Royal College of Surgeons of England

ADVANCING SURGICAL CARE

Advancing the Surgical Workforce:

2025 UK Surgical Workforce Census Report

ADVANCING THE SURGICAL WORKFORCE:
2025 UK SURGICAL WORKFORCE CENSUS REPORT

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Contents

List of abbreviations

BDA – British Dental Association

BMA – British Medical Association

CEPOD – Confidential Enquiry into Perioperative Deaths

EST – extended surgical team

JCST – Joint Committee on Surgical Training

LEDs – locally employed doctors

LTFT – less than full time

NICE – National Institute for Health and Care Excellence

NHS – National Health Service

NHSE – NHS England

PAs – programmed activities

RCS England – Royal College of Surgeons of England

SAC – specialty advisory committee

SAS – specialty and associate specialist

SPAs – supporting professional activities

TPD – training programme director

Foreword

The 2025 UK Surgical Workforce Census Report provides a clear picture of the realities of surgical practice across the UK today. Building on evidence gathered in 2023, it offers an important longitudinal picture of how pressures on the profession are evolving. I would like to thank the 4,648 consultants, resident doctors, SAS surgeons, dental colleagues and members of the wider surgical team who contributed to this work.

The census demonstrates that the surgical workforce continues to show exceptional commitment to patient care. However, the environments in which care is delivered are under increasing strain. Many consultants regularly work beyond their contracted hours. Access to operating theatres remains a significant constraint on both productivity and training opportunities. Burnout and stress are widely reported, particularly among resident doctors. These challenges are systemic in nature, and the personal and professional costs are becoming more pronounced.

The health service is now at a critical juncture. Efforts to expand surgical capacity, reduce waiting lists and reform education will not succeed without meaningful support for the surgical workforce that delivers these services. Achieving this requires sustained investment in surgical infrastructure, improved access to theatres and beds, protected time for training, and workforce planning that prioritises both retention and future supply.

This census is not simply a reflection of current pressures; it is a call to action. Its findings must inform decisions at trust and health board level, within NHS England, the Department of Health and Social Care, and the equivalent bodies in the devolved nations. As a vital advocacy tool, this report strengthens our engagement with government and NHS leaders, helping to shape policy conversations and ensure that the needs of surgical teams are recognised, prioritised and acted on at the highest levels.

As President of the Royal College of Surgeons of England, I am grateful to every member of the surgical team who contributed to this census and for all that you do for surgical patients. I remain committed to ensuring that this evidence is used to advocate for the conditions and service that our patients and our profession deserve.

Mr Tim Mitchell
President
Royal College of Surgeons of England

Executive summary

The 2025 UK Surgical Workforce Census reveals a profession that remains deeply committed to patient care but that is operating under increasing pressure. Over half of respondents (53%) identified patient care as the most rewarding part of their role and 26% said that operating was the best part of their role. Beneath this dedication lie three persistent challenges: productivity, training and workforce sustainability.

Productivity

- **Outpatient and theatre pressures continue to constrain services:** Specifically, the increasing amount of administrative work was cited by 73% of surgical consultants, while 40% reported overbooked clinics and 37% noted that backlog pressures affected how they work.
- **Theatre access remains a critical barrier:** 53% of surgical consultants identified this as a major challenge, driven by lack of theatre space (73%), availability of theatre staff (59%) and bed availability (47%).
- **Working beyond contracted hours is widespread:** 61% of surgical and 69% of dental consultants always or frequently worked beyond their contracted hours. Additionally, 38% of surgical and 41% of dental consultants did not take their full annual leave entitlement in the past 12 months.
- **The emergency workload is increasingly complex:** 73% of surgical consultants and 64% of SAS surgeons reported having on-call commitments, with the most frequent pattern being 1:5 to 1:8. This consultant-delivered emergency service often disrupts elective care.

- **Team stability is a concern:** 41% of surgical consultants do not regularly work with the same anaesthetist(s). This is despite evidence that consistent theatre teams improve efficiency.
- **Access to surgical hubs is limited:** 48% of surgical consultants reported no access to a hub.

Training

- **Theatre access is the biggest obstacle for resident doctors:** 68% of core and 60% of higher surgical trainees reported limited access to elective lists, primarily due to emergency workload, theatre space and staffing shortages.
- **Attrition risk is rising:** 56% of core and 40% of higher surgical trainees considered leaving training in the past 12 months, with burnout cited as the main reason (65% core surgical trainees, 60% higher surgical trainees).
- **Dedicated time for training is a key area for improvement:** 44% of resident doctors identified this as an issue. Reported frequency of supervision varied, with a small proportion noting that weekly meetings with their educational and clinical supervisors were limited.
- **Exposure to the independent sector is inadequate:** Just 10% of core and 7% of higher surgical trainees reported operating experience outside the NHS in the past 12 months.

Sustainable workforce

- **Consultant vacancies persist:** 68% of surgical consultants reported new appointments in their NHS trust or health board in the past 12 months (42% replacement, 50% expansion) and yet 39% reported unfilled consultant posts.
- **Retirement intentions are concerning:** 59% of surgical consultants aged 55–59 years plan to retire within four years. Note that there is variance in specialty data.
- **Wellbeing is a key issue:** 61% of surgical and 65% of dental consultants reported burnout and stress as major challenges facing the surgical team.
- **Workplace recognition is inconsistent:** While most consultants feel valued by patients and colleagues, only 32% of surgical and 26% of dental consultants always or often feel valued by managers. Among resident doctors, the figures are lower: just 11% reported always or often feeling valued by managers.

Looking ahead

The census findings confirm that the surgical and dental workforce remains motivated by patient care. Nevertheless, it is increasingly constrained by systemic pressures. Urgent steps are needed to address the challenges highlighted in this report. These include improving access to theatres, reducing the administrative burden, protecting time for training and strengthening support for wellbeing. Ensuring that surgical teams feel valued, supported and empowered will be critical to sustaining high-quality care and building a resilient workforce for the future.

Introduction

The 2025 UK Surgical Workforce Census provides the most comprehensive snapshot of the current state of surgery across the UK. Building on the **2023 census**,[1] this year's findings reveal a workforce deeply committed to patients but increasingly stretched by rising demands, limited resources, and growing concerns around training and wellbeing.

The census has been undertaken by RCS England, in collaboration with the Royal College of Surgeons of Edinburgh, the Royal College of Physicians and Surgeons of Glasgow, the ten surgical specialty associations, SAS surgeons and two of the surgical trainee associations (the Association of Surgeons in Training and the British Orthopaedic Trainees Association). Dental colleagues and the EST were also included, ensuring that the report reflects the full breadth of surgical practice across the UK.

This census explores the realities of delivering surgical care in today's NHS. It presents new data on workforce composition, service pressures, training, sustainability and wellbeing, while also tracking trends since 2023.

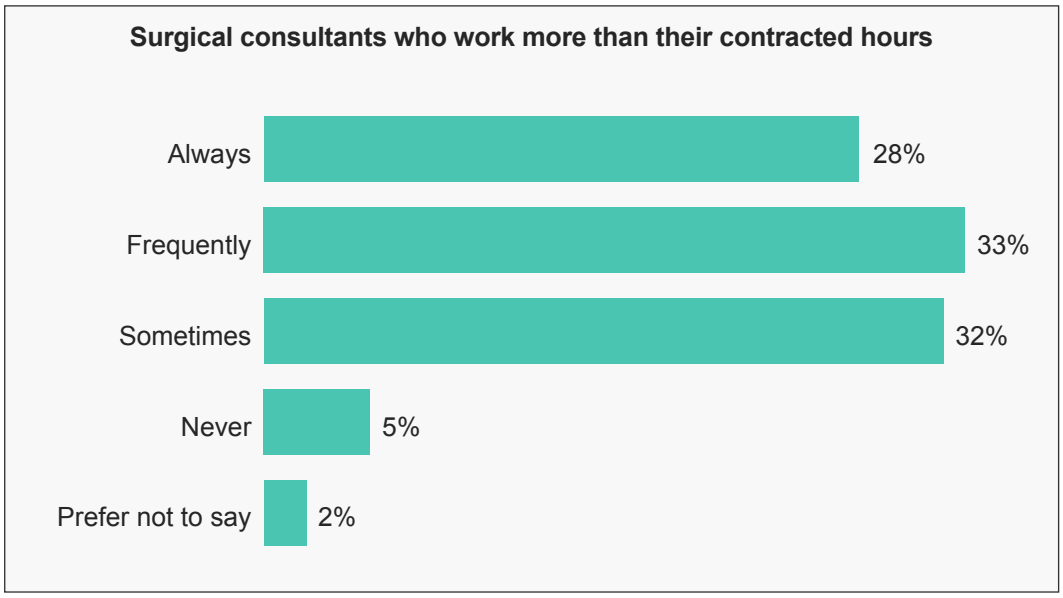
The findings come at a pivotal moment. The 10 Year Health Plan for England[2] sets ambitious goals to improve access to care and reduce waiting lists, and NHS England's medical training review[3] is rethinking how doctors are trained and supported throughout their training. This census highlights where progress towards these ambitions is most at risk (in productivity, training and workforce sustainability) and ensures that the voice of the surgical workforce remains central to shaping the future of the NHS.

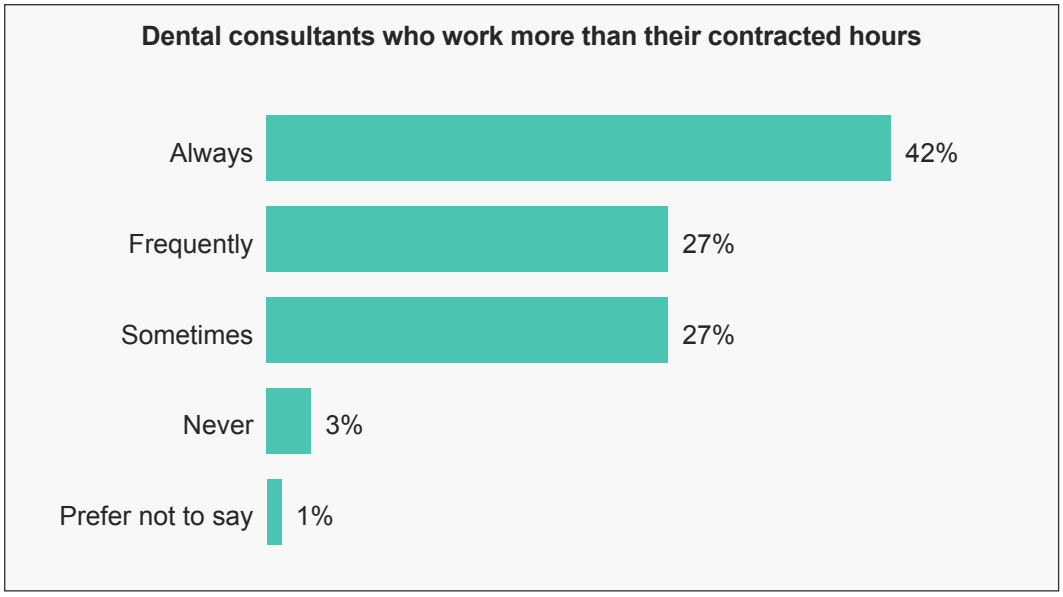
Key findings

Pillar 1: Productivity

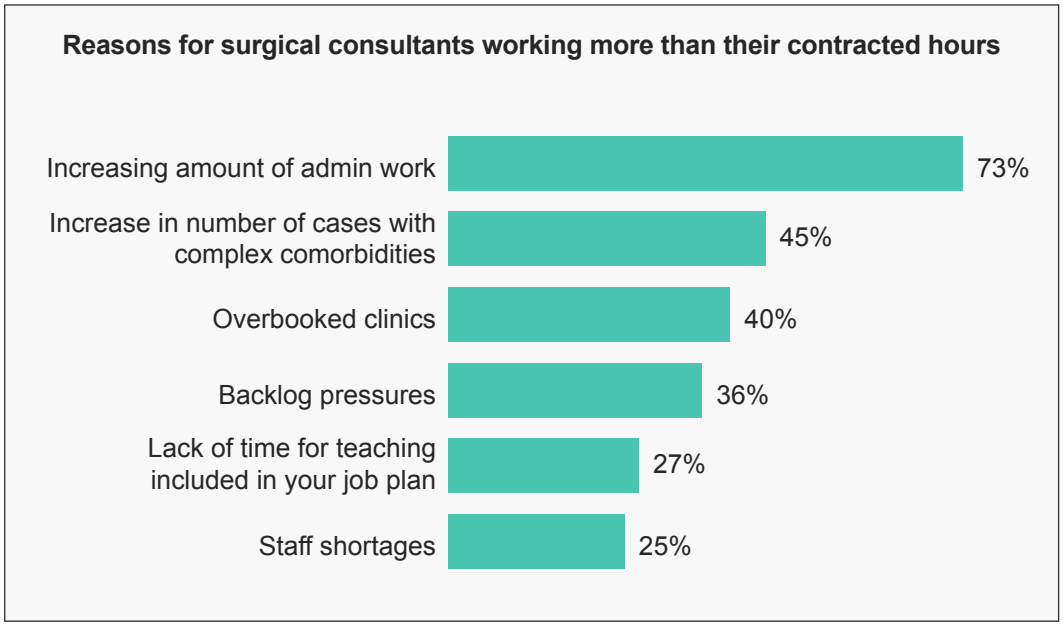
Outpatient activity and workload pressures

In 2025, 61% of surgical and 69% of dental consultants reported always or frequently working beyond their contracted hours. This reflects the ongoing pressures on outpatient services, driven by efforts to reduce waiting lists and manage increasing demands where progress towards these ambitions is most at risk (in productivity, training and workforce sustainability) and ensures that the voice of the surgical workforce remains central to shaping the future of the NHS.

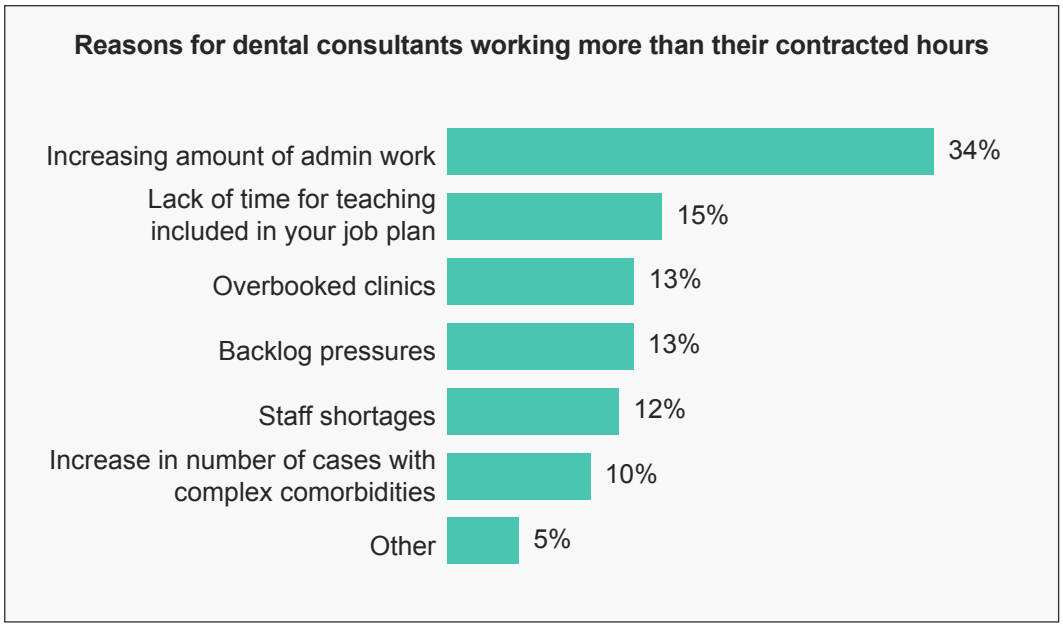




Administrative workload is the most significant pressure for surgical consultants, with 73% citing it as a reason for working beyond contracted hours. Other notable factors include the increase in cases with complex comorbidities (45%), overbooked clinics (40%) and backlog pressures (36%).



For dental consultants, administrative burden also tops the list, with 34% identifying it as a key driver of extended working hours. Additional factors include the lack of time for teaching (15%), overbooked clinics (13%) and backlog pressures (13%).

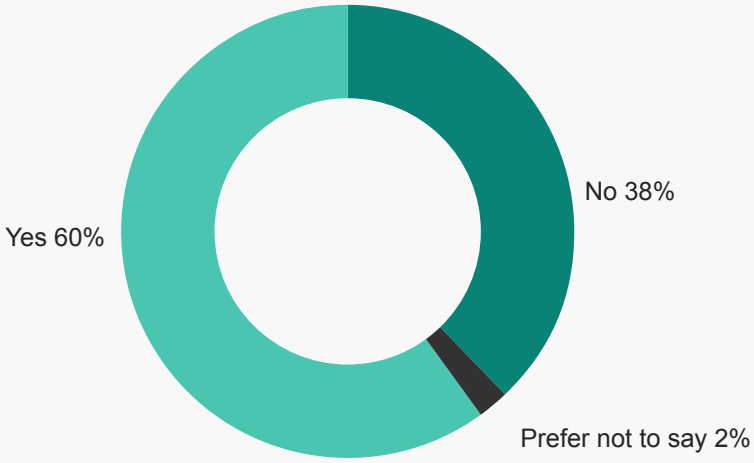


As the NHS 10 Year Health Plan sets out ambitions to move from analogue to digital systems,[2] it will be critical that this transition delivers a demonstrable reduction in administrative burden, enabling surgeons to devote more time to direct patient care.

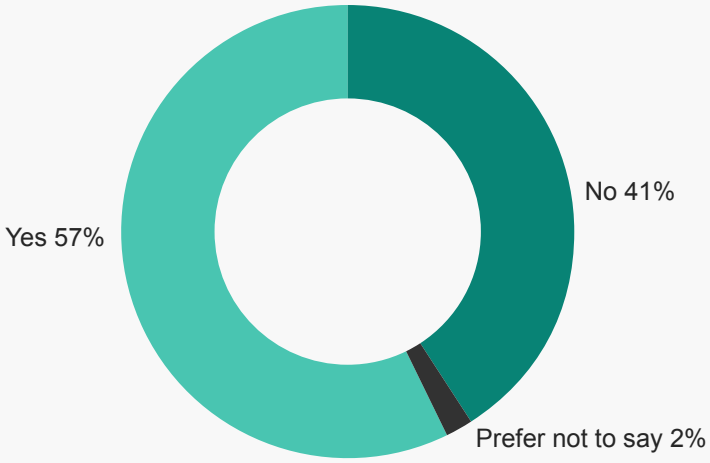
Annual leave and wellbeing

A significant proportion of consultants did not take their full annual leave entitlement in the past 12 months (38% of surgical and 41% of dental consultants).

Surgical consultants who took their full annual leave entitlement in the past 12 months



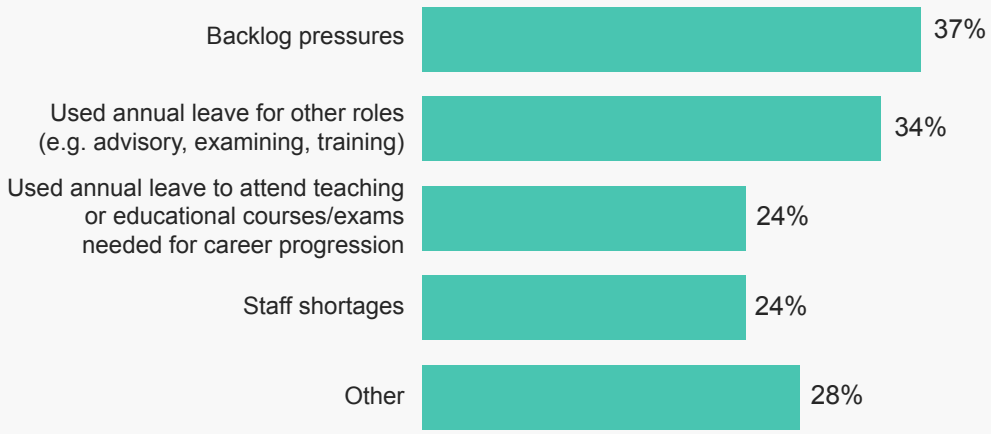
Dental consultants who took their full annual leave entitlement in the past 12 months



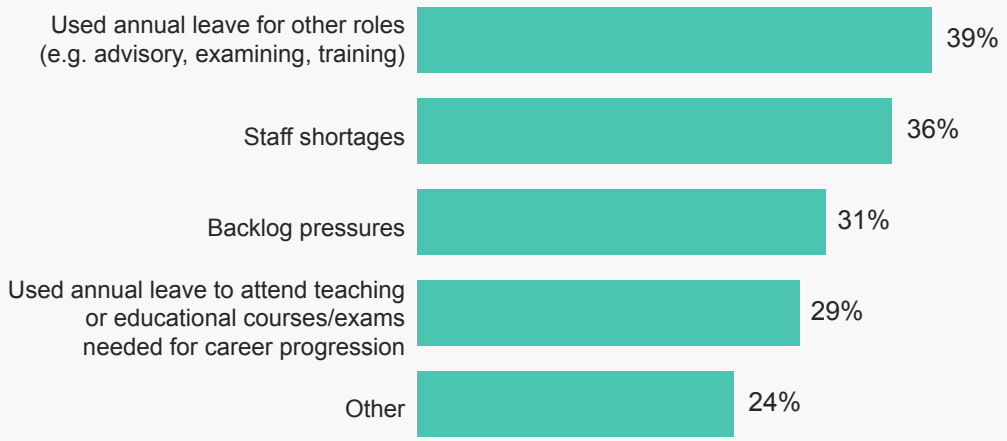
The most common reasons consultants cited for not taking their full annual leave entitlement included:

- backlog pressures (37% surgical, 31% dental);
- using annual leave for other roles such as training and teaching (34% surgical, 39% dental);
- attending educational courses (24% surgical, 29% dental);
- staff shortages (24% surgical, 36% dental).

Reasons for surgical consultants not taking their full annual leave entitlement



Reasons for dental consultants not taking their full annual leave entitlement



These findings highlight the extent to which consultants are absorbing service pressures by working longer hours and additional days, often at the expense of personal time. Many are also using their annual leave to support the wider profession, including teaching on courses, examining and training, rather than for rest or recovery.

Outpatient clinics

Consultants deliver care through a range of clinic formats. 60% of surgical consultants reported running mixed clinics that include both new and follow-up patients, while 40% reported running separate sessions for each. Most consultants run two outpatient clinics per week.

Patient volumes were relatively consistent across formats:

- 54% of consultants reported seeing 6–10 new patients per clinic
- 74% of consultants reported seeing 6–10 follow-up patients per clinic

Number of weekly clinic sessions with regard to new, follow-up and mixed clinics (surgical consultants only)

Weekly clinic sessions - new patients	%
<1	48%
1	27%
2	15%
3	4%
4	1%
5	1%
6–10	2%
Other	2%
Not applicable	1%

Weekly clinic sessions - old patients	%
<1	54%
1	27%
2	13%
3	3%
4	<1%
5	<1%
6–10	1%
Other	1%

Weekly clinic sessions - mixed new and old patients	%
<1	12%
1	35%
2	31%
3	13%
4	5%
5	1%
6–10	2%
Other	1%

Number of new and follow-up patients seen in a clinic (surgical consultants only)

New patients	%
0–5	27%
6–10	54%
11–15	14%
16–20	3%
21+	2%

Follow-up patients	%
0–5	26%
6–10	74%

Improving productivity

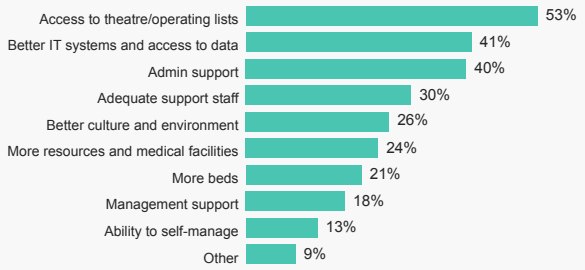
Surgical consultants identified several measures that could enhance productivity, including improved access to theatres (53%), better IT systems (41%), increased administrative support (40%) and adequate support staff (30%).

Theatre access and efficiency

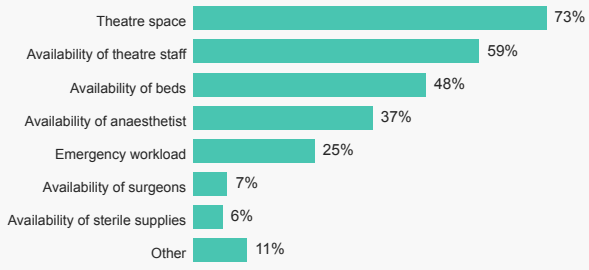
Theatre capacity remains a critical barrier to productivity. In 2025, 53% of surgical consultants identified access to theatres as their main challenge, consistent with 2023 findings.[1] The most frequently cited barriers include lack of theatre space (73%), availability of theatre staff (59%) and availability of beds (48%).

Team stability plays a critical role in surgical productivity and patient outcomes. Despite evidence that consistent theatre teams improve efficiency, 41% of surgical consultants do not regularly work with the same anaesthetist(s).

Measures to enhance productivity (surgical consultants only)



Barriers to theatre access (surgical consultants only)



Operating sessions and scheduling

Operating session distribution varies widely. For elective inpatient lists, 38% of surgical consultants reported having two sessions scheduled per week and 24% reported having one session. For elective day-case lists, 16% of surgical consultants reported having two sessions per week and 22% reported having one session.

Number of weekly elective inpatient and day-case theatre sessions (surgical consultants only)

Scheduled weekly elective inpatient theatre sessions	%
<1	19%
1	24%
2	38%
3	12%
4	4%
5	1%
Other	1%

Scheduled weekly elective day-case theatre sessions	%
<1	54%
1	22%
2	16%
3	4%
4	2%
5	1%
Other	1%

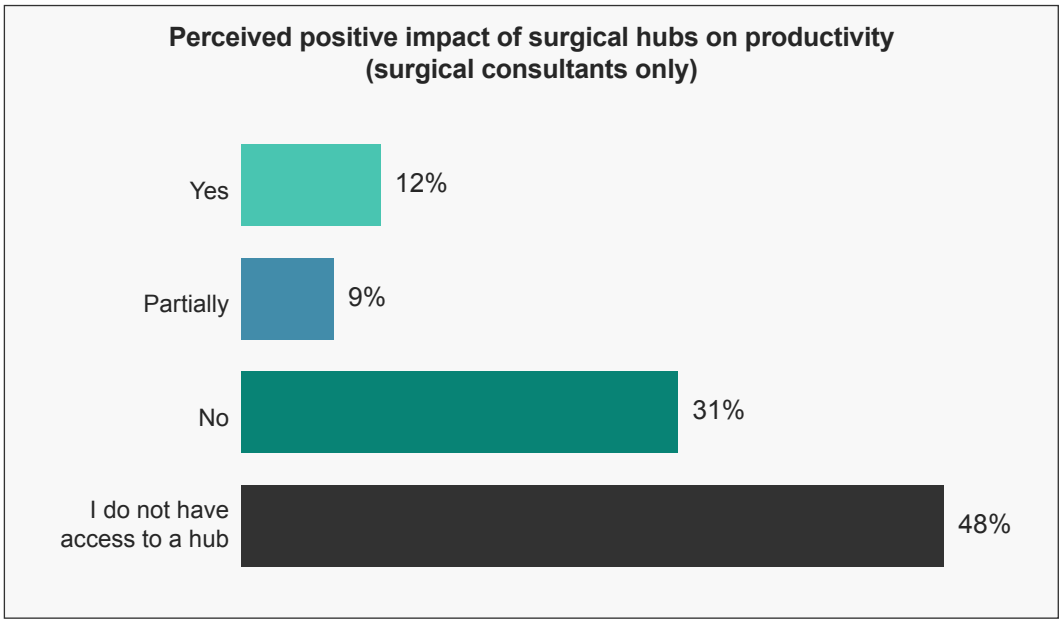
Scheduled emergency lists were less common: 7% of surgical consultants reported two sessions per week and 22% reported one session.

Number of weekly emergency theatre sessions (surgical consultants only)

Scheduled weekly emergency (incl CEPOD and trauma) theatre sessions	%
<1	68%
1	22%
2	7%
3	1%
4	1%
5	<1%
Other	1%

Surgical hubs

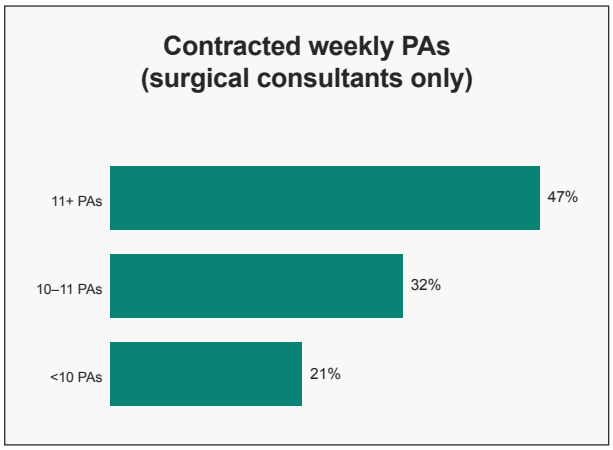
The impact of surgical hubs is not yet fully realised. Nearly half of surgical consultants (48%) reported having no access to a hub. Among those with access to a hub, feedback was mixed: 21% of consultants reported definite or some benefit but 31% reported no benefit.

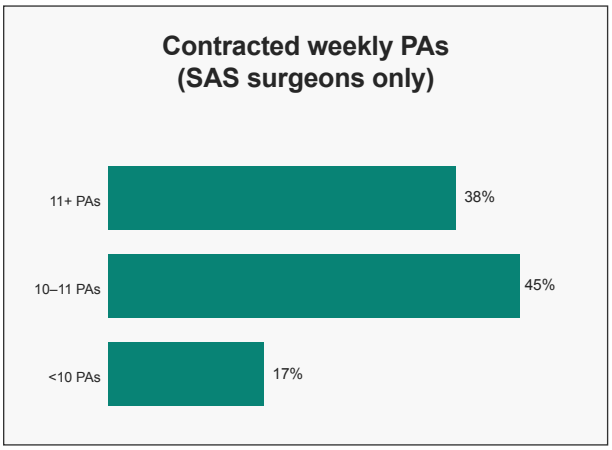


These findings highlight the need to ensure that surgical hubs are properly accredited, adequately resourced and fully integrated into surgical pathways. Crucially, while accreditation includes metrics for training (intended to support both the delivery and workforce development), the suggestion is that it is not consistently happening in practice. The MEASURE (mixed methods evaluation of the high-volume low-complexity surgical hub programme) study will play a critical role in evaluating how surgical hubs are functioning and identifying areas for improvement.[4]

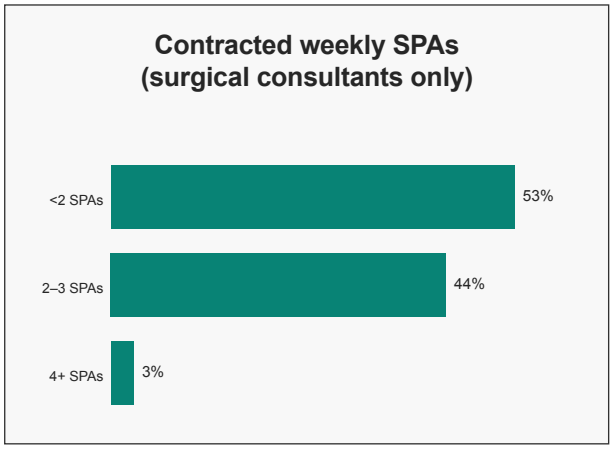
Job plans and activity

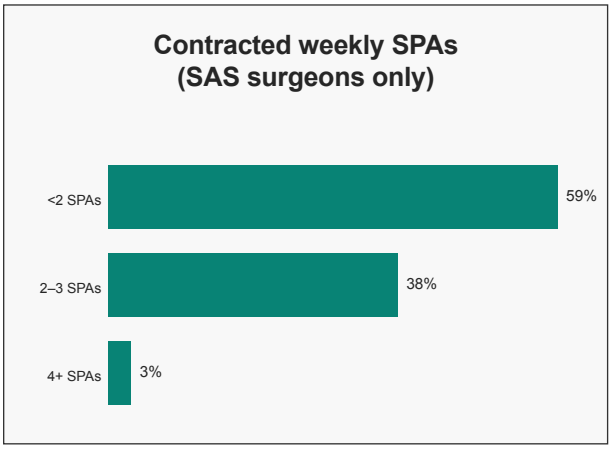
In 2025, 47% of surgical consultants and 38% of SAS surgeons reported holding a contract for 11 or more PAs per week. These figures refer specifically to weekly contracted clinical commitments and do not include additional responsibilities undertaken outside formal job plans.





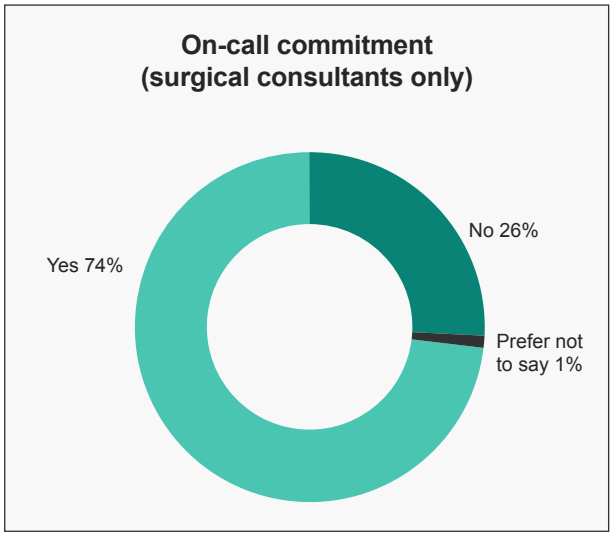
SPAs (which typically include teaching, training, research and leadership) remain limited. Most surgical consultants and SAS surgeons reported having fewer than two SPAs per week.

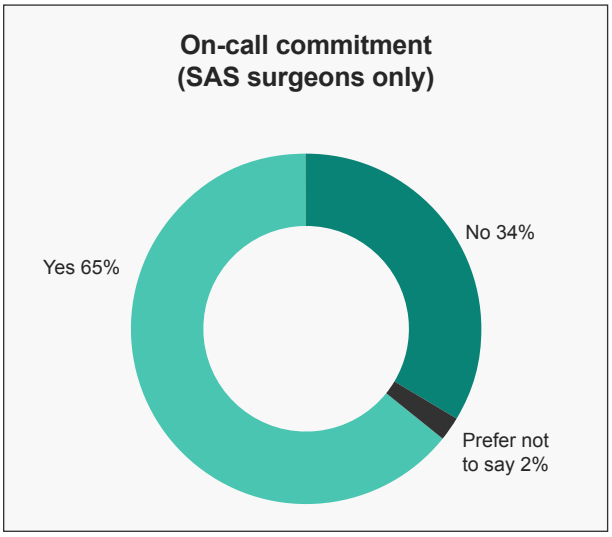




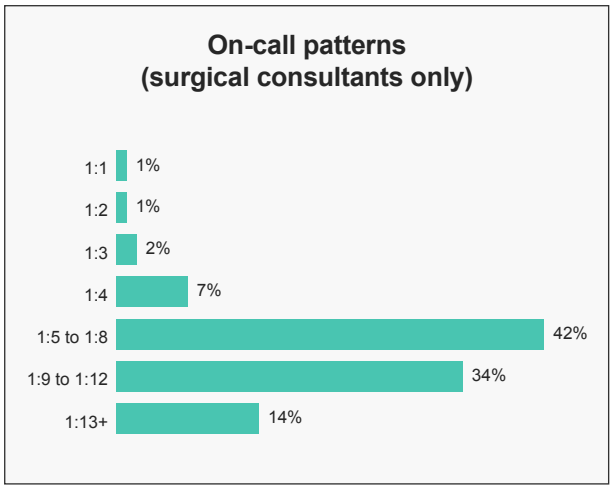
On-call commitment and frequency

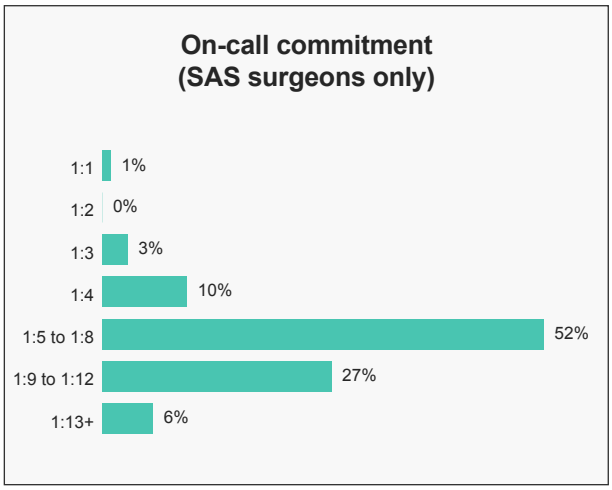
On-call responsibilities remain a core part of surgical practice. 73% of surgical consultants and 64% of SAS surgeons reported an on-call commitment.





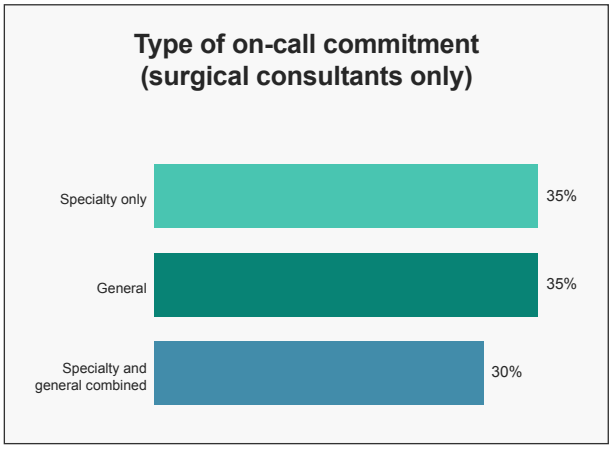
The most common on-call pattern was 1:5 to 1:8, reported by 42% of surgical consultants and 52% of SAS surgeons. A smaller proportion worked to a 1:9 to 1:12 pattern (34% of surgical consultants and 27% of SAS surgeons).





Surgical consultants reported a mix of responsibilities while on call: 35% managed unselected emergencies, 35% managed specialty-specific emergencies and 30% managed a combination of both.

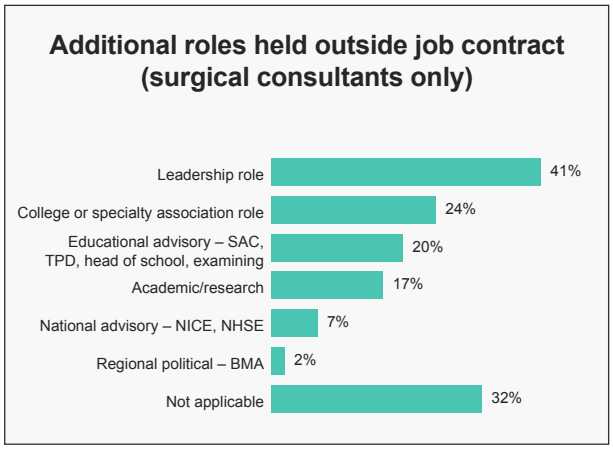
On-call commitments are part of most consultants' workload. Emergency surgical services are largely delivered by consultants, which has an impact on their availability for elective care. Investment in emergency pathways is needed, including ringfencing capacity equivalent to elective services.

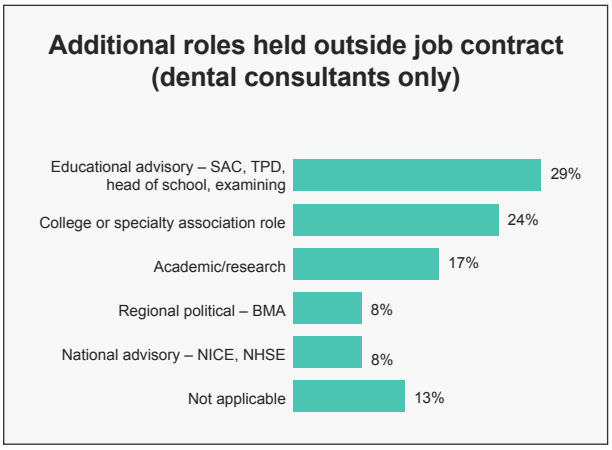


Additional roles and training responsibilities

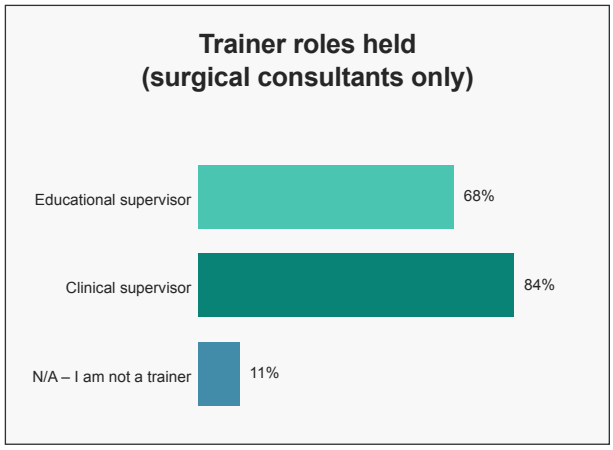
Beyond clinical work, consultants contributed significantly to the wider profession. This involved:

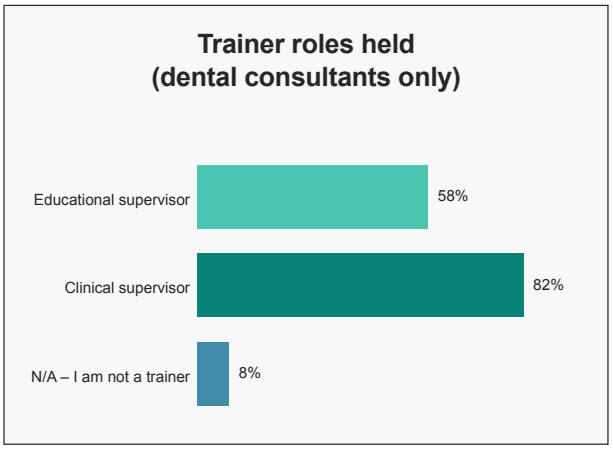
- holding leadership roles (41% surgical)
- engaging with colleges or specialty associations (24% surgical, 24% dental)
- education (20% surgical, 29% dental)





The majority of consultants were involved in surgical training. Among surgical consultants, 68% were educational supervisors and 84% were clinical supervisors, with some holding both roles. Among dental consultants, 58% were educational supervisors and 82% were clinical supervisors.





These findings underscore the extent to which consultants support the development of the next generation of surgeons, often alongside demanding clinical workloads. Ensuring adequate time and recognition for these supervisory roles is essential to sustaining high-quality training and leadership in the profession.

Key findings

Pillar 2: Training

Headline challenges

Training opportunities remain under considerable pressure. Among 1,174 resident doctor respondents (282 core surgical trainees and 892 higher surgical trainees), the top five challenges were:

- **Limited theatre access:** 68% of core surgical trainees, 60% of higher surgical trainees
- **Burnout and stress:** 66% of core surgical trainees, 62% of higher surgical trainees
- **Lack of time to train and mentor:** 59% of core surgical trainees, 49% of higher surgical trainees
- **Poor working conditions:** 59% of core surgical trainees, 53% of higher surgical trainees
- **Understaffed departments:** 52% of core surgical trainees, 46% of higher surgical trainees

These findings confirm that early-stage surgical training is particularly vulnerable to systemic pressures.

Theatre access

Theatre space was identified as the most significant barrier to theatre access for core and higher surgical trainees (cited by 47% and 70% respectively). Emergency workload also posed a major challenge (66% of core surgical trainees and 45% of higher surgical trainees). Additional limiting factors included bed availability and staffing shortages.

Factors limiting theatre access for core and higher surgical trainees

Access to theatre	Core	Higher
Availability of beds	40%	60%
Availability of theatre staff	36%	57%
Emergency workload	66%	45%
Theatre space	47%	70%

Burnout and career intentions

Burnout is a key driver of attrition: 56% of core and 40% of higher surgical trainees considered leaving training in the past 12 months. This is a significant proportion and highlights growing concerns around retention and morale in the surgical pipeline.

Among those who considered leaving, 59% of core and 49% of higher surgical trainees cited working conditions as one of the main reasons. 47% of core and 19% of higher surgical trainees cited lack of training opportunities as the reason.

Core and higher surgical trainees who considered leaving surgical training in the past 12 months

Considered leaving in the past 12 months?	Core	Higher
Yes	56%	40%
Not Considered	41%	56%
Prefer not to say	2%	4%

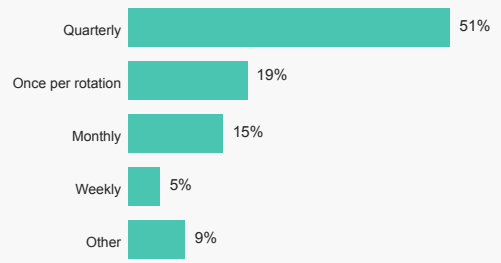
Reasons for core and higher surgical trainees considering leaving surgical training

Reasons for considering leaving	Core	Higher
Burnout	65%	60%
Lack of training opportunities	47%	19%
Poor-quality training	29%	19%
Working conditions	59%	49%

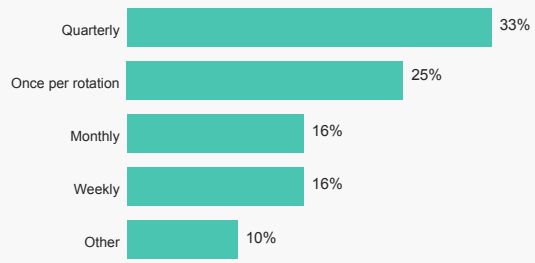
Time for training and review of training progress

Dedicated time for training was identified by 44% of resident doctors as a key area for improvement. The frequency of meetings to review progress varied, with the most commonly reported interval being quarterly (cited by 51% of resident doctors for educational supervisors and by 33% for clinical supervisors). These findings should be interpreted with caution as supervision practices differ across placements and specialties, and responses may reflect varying perceptions of what constitutes a regular review.

Frequency of progress review meetings with educational supervisors (resident doctors)

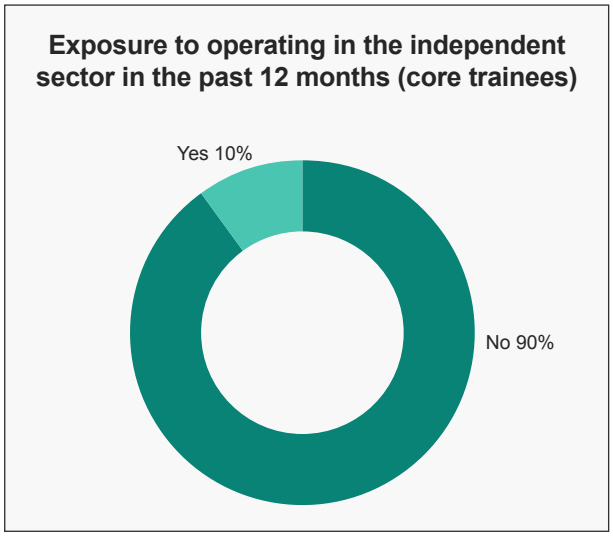


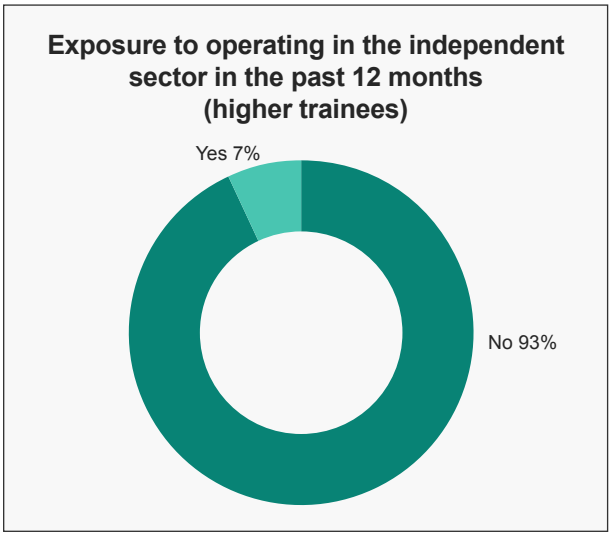
Frequency of progress review meetings with clinical supervisors (resident doctors)



Independent sector exposure

Exposure to operating in the independent sector was limited, with only 10% of core and 7% of higher surgical trainees reporting such experience in the past 12 months.

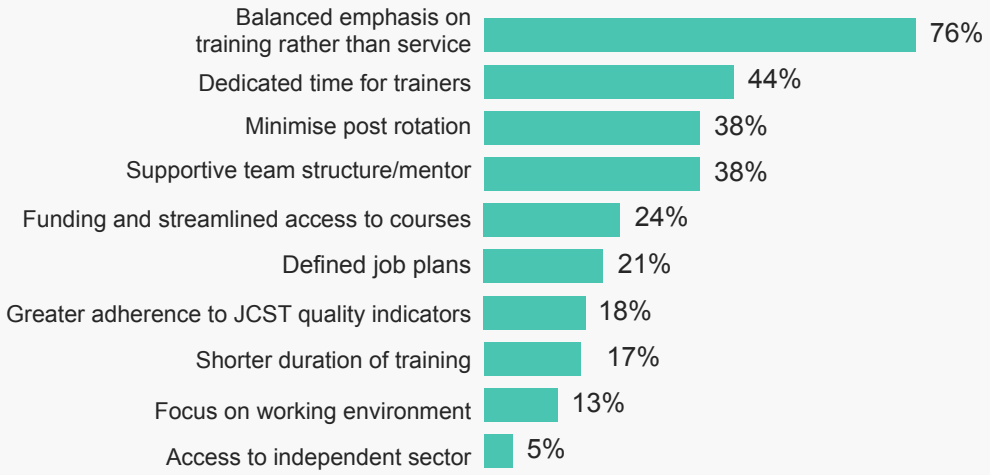




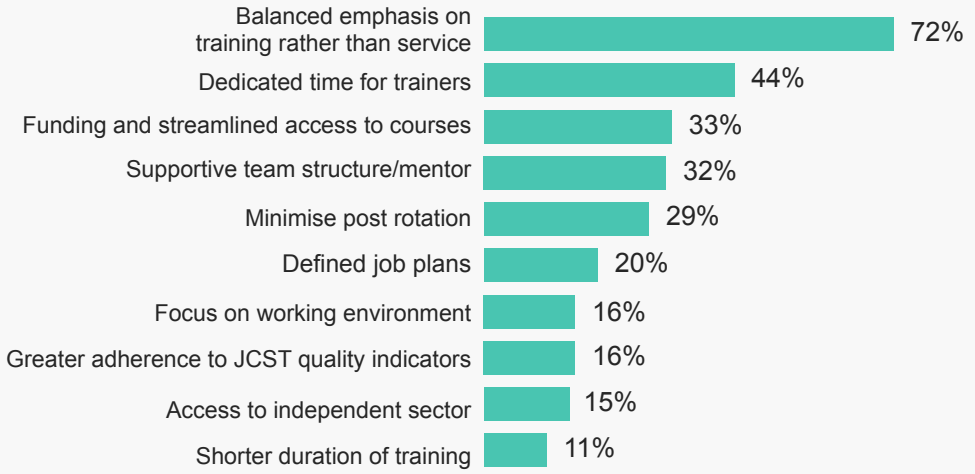
Improving access to training

Over 70% of both core and higher surgical trainees stated that a change in emphasis between training and service would improve training opportunities. This accentuates the need to rebalance priorities in surgical rotas.

Measures to improve access to training opportunities (core surgical trainees)



Measures to improve access to training opportunities (higher surgical trainees)



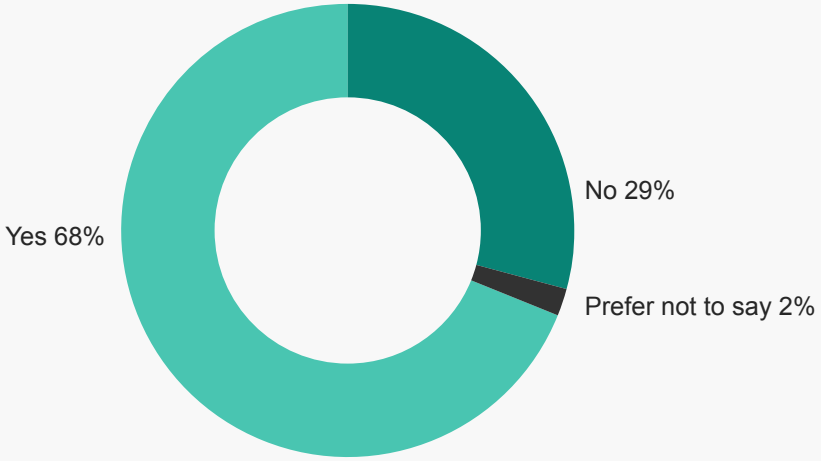
Key findings

Pillar 3: Sustainable workforce

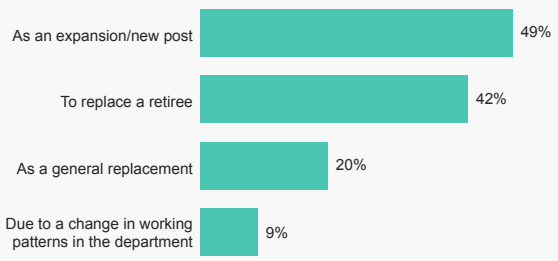
Workforce dynamics

In 2025, 68% of surgical consultants reported new appointments in their NHS trust or health board in the past 12 months. These appointments were split between replacements following retirements (42%) and workforce expansion through new posts (49%).

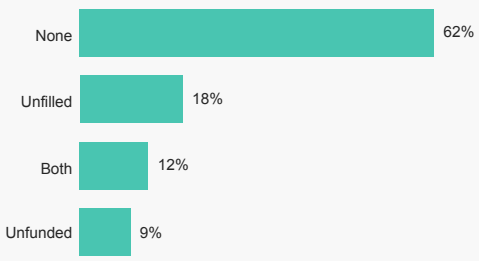
New consultant appointments in the past 12 months (surgical consultants only)



Reasons for new consultant appointments (surgical consultants only)



Unfilled and unfunded consultant posts (surgical consultants only)



Despite new appointments, 39% of surgical consultants reported unfilled consultant posts in their NHS trust or health board. This included: 18% unfilled posts, 9% unfunded posts, and 12% both unfilled and unfunded posts.

Retirement intentions

Retirement intentions remain a critical challenge. In 2025, 59% of surgical consultants aged 55–59 years plan to retire within the next four years. This highlights a growing risk of losing a significant proportion of experienced surgeons at a time of high demand. The trend reinforces the urgency of implementing and expanding retention measures to ensure that the NHS retains the skills, mentorship and leadership of senior consultants.

Retirement intentions by age group (surgical consultants only)

Age	In the next 4 years	More than 4 years from now
30–34 years		100%
35–39 years	1%	99%
40–44 years	1%	99%
45–49 years	3%	97%
50–54 years	15%	85%
55–59 years	59%	41%
60–64 years	82%	18%
65–69 years	91%	9%
70–74 years	94%	6%
75+ years	88%	13%
Prefer not to say	20%	80%

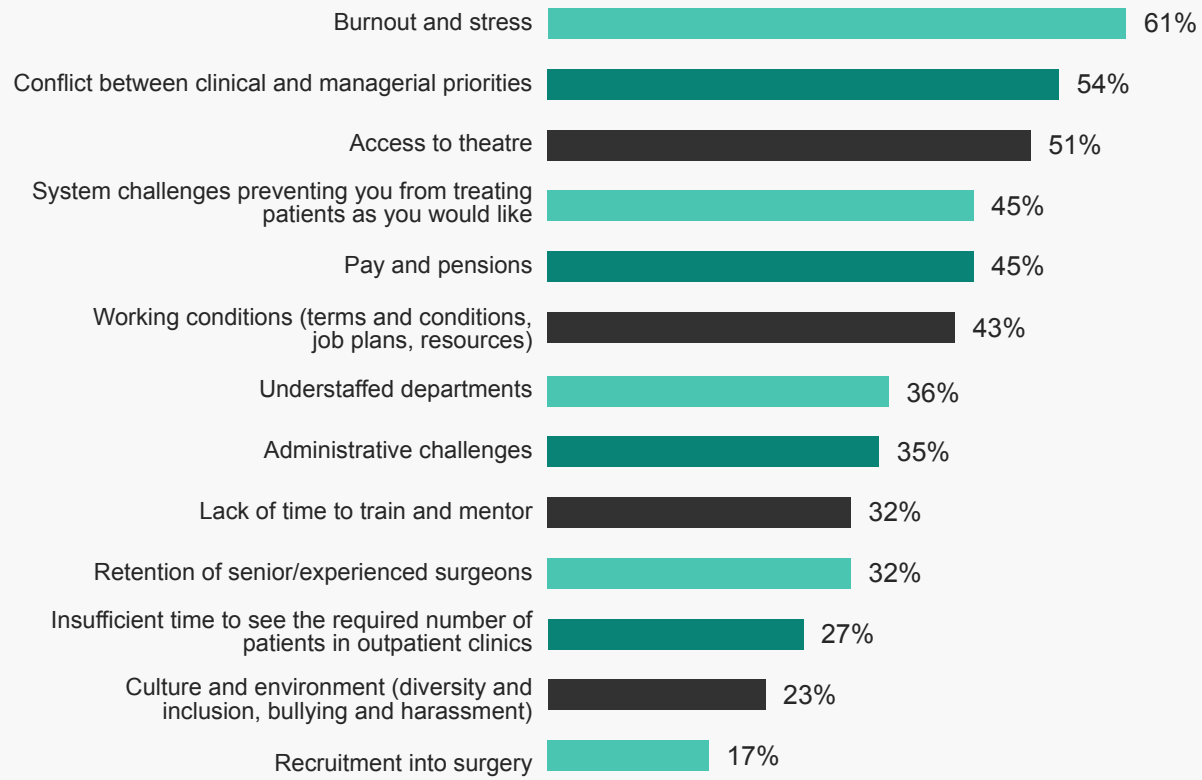
Wellbeing and working conditions

Wellbeing indicators remain poor across the surgical workforce. In 2025, 61% of surgical and 62% of dental consultants reported burnout and stress as the main challenge facing the surgical team. This issue was echoed by 66% of core and 62% of higher surgical trainees, underscoring its widespread impact across career stages.

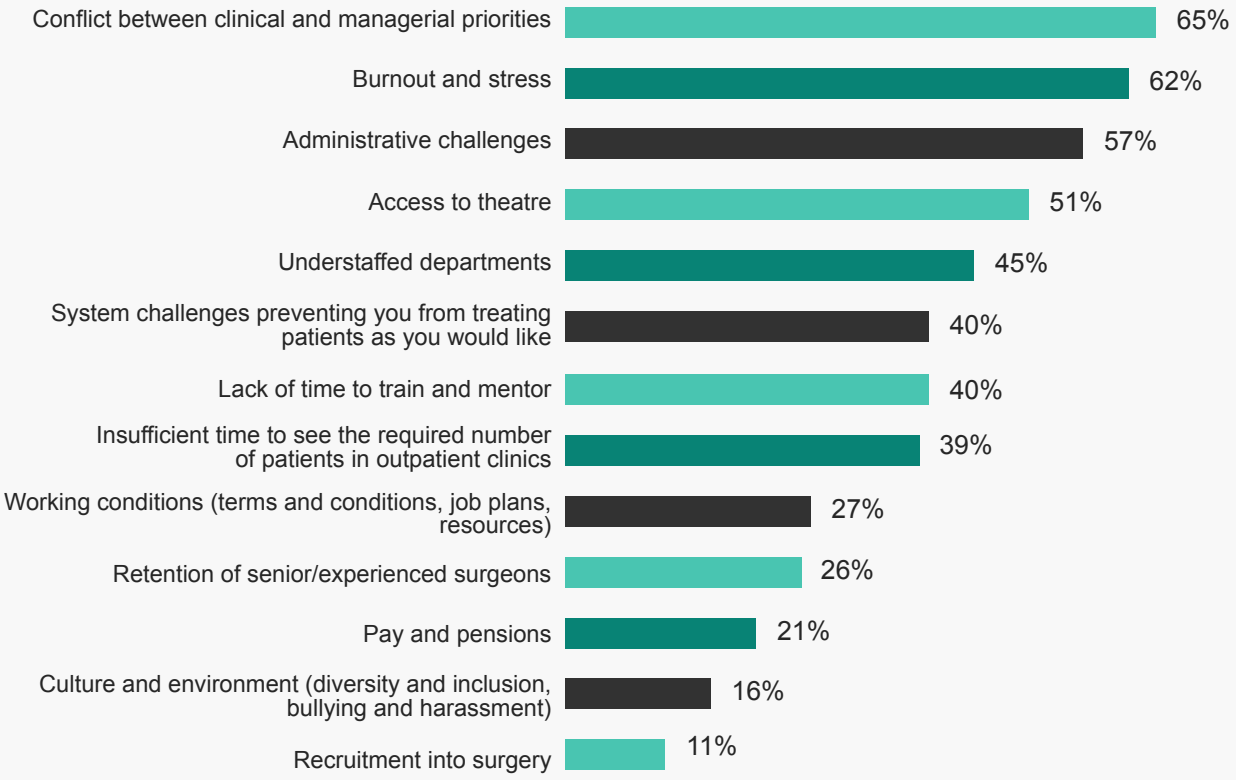
A recurring theme was the tension between clinical responsibilities and managerial expectations, which many consultants described as a source of strain. This conflict was particularly pronounced among dental consultants, with 65% citing it as their primary challenge.

These findings illustrate the complex interplay between workload, organisational culture and wellbeing, reinforcing the urgent need for targeted support and systemic change.

Main challenges facing the surgical team (surgical consultants only)

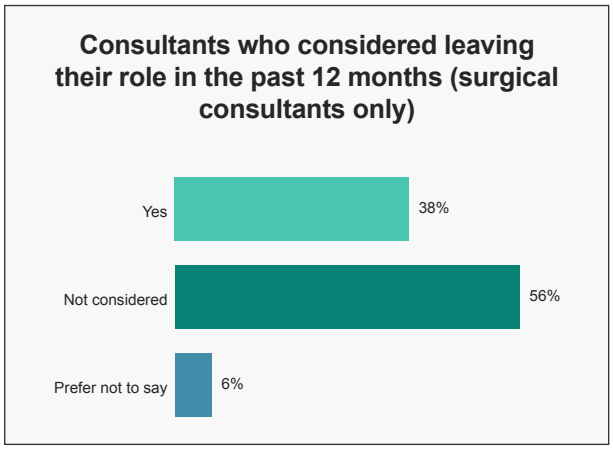


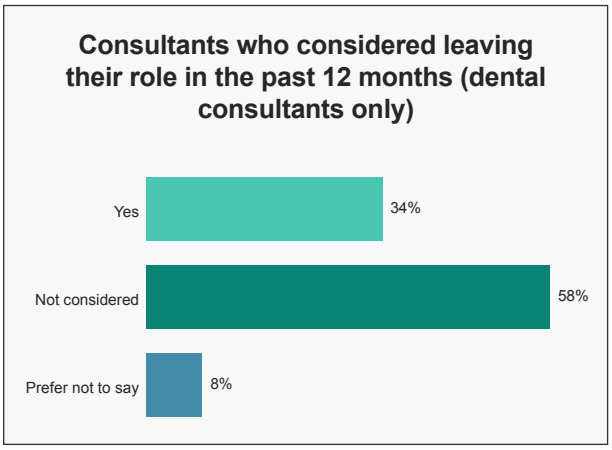
Main challenges facing the surgical team (dental consultants only)



Attrition risk

Attrition risk is high as 38% of surgical and 34% of dental consultants considered leaving their current role in the past 12 months. They cited burnout, working conditions and pressures due to lack of resources as the main reasons.



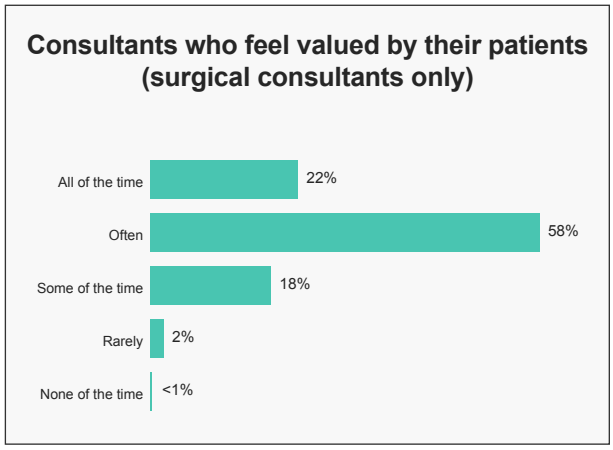


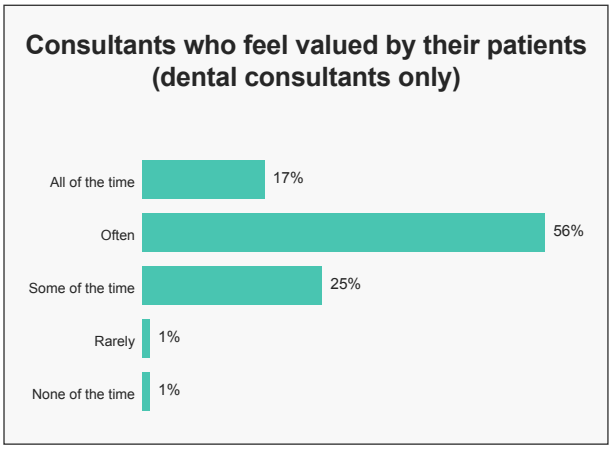
Feeling valued

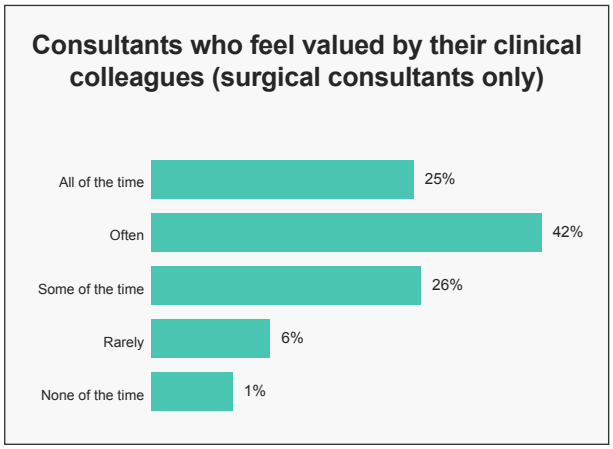
On a positive note, 80% of surgical and 73% of dental consultants always or often feel valued by patients.

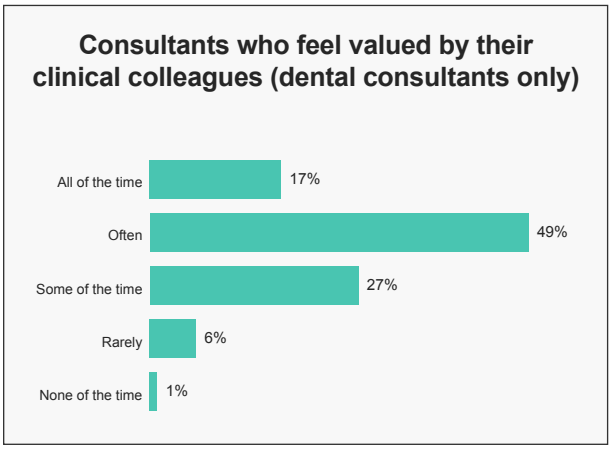
Similarly, 67% of surgical and 66% of dental consultants always or often feel valued by clinical colleagues.

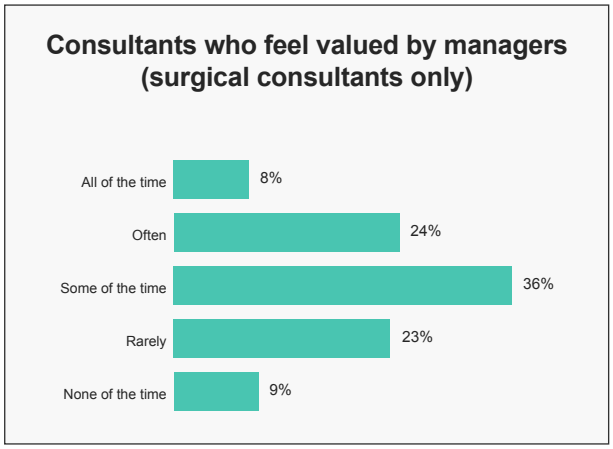
Disappointingly, only 32% of surgical and 26% of dental consultants always or often feel valued by managers, highlighting the need for better working relationships across clinical and non-clinical teams.

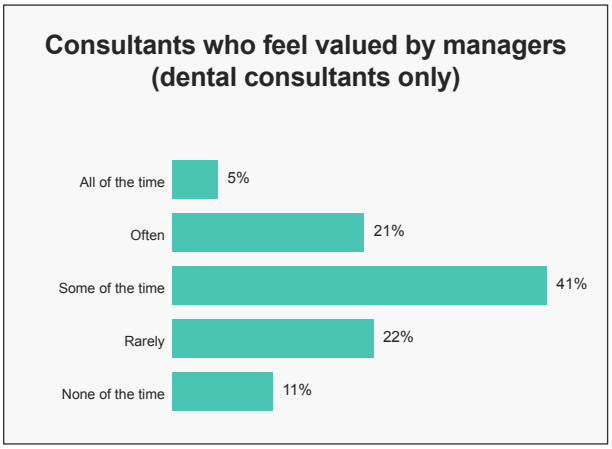





Consultants who feel valued by their clinical colleagues (surgical consultants only)
All of the time
25%
Often
42%
Some of the time
26%
Rarely
6%
None of the time
1%


Consultants who feel valued by their clinical colleagues (dental consultants only)
All of the time
17%
Often
49%
Some of the time
27%
Rarely
6%
None of the time
1%


Consultants who feel valued by managers (surgical consultants only)
All of the time
8%
Often
24%
Some of the time
36%
Rarely
23%
None of the time
9%


Consultants who feel valued by managers (dental consultants only)
All of the time
5%
Often
21%
Some of the time
41%
Rarely
22%
None of the time
11%

Conclusions

The 2025 UK Surgical Workforce Census reveals a profession steadfast in its dedication to patient care and yet it is increasingly strained by systemic pressures. At the heart of the findings are three key areas: productivity, training and workforce sustainability.

Surgical teams continue to operate under intense pressure. Limited theatre access, an increasing administrative burden and overbooked clinics are stretching capacity and having an adverse impact on morale. Many consultants work beyond their contracted hours, often without taking full annual leave entitlement. Addressing these barriers is essential to restoring balance and enabling surgeons to focus on what matters most: delivering safe, timely and effective patient care.

For resident doctors, theatre access remains the single biggest obstacle, compounded by emergency workloads and staffing shortages. Burnout is driving attrition. Training must be embedded in service delivery, supported by protected time, structured mentorship, and broader clinical exposure across both the NHS and the independent sector.

Workforce gaps and retirement intentions pose a significant threat to service continuity. Burnout and stress are widespread, and many consultants feel undervalued by management. Building a sustainable surgical workforce will require a renewed focus on wellbeing, inclusive career pathways and flexible job planning that reflects the realities of modern surgical practice.

The findings of this census are clear: the surgical workforce is at a pivotal point. RCS England is committed to driving forwards targeted action. The steps we take now will shape the strength and sustainability of surgical care for years to come.

Appendix 1: Methodology

This census was delivered as a Microsoft Forms questionnaire, accessible on both desktop and mobile devices. Participants could access it via a direct link or QR code, or through the RCS England website.

Questions were developed by the RCS England Workforce and Training Committee, with input from dental colleagues, the Royal College of Surgeons of Edinburgh, the Royal College of Physicians and Surgeons of Glasgow, the ten surgical specialty associations, the Association of Surgeons in Training, the British Orthopaedic Trainees Association and other stakeholders.

The survey included binary, multiple-choice and free-text questions. Several questions were repeated from the 2023 census[1] to enable longitudinal analysis. No personal identifiers were collected to ensure that all responses remained anonymous.

The survey was open from 1 May to 30 June 2025. It was disseminated widely across the UK surgical workforce via email, social media and professional networks. Eligible participants included consultants, resident doctors, resident dentists, SAS grades, LEDs and members of the EST.

Responses were anonymous and were analysed using Microsoft Excel and Microsoft Power BI. An interactive data toolkit will accompany the report to allow stakeholders to explore the findings independently.

Appendix 2: Limitations

This census was designed to capture a broad range of data across key topics in surgery but it was not exhaustive. Findings are limited to the scope of questions asked. Some phrasing may have influenced interpretation, and multiple-choice options may not have captured all possible responses.

The need to keep the survey concise limited the inclusion of more detailed follow-up questions. These might otherwise have provided additional insight.

Although the census was promoted through a wide range of channels, these were not comprehensive. Some members of the surgical workforce may not have been reached or may have been unaware that the census was open.

Participation in the census was voluntary, which may have led to self-selection bias in the data. In order to encourage participation, the survey was conducted anonymously. Accordingly, we did not send individualised survey links or collect respondents' IP addresses. It was therefore possible for individuals to submit more than one response.

Percentages reported in this document and associated graphics exclude 'blank' responses, which represented only a small proportion of answers.

We will continue to refine our approach in future iterations of the census to improve accuracy, reach and quality of findings.

Appendix 3: Acknowledgements

RCS England would like to express its gratitude to all those who contributed to the 2025 UK Surgical Workforce Census Report.

We are grateful for the support and involvement of the Federation of the Surgical Specialty Associations, the Royal College of Surgeons of Edinburgh, and the Royal College of Physicians and Surgeons of Glasgow.

We especially thank the RCS England Workforce and Training Committee, and extend our particular appreciation to Deborah Eastwood and Bill Allum for their leadership and guidance.

We wish to acknowledge the valuable contributions of the following organisations and specialty groups:

- **ASiT** (representing surgeons in training from all 10 surgical specialties)
- **BOTA**
- **Cardiothoracic surgery**
  - SCTS
- **General surgery**
  - ASGBI
- **Neurosurgery**
  - SBNS
- **Oral and maxillofacial surgery**
  - BAOMS
- **Otolaryngology**
  - ENT UK
- **Paediatric surgery**
  - BAPS
- **Plastic surgery**
  - BAPRAS
- **Trauma and orthopaedic surgery**
  - BOA
- **Urology**
  - BAUS
- **Vascular surgery**
  - Vascular Society

We also acknowledge the contributions and support of trainee associations, subspecialty associations and dental associations.

At a staff level, we extend our heartfelt thanks to:

- Karen Smith
- Patrick Leahy
- Nicola Kane
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- TJ Gribben
- Tilly Russell
- Tim Hampton
- Claire Wimborne
- Francesca Treadaway
- Mandy Webb
- Jessica Sheridan-Sneyd
- Kate Shehan
- Susannah Harrison

Appendix 4: Demographics of respondents

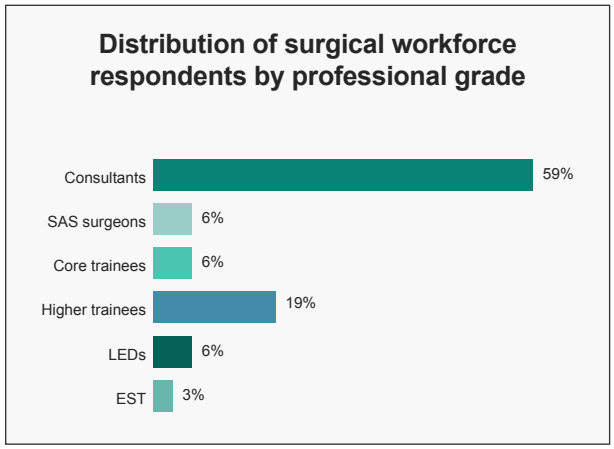
This appendix presents the demographic profile of respondents to the 2025 UK Surgical Workforce Census. It includes breakdowns by professional grade, specialty, place of work, working pattern, age, gender identity and ethnicity.

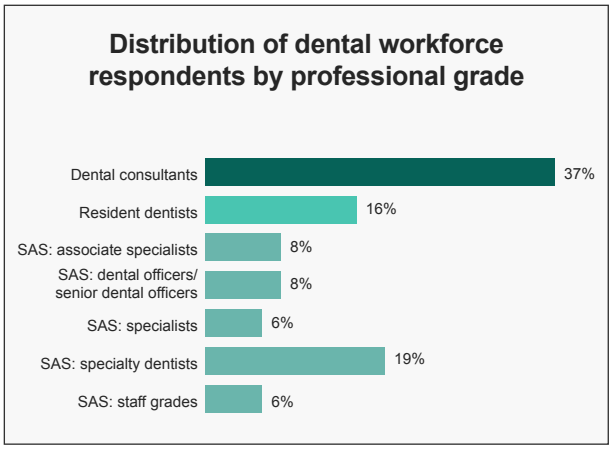
There were 4,648 responses from different members of the surgical team, which represents approximately 16% of the current workforce. Of these, 4,238 were from the surgical workforce and 410 were from the dental workforce.

Professional grade

Of those responding from the surgical workforce:

- 59% were consultants
- 25% were resident doctors
- 6% were SAS surgeons
- 6% were LEDs
- 3% were members of the EST





Of those responding from the dental workforce:

- 37% were consultants
- 16% were resident dentists
- 47% were SAS surgeons

Specialty

The 4,238 respondents from the surgical workforce represented all 10 surgical specialties. In addition, there were 410 responses from the dental workforce.

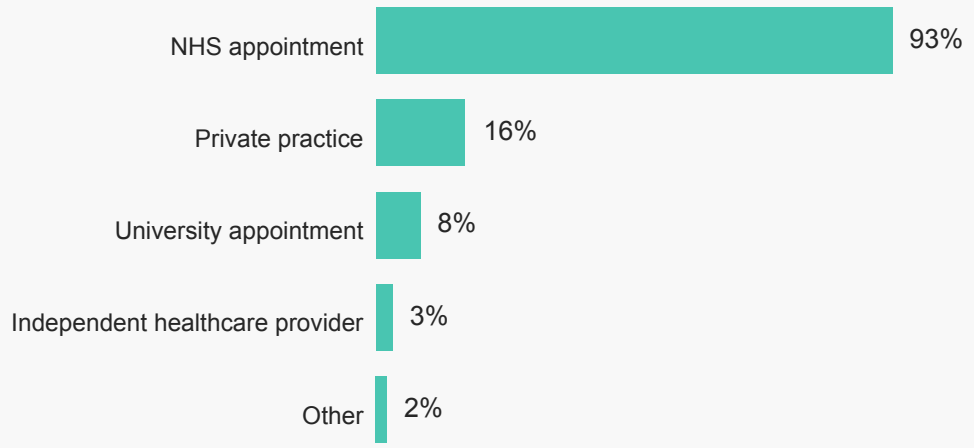
Distribution of surgical workforce respondents by specialty

Specialty	Count	%
Cardiothoracic surgery	173	4%
General surgery	1,136	27%
Neurosurgery	202	5%
Oral and maxillofacial surgery	70	2%
Otolaryngology	315	7%
Paediatric surgery	300	7%
Plastic surgery	130	3%
Trauma and orthopaedic surgery	244	6%
Urology	25	1%
Vascular surgery	1,108	26%
Not applicable	303	7%
Prefer not to say	232	5%

Place of work

93% of respondents held an NHS appointment. Of those, 75% held only NHS appointments. 16% of respondents worked in private practice. Of those, 2% worked solely in private practice.

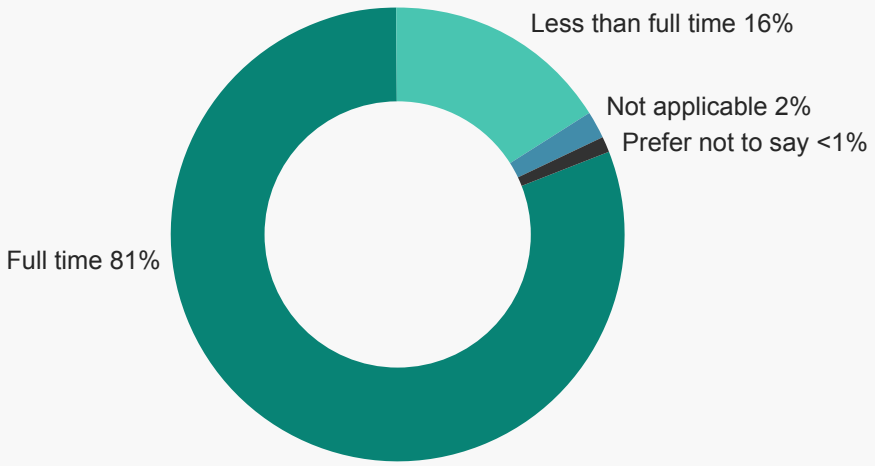
Distribution of all respondents by place of work



Working pattern (full time/LTFT)

Overall, the majority of respondents (81%) reported working full time while 16% worked LTFT.

Distribution of all respondents working full time / LTFT



LTFT working increased significantly with age. Only 11% of respondents aged 25–34 years worked LTFT but this rose to 25% for those aged 55–64 years and 45% for those aged 65–74 years.

Distribution of all respondents working full time / LTFT by age

Age	Full time	Less than full time	Not applicable	Prefer not to say
16–24 years	80%		20%	
25–34 years	86%	11%	2%	<1%
35–44 years	84%	15%	1%	<1%
45–54 years	89%	9%	1%	<1%
55–64 years	73%	25%	2%	<1%
65–74 years	39%	45%	16%	<1%
75+ years	9%	36%	55%	
Prefer not to say	89%	9%	2%	

Among surgical respondents, the majority worked full time although patterns vary somewhat by professional grade:

- 83% of consultants worked full time while 14% worked LTFT. This suggests greater uptake of flexible working at senior levels.
- 88% of SAS surgeons worked full time, with 10% working LTFT.
- 86% of core surgical trainees worked full time and 12% worked LTFT, showing similar trends to SAS surgeons.
- 83% of higher surgical trainees worked full time whereas 16% worked LTFT, a slightly higher proportion than for those in core training.

Distribution of surgical respondents working full time/ LTFT by professional grade

Professional grade	Full time	Less than full time	Not applicable	Prefer not to say
Consultants	83%	14%	3%	<1%
SAS surgeons	88%	10%	2%	<1%
Core trainees	86%	12%	2%	
Higher trainees	83%	16%	1%	<1%
LEDs	86%	7%	6%	
EST	80%	14%	3%	3%

Looking at dental workforce respondents, working patterns showed greater variation across professional grades than for surgical respondents:

- 63% of consultants worked full time while 35% worked LTFT.
- 86% of resident dentists worked full time and 9% worked LTFT.
- LTFT working was most prevalent among senior SAS roles.

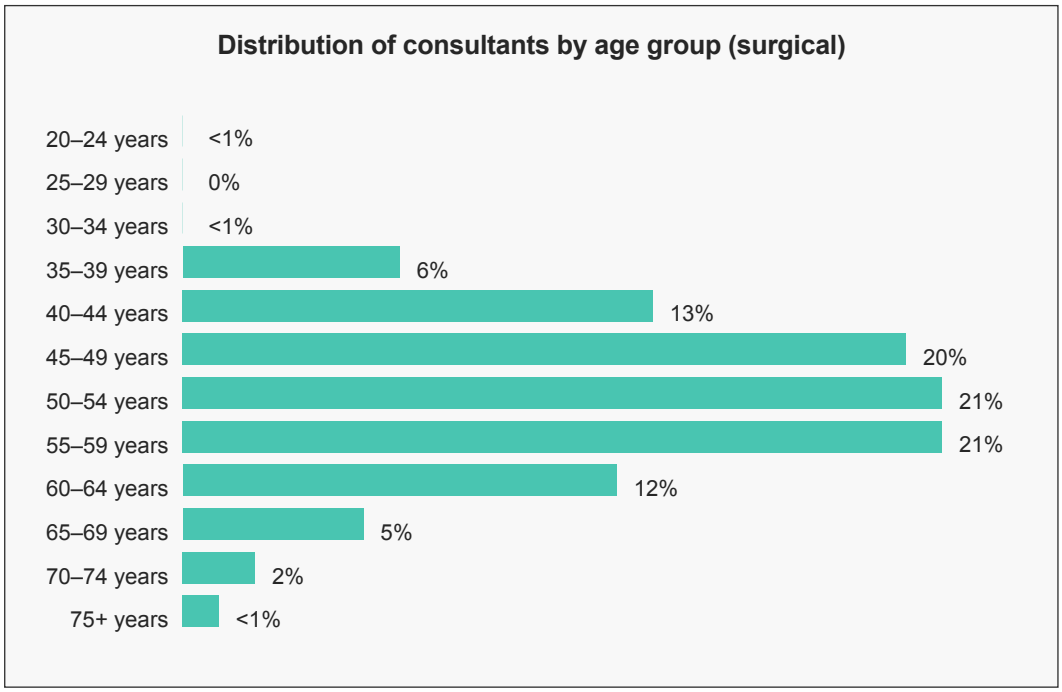
Distribution of dental respondents working full time/ LTFT by professional grade

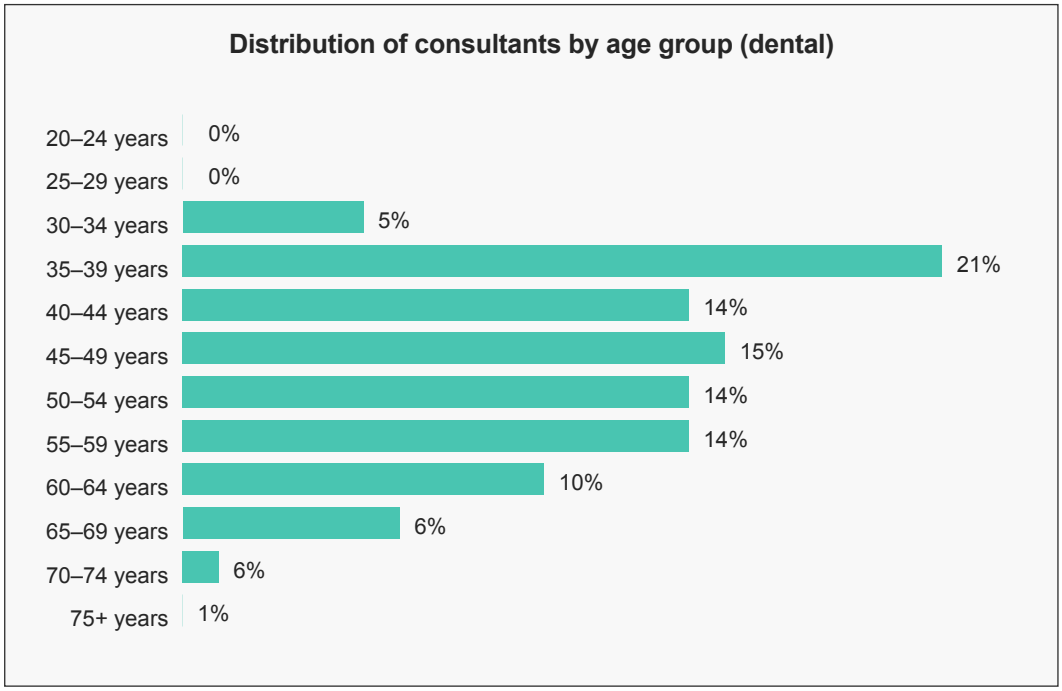
Professional grade	Full time	Less than full time	Not applicable	Prefer not to say
Dental consultants	63%	35%	2%	1%
Resident dentists	86%	9%	3%	2%
SAS: associate specialists	47%	50%	3%	
SAS: dental officers/ senior dental officers	56%	41%		3%
SAS: specialists	26%	70%	4%	
SAS: specialty dentists	42%	51%	5%	1%
SAS: staff grades	40%	60%		

These trends demonstrate the importance of embedding flexibility into workforce planning. Supporting diverse working patterns is essential to retention, career progression and wellbeing across all stages of surgical careers.

Age distribution

The age profiles of surgical and dental consultants reveal distinct patterns. Almost half of surgical consultants (42%) are aged 50–59 years. In contrast, only 28% of dental consultants are in this age group. The highest representation of dental consultants is in the 35–39-year category (21%).





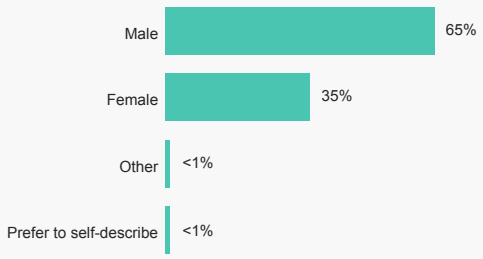
Gender identity

35% of all respondents identified as female.

23% of surgical consultants identified as female.

51% of dental consultants identified as female.

Distribution of all respondents by gender identity



Ethnicity

The 2025 census data highlight the ethnic diversity in the surgical workforce.

Distribution of consultants by ethnic group (surgical)

Ethnic Group	%
Arab	2%
Asian or Asian British – Bangladeshi	<1%
Asian or Asian British – Chinese	3%
Asian or Asian British – Indian	13%
Asian or Asian British – Pakistani	3%
Asian or Asian British – Other Asian background	2%
Black or Black British – African	1%
Black or Black British – Caribbean	<1%
Black or Black British – Other Black background	<1%
Mixed – White and Asian	1%
Mixed – White and Black African	<1%
Mixed – White and Black Caribbean	<1%
Mixed – Other mixed background	1%
White – British, English, Welsh, Scottish, Northern Irish	53%
White – Gypsy or Irish Traveller	0%
White – Irish	2%
White – Other White background	9%
Other	1%
Not disclosed	8%

Distribution of consultants by ethnic group (dental)

Ethnic Group	%
Arab	3%
Asian or Asian British – Bangladeshi	0%
Asian or Asian British – Chinese	1%
Asian or Asian British – Indian	14%
Asian or Asian British – Pakistani	0%
Asian or Asian British – Other Asian background	1%
Black or Black British – African	0%
Black or Black British – Caribbean	1%
Black or Black British – Other Black background	0%
Mixed – White and Asian	1%
Mixed – White and Black African	0%
Mixed – White and Black Caribbean	0%
Mixed – Other mixed background	1%
White – British, English, Welsh, Scottish, Northern Irish	53%
White – Gypsy or Irish Traveller	0%
White – Irish	5%
White – Other White background	7%
Other	1%
Not disclosed	12%

Distribution of resident doctors by ethnic group

Ethnic Group	%
Arab	5%
Asian or Asian British – Bangladeshi	1%
Asian or Asian British – Chinese	5%
Asian or Asian British – Indian	10%
Asian or Asian British – Pakistani	4%
Asian or Asian British – Other Asian background	4%
Black or Black British – African	3%
Black or Black British – Caribbean	1%
Black or Black British – Other Black background	<1%
Mixed – White and Asian	2%
Mixed – White and Black African	1%
Mixed – White and Black Caribbean	<1%
Mixed – Other mixed background	1%
White – British, English, Welsh, Scottish, Northern Irish	41%
White – Gypsy or Irish Traveller	0%
White – Irish	1%
White – Other White background	11%
Other	2%
Not disclosed	7%

Distribution of resident dentists by ethnic group

Ethnic Group	%
Arab	5%
Asian or Asian British – Bangladeshi	0%
Asian or Asian British – Chinese	2%
Asian or Asian British – Indian	9%
Asian or Asian British – Pakistani	5%
Asian or Asian British – Other Asian background	11%
Black or Black British – African	0%
Black or Black British – Caribbean	0%
Black or Black British – Other Black background	0%
Mixed – White and Asian	2%
Mixed – White and Black African	0%
Mixed – White and Black Caribbean	0%
Mixed – Other mixed background	3%
White – British, English, Welsh, Scottish, Northern Irish	44%
White – Gypsy or Irish Traveller	0%
White – Irish	0%
White – Other White background	6%
Other	2%
Not disclosed	14%

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