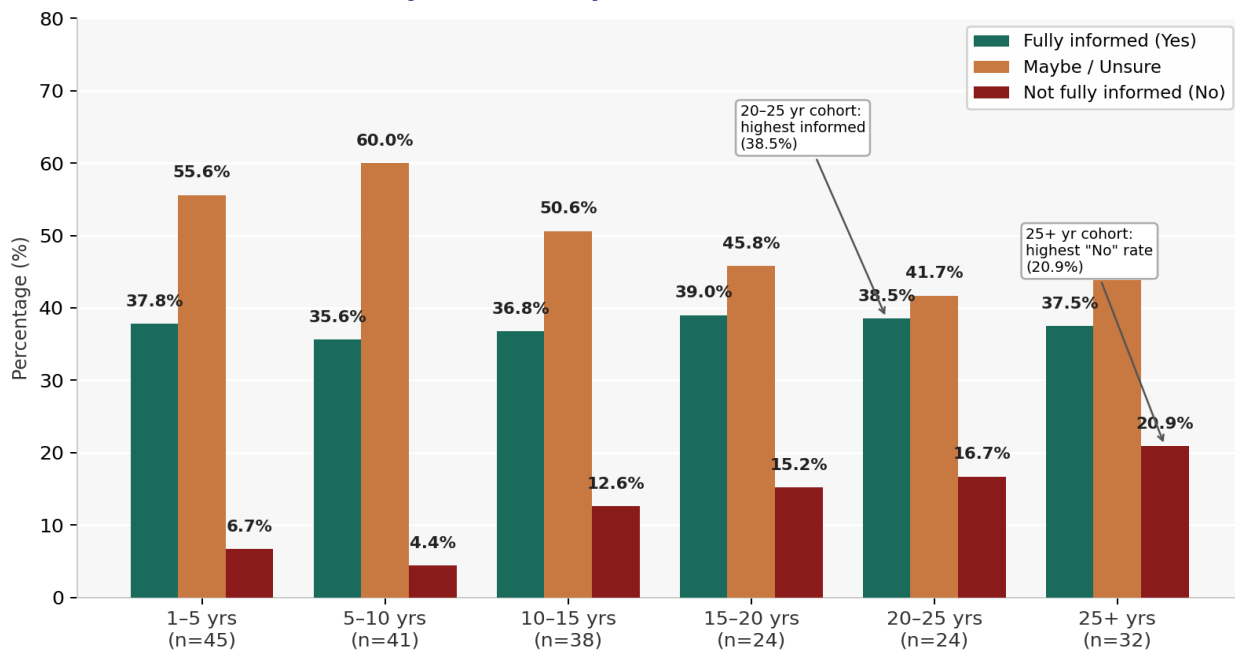


Figure 2.6a & 2.6b: Support versus informed support of professional regulation by years of experience (2025)

Section 3: Intersectional Analysis

Definitions:

Intersectional analysis examines the “flashpoints” in how overlapping characteristics meet and interact with shaping the workforce experience.

Signal strength measure in percentage point difference (pp) is calculated between the highest and lowest subgroups. Sample size caveats apply per Section 9; subgroups with fewer than 10 respondents should be treated as indicative only.

Signal Strength Key

Strong (concern)	15 or more percentage point difference between subgroups within the intersection	Moderate (concern)	8–14 point difference, or structural pattern in data distribution
Positive	Improvement versus 2022 or majority-positive finding		

The following tables and charts are presented in landscape format for readability.

3.1 Areas of Concerns

Intersection	Key Data Points	Signal
Experience × Burnout	5-10 yr post-qual: 34.1% burnout 65.9% considered leaving; 53.7% poor work-life balance. Predominantly Band 8A/8B	Strong +9.7 pp vs next highest
Band 8B × Burnout	Band 8B: 32.1% burnout vs 12.5% (Band 7) 24.2% (Band 8A)	Strong +19.6 pp vs Band 7
Band 8A × Leaving Intention	Band 8A: 62.1% considered leaving highest of any band vs 48.2% (Band 8B) 20.8% (Band 7)	Strong +13.9 pp vs Band 8B
On-Call × Leaving Intention	1:4 generates 47.0% leaving intent vs 55.6% (1:2 or less) 45.5% (1:3) On-call itself, not just frequency, is the driver	Moderate systemic signal
On-Call × Safe Staffing × Burnout	1:4 rota + poorly staffed department: 60.0% burnout vs 11.5% on same 1:4 rota in well-staffed department	Strong +48.5 pp
Safe Staffing × Leaving Intention	Rarely/sometimes: 60.0–80.0% leaving intent vs 41.7% where always safely staffed	Strong +14-38 pp
Safe Staffing × Burnout	Rarely/sometimes: 40.0–57.5% burnout vs 9.4% where always safely staffed	Strong +30-48 pp

Figure 3.1b: Banding × Burnout and Leaving Intention (2025)

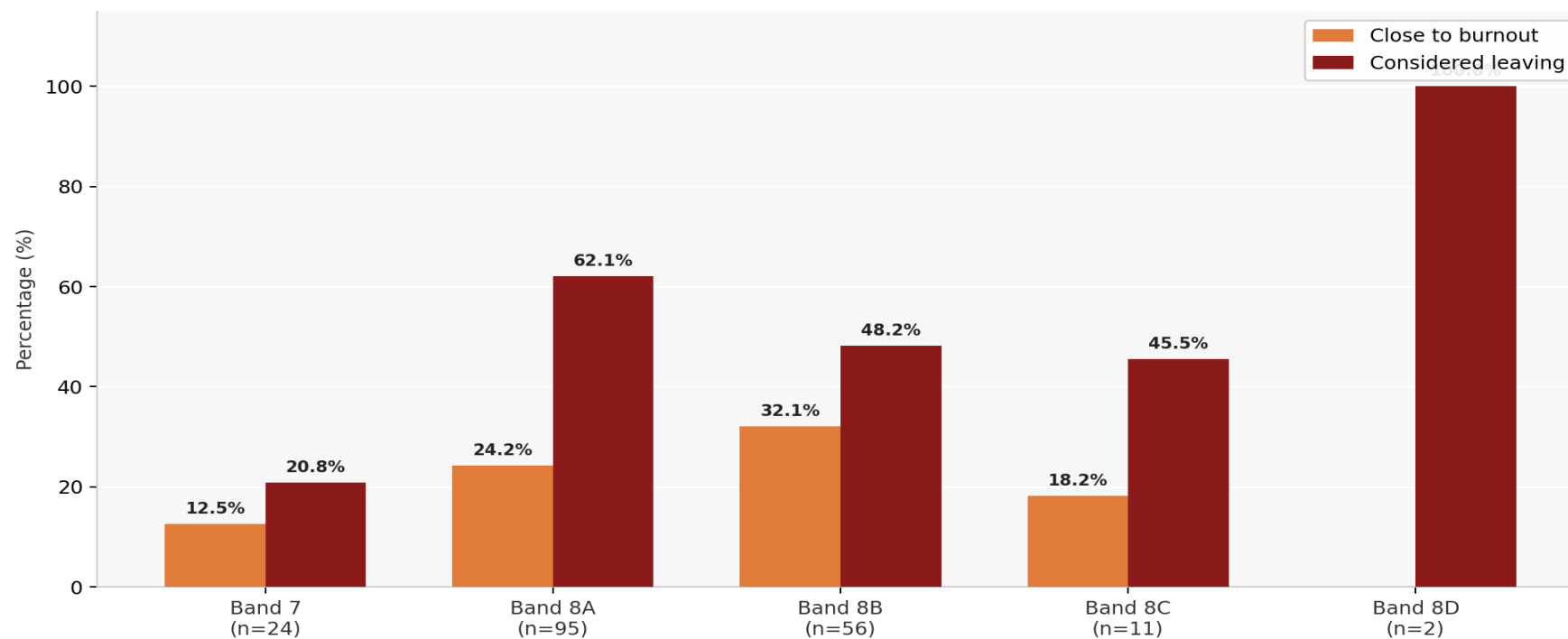


Figure 3.1b: Banding × Burnout and Leaving Intention (2025)

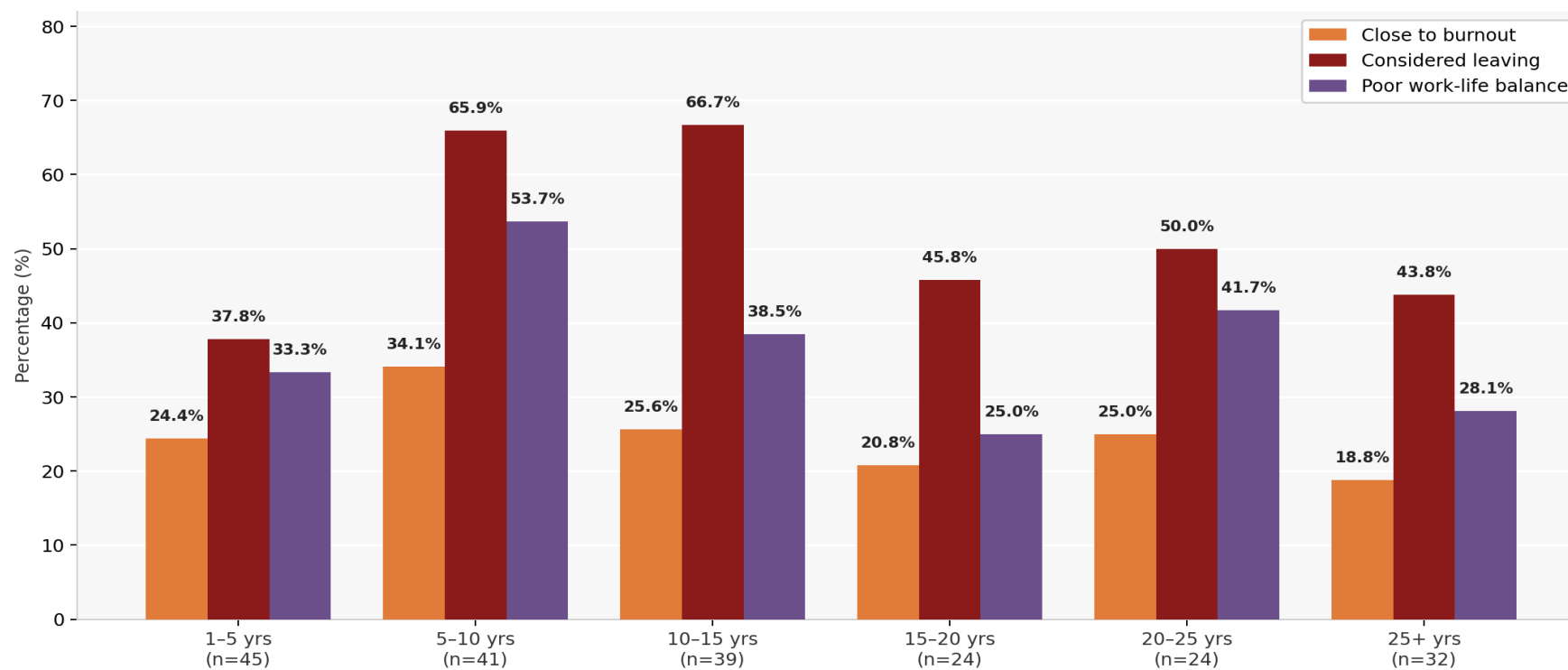
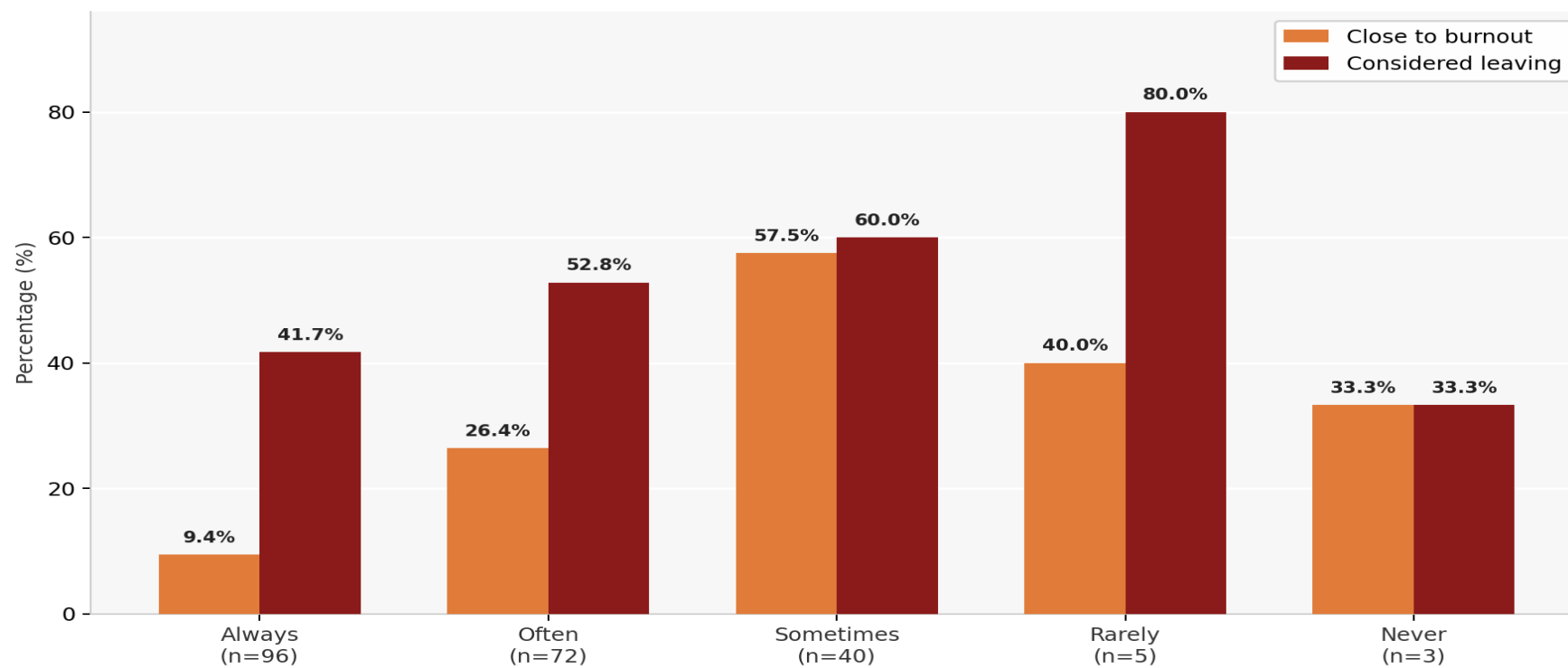
Figure 3.1c: Experience × Burnout, Leaving Intention and Poor Work-Life Balance (2025)*Figure 3.1c: Experience × Burnout, Leaving Intention and Poor Work-Life Balance (2025)*

Figure 3.1d: Safe Staffing Perception × Burnout and Leaving Intention (2025)*Figure 3.1d: Safe Staffing Perception × Burnout and Leaving Intention (2025)*

3.2 Areas of Progress and Positive Signals

Intersection	Key Data Points	Signal
Experience × Wellbeing (25 yr+ cohort)	25 yr+: 18.8% burnout 71.9% positive wellbeing. Second lowest burnout; strongest wellbeing of any experience group	Positive
Band 7 × Burnout (early career)	Band 7: 12.5% burnout lowest of any standard band. Sharp rise begins at Band 8A (24.2%)	Positive

3.3 Possible context for Data

Overnight and emergency work has become significantly more complex. Procedures once considered fringe, such as Type A aortic dissection, are now routine in overnight cardiothoracic centres due to improved screening. Sustained antegrade cerebral perfusion, often lasting many hours, adds to the technical and cognitive burdens from standard CPB. The growing expectation to support Type B dissection and out-of-hours emergency programmes further extends perfusionist exposure to highly complex work, on a regular basis.

The perfusionist managing cardiopulmonary bypass under these circumstances does so with high levels of focus over prolonged periods, sometimes exceeding 12-15 hours, whilst analysing multiple data points, at minutely intervals. Solo working in this context results in significant mental, emotional, and physical strain sustained for undefined length of time, further exacerbated by lack of sleep, rest, nourishment, and comfort breaks.

The broader multidisciplinary team in cardiac surgery includes assistants, practitioners, and juniors at most grades. The perfusionist, by contrast, operates alone in some centres; solely bearing responsibility for the patient's life during bypass, without the safety net of a peer or assistant. This insular role also burdens with non-clinical responsibilities as well as support work roles. SCPS has previously noted that incident reporting tends to capture catastrophic events, with under-reporting of lesser events; a predictable consequence of the emotional bandwidth required to report when the immediate clinical environment is already demanding.

The growing use of ECMO, both as a salvage procedure and for out-of-hospital arrests, further intensifies workload across departments. Safe staffing for on-call is a necessity for patient safety, perfusion quality, and the professional health of the workforce.

3.4 Chiefs as a Distinct Cohort

The chief perfusionist profile represents a markedly different demographic to the general workforce: 86% male, 53% aged 51–60, and 60% with 25 or more years of experience.

Figure 3.5: Chief Perfusionist Profile (2025, n=30)

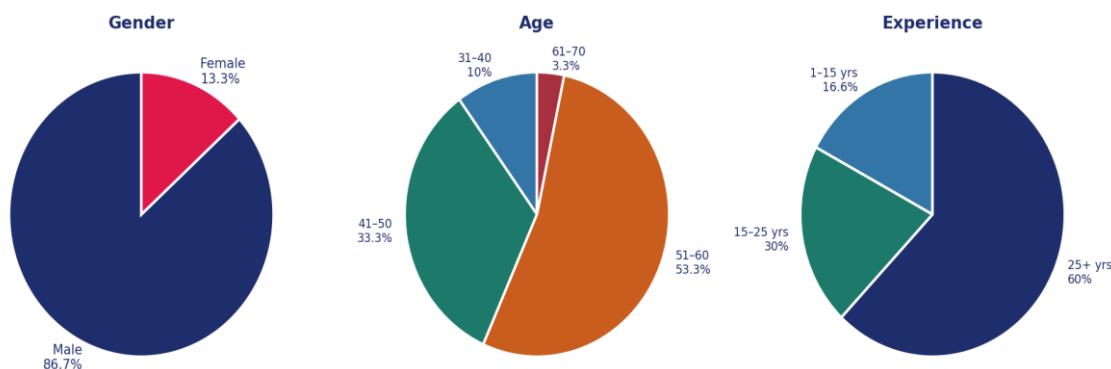


Figure 3.5: Chief Perfusionist Profile (2025, n=30)

Of the 30 chiefs who responded, **43% report that their line manager does not fully understand the perfusion role, and 43% do not feel fully supported by their manager.** This has practical implications for departmental funding, equipment procurement, and personal and departmental wellbeing. Perfusion remains among the more resource/cost-intensive components of cardiothoracic surgery for both equipment and personnell. The third census should explore in more depth the relationship between line management quality and chief wellbeing, recruitment success, and departmental safety outcomes.

Figure 5.2: Departmental Capacity to Meet Present & Future Demand (Chiefs, n=30)

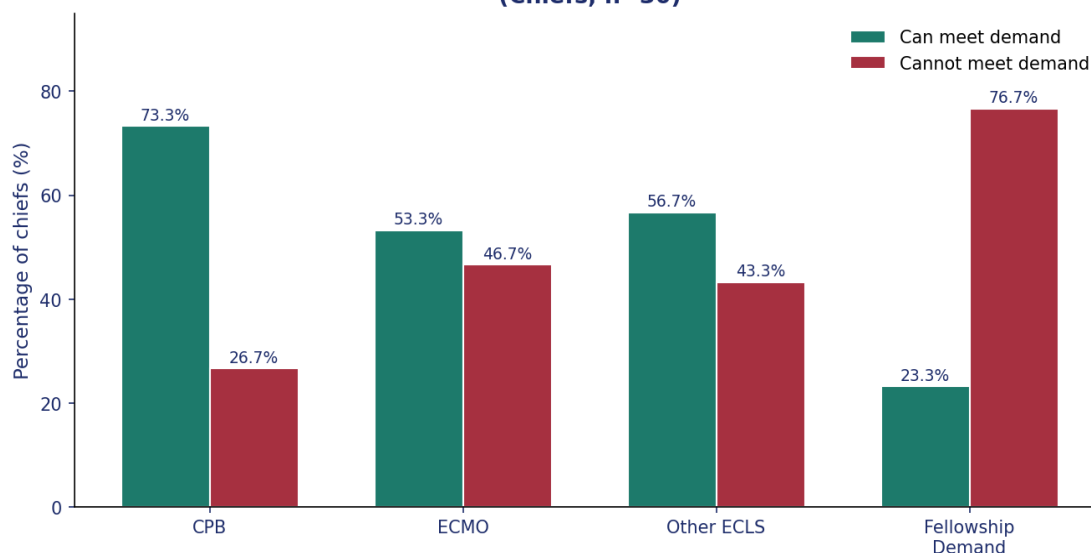


Figure 5.2: Departmental Capacity to Meet Present and Future Demand as Forecasted by Perfusion Chiefs (n=30)

Section 4: Comparative Analysis: 2022 vs 2025

4.1 What Has Improved

The response rate increased from 33.6% (181 of 538) to 44.8% (246 of 549), reflecting a 33% improvement and growing engagement with the census process.

Disability disclosure increased from 1.6% to 3.2%, suggesting improved psychological safety around disclosure. LGBTQ+ disclosure increased modestly from 2.9% to approximately 4.3%.

The design and scope of the 2025 survey has significantly expanded, covering chief level, wellbeing, regulation, patient safety reporting, and intersectional analysis not captured in 2022.

The most significant structural shift is the increase in female representation at Band 8C+: from 14.8% in 2022 to 46.2% in 2025; a 31-point improvement and the largest DEI shift in the dataset.

4.2 What Has Remained the Same

Gender imbalance remains in survey participation, with female respondents completing the survey at higher rates than male respondents in both cycles. Ethnic diversification remains stable, with approximately 84 vs 86% of respondents identifying as White across both censuses in 2022 versus 2025, respectively. Band 8A remains dominant in both, and part-time working has remained broadly stable (approximately 20% in 2022 vs 24% in 2025).

4.3 What Has Worsened or Warrants Concern

The newly captured data on burnout immediately signals high levels of professional dissatisfaction, attrition in workforce numbers from retirement and stress is concerning.

The gender disparity at chief level (86% male) requires examination of what structural barriers may be limiting female progression to senior roles as well as any structural barriers leading to 94% of the workforce with inadequate time or resources for CPD.

Section 5: Patient Impact and Clinical Scope

5.1 Perfusionist Impact on Patient Experience and Outcomes

Perfusionists report a strong belief in the clinical value of their contribution. 83% believe perfusion input in the perioperative setting always or often positively impacts patient care. This reflects the established role, globally, of the perfusionist in preoperative patient optimisation: management, peri-operative hemodynamic, antiplatelet therapies, blood disorder, oxygenator selection, cardioplegia strategy, and use of adjunct technologies such as adsorbents and filtration.

Views on postoperative impact are variable, with 50% reporting always or often positive impact. Much of postoperative care occurs in ICU settings for ECLS, IABP, and VAD patients. This figure also reflects the current limitations because of the time and resource poverty described in Section 2.4, in post-operative clinical audit to improve surgical/ perfusion quality.

5.2 Clinical Scope

Among chiefs, only 67% report their department can meet present and future demands for CPB. The picture worsens for ECMO (53%) and other ECLS (57%), suggesting growing capacity concerns in advanced modalities.

Incident reporting is predominantly via Datix (63%), with 12% also using the SCPS reporting portal. SCPS should consider strategies to better improve incident reporting, link in with national reporting systems to ensure oversight of perfusion reporting.

Section 6: Recommendations

The following recommendations are informed by the data presented across this report and the exit survey findings detailed in Section 7.

All recommendations are designed to be practicable within the resource constraints of a voluntary professional society.

Rec #	Recommendation / Action	Rationale	Owner	Timeframe
6.1.1	Re-issue on-call guidance to chiefs for escalation to managers	On-call frequency and staffing pressures are linked to burnout and unsafe staffing thresholds.	SCPS chair	Immediately
6.1.2	Facilitate burnout management content by inviting psychologists with burnout expertise to contribute to a Perfusionist publication tailored to the perfusion realities.	25% close to burnout. Free-text repeatedly cites on-call/workload as drivers.	DEI chair	12 months
6.1.5	Distribute this report to NHS England, NHSE Workforce, Health Education England, DHSC, devolved equivalents, and the Professional Standards Authority & national workforce planning.	Evidence base supports national workforce planning frameworks.	SCPS chair	12 months
6.1.4	Coordinate SCPS DEI and Education & Training subcommittees to prepare trainee/newly qualified cohort engagement for the third census (pipeline signal).	Trainee representation is low; recruitment/pipeline conclusions limited.	DEI and E&T chair	12 months
6.1.3	Launch targeted regulation communication campaign using plain language. Ensure that materials are accessible. Provide timelines and historical context.	Over half cannot confirm they feel fully informed about regulation.	IT chair/ Editor	6 months

6.1.4	Co-design next census with membership by publishing a live draft and inviting suggestions over the three-year cycle.	Strengthen relevance and engagement; improve longitudinal comparability.	IT chair	36 months
6.1.5	Incident reporting innovation: improve accessibility of SCPS reporting portal; encourage reporting of minor events; engage with national reporting oversight.	Under-reporting risk; need oversight and learning system integration.	Safety committee	24 months
6.1.6	Examine structural barriers by commissioning ad hoc surveys between census cycles to gather additional data.	Fill evidence gaps (e.g., progression barriers, subgroup experiences).	All executives & College representatives	Ongoing
6.1.7	Track longitudinal metrics: commit to consistent question sets in 2028 so trends can be measured with statistical confidence.	Series value depends on comparability across cycles.	DEI chair	Per census/ 36 months
6.1.8	Distribute report to all SCPS members.	Improve transparency, feedback loop, and engagement.	DEI chair	Immediately
6.1.9	Consider journal publication of this report to build a peer-reviewed evidence base for advocacy.	Increase credibility and reach beyond the profession.	DEI chair	12 months

Section 7: Exit Survey; Voices of Those Who Left

NB: The exit survey has 13 respondents; too small for statistical analysis. It provides a qualitative corroboration of census themes.

Between 2024 and 2026, thirteen perfusionists responded to the SCPS exit survey. The exit survey was conceived in 2024 and distributed retrospectively, with permission, to former members. This section focuses on the depth of response from a cohort of senior and experienced practitioners: 4 Seniors, 3 Chiefs, 2 Deputies, 2 Staff Grades, 1 Lead, and 1 Head of Clinical Services. Nine of the thirteen had served 21 or more years in the profession.

7.1 Why They Left

Retirement was cited by five respondents, but for at least two of these it appeared alongside work-related stress, work-life imbalance, or health, suggesting that even some retirements were accelerated by working conditions. Non-retirement departures now form the majority of responses: work-related stress and burnout was cited by **six of the thirteen (46%)**, work-life imbalance by five, and limited career progression by three, with individual respondents also citing pay, dangerous working conditions, lack of support or mentorship, and lack of professional recognition.

When asked to rate the contribution of specific factors (1 = not at all, 5 = very significant), on-call demands remained the single most consistently highly rated factor: nine of thirteen respondents (69%) scored it 4 or 5, including six scores of 5. Workload and work-life balance each received a score of 4 or 5 from seven respondents (54%). Notably, respondents rated their overall career satisfaction highly (mean 4.2 of 5): these were not disaffected practitioners.

7.2 What Corroborates the Census

Exit survey ratings align with the census findings on burnout and poor work-life balance as leading pressures. Support for professional regulation is even stronger among leavers than in the census: ten of thirteen (77%) support regulation, seven of them strongly. On resources, most leavers (62%) said resources were sufficient but could be improved; only two said they were not sufficient at all.

7.3 New Insights Not Captured in the Census

The return-to-practice barrier is corroborated by multiple respondents. One noted that returners with 10 or more years of experience face the same practical examination standard as new qualifiers; a second said their return would be "dependent on not having to take the full practical exam again";

and a third, now practising overseas, contrasted the UK approach with New Zealand, where practitioners retain their registration. This is a return-to-practice policy that SCPS could benchmark against multidisciplinary and international comparators.

Six of thirteen respondents (46%) said they would not return to the profession. However, three said they would definitely return and three more said maybe meaning nearly half of these experienced leavers are potentially recoverable under the right conditions, most commonly reduced on-call exposure and a proportionate re-entry pathway. One respondent, two years out, wrote of still missing being a perfusionist.

Three respondents rated workplace incivility, hostility or bullying at 4 or 5 as a factor in their departure, and three rated harassment or discrimination at 4 or 5. Census free-text responses include an explicit mention of being bullied as a trainee quite severely. Both datasets suggest this is an underreported but real issue; worth capturing directly in the third census.

7.4 What Could Have Kept Them

Among those who left for non-retirement reasons, common themes in response to "what could have been done differently" included: better workforce management and staffing levels; support for wellbeing and health from employers; a clearer and more compassionate return-to-practice pathway; and systemic changes to on-call load.

"I didn't fully recognise the extent of my burnout,

particularly in the aftermath of COVID-19.

Ultimately, stepping away seemed like the right decision."

Exit survey respondent (21+ years, left due to burnout)

Section 8: Comparative Analysis: The O'Neill N+1 Survey (O'Neill, 2023)

The N+1 Survey surveyed departmental chiefs across 49 of 52 registered perfusion units with a 94% response rate, using a structured questionnaire and the College's Perfusion Staffing Calculator to assess N+1 compliance nationally. It was conducted by John O'Neill in August 2023. Section 8 aims to contextualise the findings of the SCPS DEI Census 2025 against the College N+1 Survey. Its scope, methodology, and respondent base are fundamentally different from the DEI Census; it is presented here as a complement for the census findings to be understood in a broader structural context.

8.1 Methodology Note

First, the unit of analysis: O'Neill surveyed departments by means with chiefs reporting whilst DEI Census surveyed individuals, capturing their personal experience of working conditions within those departments.

Second, response rates differ significantly. O'Neill mandated survey participation as part of departmental re-accreditation; the DEI Census is a voluntary professional survey achieving 44.8% of individual perfusionists. O'Neill's data is closer to a census of departments; the DEI data carries the self-selection caveats detailed in Section 9.

Third, the O'Neill data was collected between November 2022 and August 2023, approximately two years before the DEI Census. Some findings may have evolved in the interim.

8.2 Where the Two Datasets Align

The most notable area of alignment is on-call frequency. O'Neill found 9 units operating above the 1:3 threshold and 10 at exactly 1:3; meaning approximately 38% of units were at or beyond the limit the profession's own standards describe as too onerous, the proportions are consistent and mutually reinforcing between surveys. Both datasets confirm that a significant minority of the perfusion workforce is operating above safe thresholds and have good contingency.

Both reports independently identify management time constraints resulting from staffing pressures. O'Neill notes that protected management time is routinely lost to chronic staff shortages, leaving chiefs unable to develop quality management systems, governance, conduct emergency drills, or implement drug protocols much like the findings in the DEI Census.

The retirement risk is corroborated across both datasets. On professional regulation, both reports arrive at the same conclusion from opposite directions. O'Neill states explicitly that the College's inability to enforce N+1 standards over many years of accreditation visits is an argument for statutory regulation and the DEI Census finds 65% of perfusionists support regulation.

8.3 Where the Two Datasets Diverge

O'Neill's calculator-based analysis found that only 33% of units meet N+1 when accounting for staff on the on-call rota. The DEI Census found that 60% of individual respondents believe their department always runs N+1; a 27-point gap. A substantial proportion of perfusionists believe they are working in N+1-compliant departments when structural analysis suggests they are not.

This is consistent with the well-documented phenomenon of normalisation of deviance: when persistent conditions do not change, the perception of those conditions adjusts. Interestingly, DEI Census free-text responses include individuals providing descriptions of departments as safely staffed yet peculiarly describe burning out, thin rotas, and walking on thin ice. This cognitive dissonance is a maladaptation to persistent conditions.

O'Neill also identifies three centres with sufficient staffing to provide N+1 out of hours who choose not to. The DEI Census cannot identify which category a respondent's department falls into; only the O'Neill report provides this distinction.

8.4 Reading the Two Reports Together

The O'Neill N+1 Survey and the SCPS DEI Census 2025 capture different data, at different times, from different perspectives. Alongside the 2022 Census and Section 7 Exit Survey, they form a longitudinal and multi-perspectival evidence base for the state of the perfusion profession. Four independent sources arrive at a consistent picture.

Section 9: Methodology and Data Quality

9.1 Response Rates

DEI census is a voluntary professional survey distributed to all registered perfusionists. Voluntary surveys typically achieve response rates of 20–35%. The 2025 rate of 44.8% (246 of 549) exceeds this benchmark and the membership should be proud of the turnout; SCPS should take every effort to act on these findings and continue to advocate for the wellbeing of the profession.

9.2 Margins of Error

At 95% confidence, the 2025 perfusionist sample ($n=216$) carries a margin of error of approximately ± 6.7 percentage points for proportions near 50%. For more extreme proportions, for instance the 25% burnout figure, the margin narrows to approximately ± 5.8 percentage points. This means the true burnout rate lies between approximately 19% and 31% with 95% confidence.

The chief cohort ($n=30$) carries a margin of approximately ± 17.9 percentage points at 95% confidence. Chief-level findings should be treated as directional and contextual.

9.3 Subgroup Reliability

Main findings for the full perfusionist cohort, female respondents ($n=114$), male respondents ($n=98$), Band 8A ($n=95$), and Band 8B ($n=56$) are statistically reliable. Ethnic minority ($n=29$), LGBTQ+ respondents (approximately $n=9$), trainees ($n=12$), and respondents with a disability ($n=7$) are too small for standalone analysis.

9.4 Self-Selection Bias

Both 2022 and 2025 are self-selected samples. Perfusionists who responded may differ systematically from those who did not. Those experiencing higher levels of distress or engagement may be more likely to participate. This means the reported levels of burnout, intent to leave, and staffing concerns may underestimate the true picture across the full workforce.

Section 10: Conclusion

The 2025 census produces a clear picture for those willing to read it without sentimentality. The strong signals of on-call demand, burnout, leaving intention and attrition risk are structural. They will not resolve without deliberate intervention, and they will worsen if the underlying conditions remain unchanged or ignored.

The findings are a mixed picture, as is to be expected of any complex workforce. There are areas of genuine progress; and at the same time, the data identifies pressures that are persistent and, in some respects, worsening. One in four perfusionists is close to burnout. Half have considered leaving the profession. On-call demand is the single most consistently cited factor by those who have left. Safe staffing is neither universal or fairly distributed nationally. Resources and protected time for professional development are severely constrained.

SCPS exists in the same constrained environment as its membership: limited funding, de facto regulatory responsibilities without statutory authority, and a geopolitical and economic backdrop that makes every discretionary NHS or private expenditure harder to justify. The temptation in that context is to report and wait. This report advocates against waiting. What the longitudinal series ultimately signals for is **accountability, ownership of the problem and drive to ensure transformational and lasting change**; for the profession, for its workforce, and for the patients. This report is the second installment of that record.

A dramatic response is what the data asks for as well as for a consistent one. SCPS's role is to monitor, report, and advocate on behalf of its membership and its patients; and to demonstrate that the data its members contribute produces visible, meaningful action. The recommendations in Section 6 are designed to be practicable within the resources of a voluntary professional society. Acting on them, and reporting that action at the 2028 census, is how the longitudinal series acquires and retains its value.

“The Society of Perfusionists, as it was previously known, was formed in 1974. We are an elected body of experienced Clinical Perfusion Scientists from across Great Britain and Ireland. Our main objectives are to promote the advancement of perfusion technology and to represent the thoughts and interests of the profession.”



References

O'Neill, J. (2023). N+1 Survey Report. Submitted to the College of Clinical Perfusion Scientists Council, August 2023.

Society of Clinical Perfusion Scientists of Great Britain and Ireland (2022). Report on the first SCPS/CCPS Census 2022. SCPS.

Society of Clinical Perfusion Scientists of Great Britain and Ireland (2024). Recommendations for Standards of Monitoring and Safety during Cardiopulmonary Bypass. SCPS.

Appendix

i) Exit survey

Exit Survey: Perfusionists leaving the UK accreditation register

This survey is conducted by the Society of Clinical Perfusion Scientists of Great Britain and Ireland (SCPS) in collaboration with CCPS and healthcare organisations across the UK. Your responses will provide valuable insight into your experience as a perfusionist and help us identify opportunities for improving recruitment and retention within the profession. All responses are confidential.

Name:	Center:
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Section 1: Background Information

1. How long have you been working as a clinical perfusionist?

Less than 1 year	1-5 years	6-10 years	11-20 years	21+ years	Trainee
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2. Which region of the UK are you primarily employed in?

England	Scotland	Wales	Northern Ireland	Ireland
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3. What type of employer did you work for?

NHS	Private hospital	Locum	Other:
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4. What was your designation as a perfusionist?

Trainee	Staff grade	Clinical	Senior	Lead
Deputy	Chief	Service manager	Other	

Section 2: Reasons for leaving the UK accreditation register

5. Will you be practising on a Perfusion accreditation register *outside of the UK*?

Yes	No
If yes, where?	

6. What are the main reasons for your decision to leave the profession? (Select all that apply)

Work/ life balance	Salary and value	Career progression limitation	Work related stress/ burnout	Lack of professional recognition/ respect
Job satisfaction	Health	Relocation	Family/ personal reasons	Lack of support/ mentorship
Retirement	Dangerous working conditions	Pay/ remuneration for roles/ responsibilities	Other (please specify)	
Comments:				

7. How would you rate your overall job satisfaction in your role as a perfusionist?

Very satisfied	Satisfied	Neutral	Dissatisfied	Very dissatisfied
Comments:				

8. How would you rate your overall mental health in your role a perfusionist?

Excellent	Good	Fair	Poor	Very poor
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- **Excellent** – I feel well-balanced, focused, and rarely experience stress in my role.
- **Good** – I manage stress well and generally feel mentally healthy, though occasionally, the demands of the role can be challenging.
- **Fair** – I experience moderate stress and mental fatigue, but I can generally cope with the demands of my role.
- **Poor** – I find the mental demands of my role challenging, and stress sometimes impacts my ability to perform effectively.
- **Very Poor** – My mental health has been significantly impacted by the stress of the role, and I often struggle to cope with the demands.

9. To what extent did the following factors contribute to your decision to leave the profession? (Please rate each factor on a scale of 1–5, where 1 is "Not at all important" and 5 is "Extremely important")

Factors	Score	Factors	Score
Workload / work demands		On call demands	
Support from line manager		Support from colleagues/ peers	
Opportunities for research/ academic development		Professional development and career progression opportunities	
Clinical and professional recognition		Civility in the workplace/ hostile workplace/ bullying	
Salary and benefits		Salary commensurate to roles and responsibilities	

Work life balance		Harassment/ discrimination	
Other contributing factors:			

Section 3: Challenges and obstacles

10. What were the biggest challenges you faced during your career as a perfusionist?
(Select all that apply)

Inadequate training	Inadequate professional development opportunities	Inconsistent staffing	Heavy workload
Heavy on call load	Stressful work environments	Hostile work environment	Bullying by fellow perfusionists
Bullying by surgeons	Bullying by anaesthetists	Bullying by wider MDT	Harassment
Lack of support from senior management	Insufficient resources of equipment	Ethical dilemmas	Limited research opportunities
Limited career progression opportunities	Navigating complex organisational structures	Lack of recognition for the role of profession	Civility at work
Other/ your comments:			

11. Do you believe there were sufficient resources to support your role as a perfusionist?

Yes, fully	Yes, but could be improved	No, not at all	Not sure
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12. What could have been done differently to help you remain in the profession?
(Open-ended)

Section 4: Successes and positive aspects

13. What aspects of your career as a perfusionist did you find most rewarding?
(Select all that apply)

Patient care and making a difference	Collaboration with MDT	Opportunities for skill development	High technical skills acquired	High scientific knowledge attained
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High data analysis and interpretation skills acquired	Job security	Colleagues and peers' relationships	The operating	Pay/ remuneration
Other (please specify)				
Comments:				

14. How would you rate the level of support you received from the SCPS during your career?

Excellent	Good	Fair	Poor	N/A (never interacted with SCPS)
Comments:				

15. How would you rate the level of support you received from the CCPS during your career?

Excellent	Good	Fair	Poor	N/A (never interacted with CCPS)
Comments:				

16. In your opinion, what are the strengths of the perfusion profession?

17. In your opinion, what are the weaknesses of the perfusion profession?

Section 5: Recommendations for the future

18. What changes or improvements do you believe should be made within the perfusion profession to improve retention?

19. How could have the SCPS/CCPS done better support perfusionists to improve your retention?

20. In your opinion, what role does professional regulation play in the future of perfusion practice and its impact on workforce retention?

Strongly support professional	Support professional regulation, with conditions	Neutral	Oppose professional regulation	Strongly oppose professional regulation	Unsure
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Comments

21. Do you have any further comments or suggestions on how the profession could be improved, particularly in terms of retention, support, or development?

Section 6: Closing thoughts

22. Would you consider returning to the profession in the future?

Yes, definitely	Yes, possibly	No	Not sure
If yes, what would be the circumstances?			

23. If you would like to be contacted for follow-up or further discussion about your experience, please provide your contact details (optional).

Contact number:
Contact email:

Thank you for taking the time to complete this survey. Your feedback means a great deal to us as we work to improve the profession and better support our membership. Both the SCPS and CCPS are truly grateful for your service and the positive impact you have had on our patients undergoing cardiopulmonary bypass and are deeply committed to creating a community that supports and uplifts you. Best wishes for your continued success.

