

Surgical Workforce 2010

Profile and Trends

*A report from The Royal College of Surgeons of England
in collaboration with the surgical specialty associations*



RCS

ADVANCING SURGICAL STANDARDS

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The Association of Surgeons of Great Britain and Ireland

The British Orthopaedic Association

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The British Association of Otorhinolaryngologists

The British Association of Oral and Maxillofacial Surgeons

The British Association of Plastic, Reconstructive and Aesthetic Surgeons

The Society for Cardiothoracic Surgery in Great Britain and Ireland

The Society of British Neurological Surgeons

The British Association of Paediatric Surgeons

Acknowledgements

We would like to express our appreciation to the surgical specialty associations for their collaborative efforts and contributions to the data. Above all we would like to thank all the surgeons who completed the survey and made this report possible.

Further information

Visit www.rcseng.ac.uk/service_delivery/workforce

or email workforce@rcseng.ac.uk

Produced by the Publications Department, The Royal College of Surgeons of England

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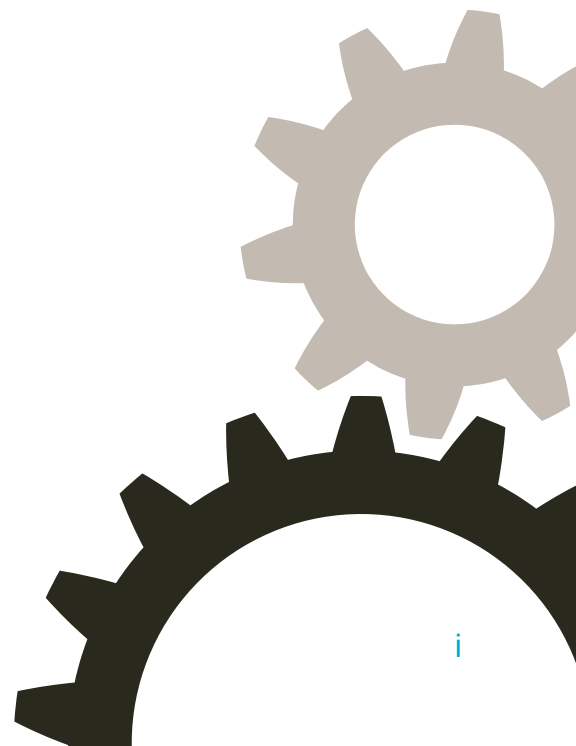
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Foreword

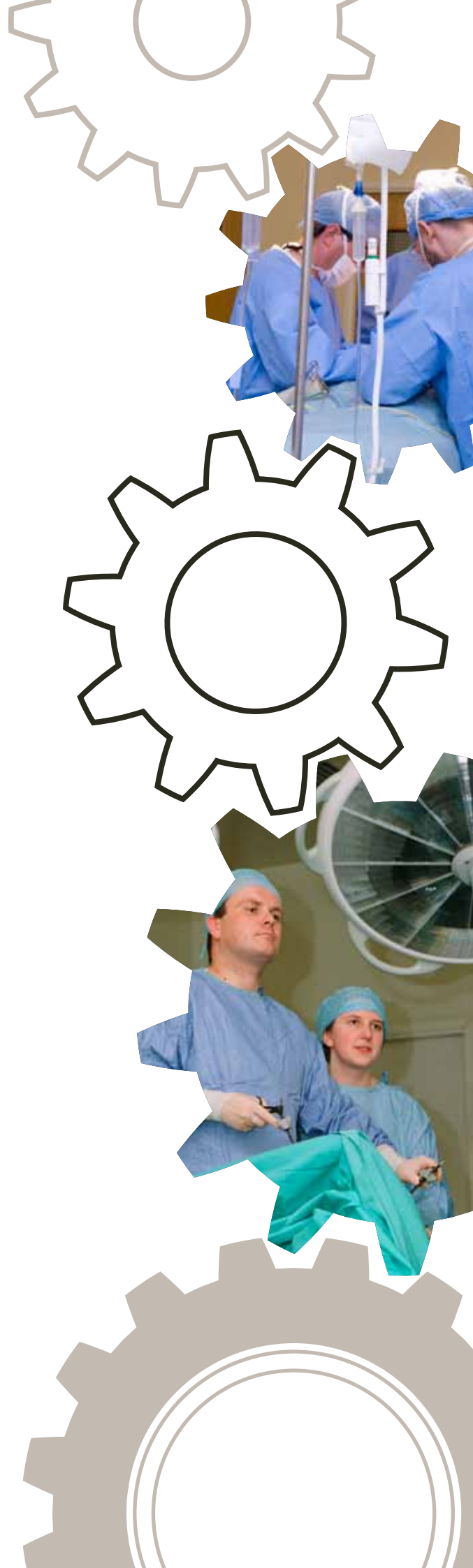
I am pleased to present the College's first comprehensive workforce survey of all surgical specialties. The current climate of major change in the NHS, combined with the introduction of European Working Time Regulations places significant challenges on workforce planning.

As part of its mission, the College is committed to supporting the improvement of surgical services. To achieve the safest and most effective patient care the NHS needs properly configured staffing in surgical units. Sensible workforce planning and policy making to this end is not possible without accurate data. This can be surprisingly difficult to obtain. The solution is for the College to collect it directly from the surgical profession.

We are grateful to the many surgeons who contributed and encourage them to continue to do so in the future. The data is robust because it has been collected from the professionals themselves.

We thank particularly the nine surgical specialty associations for their collaboration and their contributions to this vital work.

John Black
President
The Royal College of
Surgeons of England



Preface



The training of surgeons is a long and expensive process. It is incumbent on those responsible for delivering an adequate number of trained surgeons to ensure that processes are in place to achieve, as effectively as possible, a reasonable match between supply and demand. This is a challenging task because there are so many variables in the equation.

Regulations on hours of work and rest for trainees have placed huge pressures on surgical training. Societal changes have resulted in a generation that may look for a different work–life balance to that experienced by their predecessors. The impact of feminisation of the medical workforce in the UK is at present uncertain, but with around 60% of medical students being female it is probable that some impact will eventually manifest.

In craft specialties that require experiential practice as well as structured learning, a long lead time between planning and delivery compounds the challenge. Together with the wonderful and ongoing developments in pharmacology and medical technology that transform delivery of surgical care, the ever changing demands of an ageing population could lead the more cynical to suggest the task is insurmountable.

Workforce planning has however enjoyed some success and there is increasing experience in modelling supply against demand. The success of such modelling

is of course dependent on accurate data being fed into the modelling equation. It is for this reason that The Royal College of Surgeons of England has combined with the surgical specialty associations in developing and implementing an annual workforce survey across all specialties. It is the profession's opinion that workforce data provided by surgeons themselves are likely to provide the most accurate source of information.

I am therefore delighted to be writing this short preface, as it signals the profession's intent to increasingly contribute and influence the policy makers and planners. I am grateful to all the specialty associations who have engaged enthusiastically and am equally grateful for the many colleagues around the UK who took time in their busy schedules to complete the questionnaire; without their contribution there would be no report.

This is the first of what will be annual reports and as such creates a baseline. With time these will hopefully prove increasingly helpful to surgical workforce planning in the UK for the benefit of surgeons, surgical trainees and most importantly their patients.

Robert Greatorex LDS FRCS
Council Lead for Workforce

Shaping surgical workforce policy: the experience of the American College of Surgeons

It is my great pleasure to write this brief article to accompany the release of The Royal College of Surgeons of England's (RCS) first annual workforce survey. I commend the RCS for undertaking such a wide-reaching survey of the consultant workforce at a time when better data are needed to shape workforce planning decisions in difficult economic times. Our experience with collecting similar data through the American College of Surgeons' Health Policy Research Institute (HPRI) has demonstrated how valuable it is for the profession to have access to objective, rather than anecdotal, information about the size, distribution, specialty mix, demographics and practice characteristics of the surgical workforce. In undertaking this workforce survey, the RCS has collected information that will benefit multiple stakeholders who all share responsibility for ensuring that patients have sustainable access to the right surgeon in the right place at the right time.

Assembling the basic data required to conduct robust surgical workforce analyses and achieve the vision of the 'right surgeon, right place, right time' is an incremental process. This survey is the first, and arguably most important, cornerstone of what will eventually form a larger foundation of data that patients, the profession, surgical specialty societies, policy makers, employers and other stakeholders can draw upon. One of the great strengths of the survey is that it did not attempt to paint the surgical workforce with one brush—it collected

data on each of the nine surgical specialties which face very different service demands and different workforce demographics. For example the data show that while just 4% of the trauma and orthopaedic surgery workforce is female, 20% of the paediatric surgery workforce is comprised of women. Studies have shown that female surgeons work fewer hours than their male counterparts, particularly during childbearing and childrearing years. Having data on the gender and age structure of the workforce will facilitate better workforce models that can adjust the head count to full-time equivalent (FTE) ratio to reflect these demographic trends. More recent research has also found that it is not just about gender; newer generations of surgeons work fewer hours in pursuit of a 'work-life balance' and some observers have speculated that these younger generations trained under the duty hour restrictions of the Working Time Directive (WTD) may work reduced hours throughout their careers compared to earlier generations. Because the survey collects data on hours worked and part-time status, the RCS can monitor these trends in future years. It will be particularly interesting to track whether the percent of consultant surgeons opting out of the WTD—20% in this survey—and the frequency of call taken changes as these generational shifts ripple through the workforce.

Our experience collecting and publishing workforce data on the surgical workforce in the United States has convinced us

of the value of engaging the surgical specialties as partners in improving both the amount and quality of data collected. When we have published reports, there are inevitable challenges from some who question the validity of the results. The surgical specialties play a pivotal role in these discussions because they can review the data on their specialty to determine if it ‘feels right’. These tests of the face validity of workforce data are useful because they engage the profession, as well as other stakeholders, in discussions about how to improve data quality through increased response rates (although an overall 60% response rate for this first survey is quite an impressive start!) or changing the way survey questions are asked. Workforce surveys often generate as many questions as they answer and thus this first survey will likely spur dialogue about additional information needed in the future.

But why collect any data at all? The simple answer is that workforce decisions require long range planning and a lack of data has hampered the ability to proactively, rather than reactively, plan for the workforce needed. All too often, resources are not invested wisely and short-term decisions are made (ie rapid growth in posts to meet increased demand) which have long-term consequences (ie an excess supply of surgeons in a particular specialty in a later period). The risk of not using data to workforce plan is a system that lurches from oversupply to shortage and remains one in which patient access to

surgical services is unequally distributed across geographies. Armed with better data, the RCS will be able to weigh in on important decisions about the numbers and location of surgical training posts needed now and in the future. In these times of constrained funding, the need for data has never been greater to inform policy decisions in a rapidly changing and evolving health care system.

[Erin Fraher PhD MPP](#)
Associate Director
Health Policy Research Institute
The American College of Surgeons



Introduction

The Royal College of Surgeons of England is committed to improving patient safety and the delivery of surgical services through setting and maintaining standards. We believe that effective workforce planning through the collection of reliable and useful workforce data is essential for ensuring the future provision of safe and effective patient care.

As part of this commitment, we undertook the first individual survey of surgeons employed in England, Wales and Northern Ireland. In collaboration with the surgical specialty associations we generated this first workforce report with data and information collected directly from practising surgeons. Although this is the first year that the survey was run, we aim to carry out a regular census of the surgical workforce and are committed to improving accuracy, relevance and return rates year on year.

The aim of this report is to provide reliable and useful data to support policy development for the provision of surgical care. It provides a picture of the surgical workforce as well as surgeons' areas of special interests, contract arrangements and working patterns of consultant surgeons.

The supply of surgeons is dependent upon many different public and institutional policies and the individual decisions of medical students and specialty trainees. This document is intended to support those decisions and the policy making process. In particular it aims to assist those responsible for the development of services such as workforce planners and advisers, Departments of Health, the Centre for Workforce Intelligence and Strategic Health Authorities in England, the Human Resources Directorate of the Welsh Assembly Government and those



concerned with the training, development and employment of surgeons.

Part One of the report provides the overview of the surgical workforce in England, Wales and Northern Ireland, presenting an analysis of the number and gender of consultant surgeons by surgical specialty. It also gives the profile of age and workload patterns, such as number of working programmed activities, on-call commitment, part time work and retirement intentions. The latter information on workload patterns refer to data collected from England and Wales. Subsequent surveys will include information on consultant workload for all three countries.

Part Two of the report provides workforce information that is specific to each of the nine surgical specialties and includes the specialty associations' recommendations for their consultant workforce.

The numbers presented may vary at times from other reports and summaries and this is to be expected, as those reports may use different categories and selection criteria. Please pay close attention to the notes included in this report before making direct comparisons to other data.

Recommendations provided by the specialty associations can be interpreted against the backdrop of the UK population and national projections statistics from the Office for National Statistics (Table 1).

TABLE 1 Population projections for the UK, England, Wales, Scotland and Northern Ireland from 2008–2033

	2008 (000s)	2013 (000s)	2018 (000s)	2023 (000s)	2028 (000s)	2033 (000s)
United Kingdom	61,393	63,498	65,645	67,816	69,832	71,623
England	51,460	53,332	55,252	57,209	59,051	60,715
Wales	2,990	3,056	3,137	3,219	3,290	3,347
Scotland	5,169	5,271	5,360	5,442	5,505	5,544
Northern Ireland	1,775	1,839	1,896	1,946	1,986	2,016

Notes on methodology

This report provides data on consultant surgeons practising in England, Wales and Northern Ireland. Surgeons classified as retired, temporarily not in practice, surgeons in training and non-consultant grades are not included in this report.

The Royal College of Surgeons of England ran an online survey from October 2009 to April 2010. A personalised link to the online survey was sent to all surgeons in the College database, followed up by email reminders. For those surgeons without email addresses hard copies of the survey were sent by post.

The results were shared with the nine surgical specialty associations as defined by the Specialist Advisory Committees. The specialty associations provided workforce information and recommendations for each of the surgical specialties.

The survey achieved 60% response rate and collected data on the surgical workforce and information on consultant surgeons' working practice.

In this year's survey, information on the number, gender and age profile of consultant surgeons refer to data for England, Wales and Northern Ireland. Information on consultant workload refer to data for England and Wales. In subsequent surveys, information on consultant workload will include data for all three countries.

The primary data sources for this report include:

- » consultant responses to the survey of The Royal College of Surgeons of England
- » surgical database of The Royal College of Surgeons of England*
- » data from the surgical specialty associations

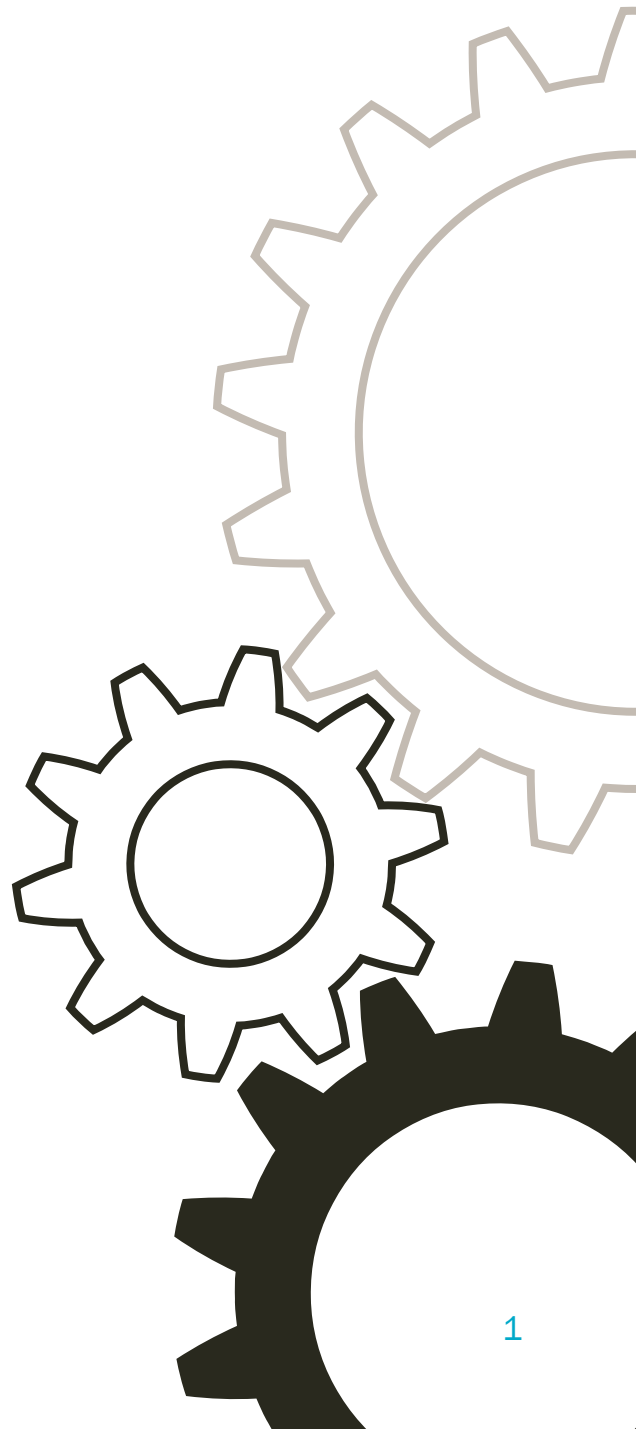
The source of each piece of information presented in this report is indicated throughout.

* The database not only includes RCS fellows and members but also all consultants who practise in England, Wales and Northern Ireland.

PART ONE

Overview of the surgical workforce

- 2 Number and gender of consultant surgeons in all surgical specialties
- 4 Age profile of consultant surgeons in all surgical specialties
- 5 Profile of workload for consultant surgeons in all surgical specialties

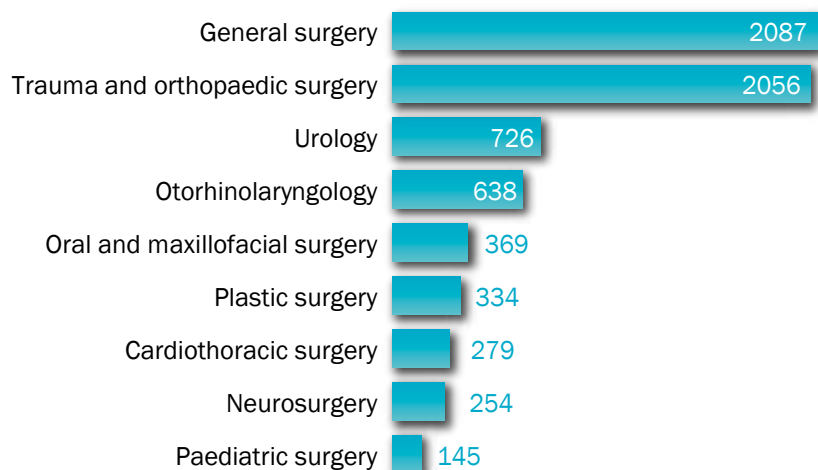


Number and gender of consultant surgeons in all surgical specialties

TABLE 1 Number of consultant surgeons by surgical specialty

Specialty	England	Wales	Northern Ireland	Total
General surgery	1,888	123	76	2,087
Trauma and orthopaedic surgery	1,882	122	52	2,056
Urology	663	43	20	726
Otorhinolaryngology	571	41	26	638
Oral and maxillofacial surgery	341	21	7	369
Plastic surgery	313	11	10	334
Cardiothoracic surgery	257	13	9	279
Neurosurgery	240	8	6	254
Paediatric surgery	134	5	6	145
All specialties	6,289	387	212	6,888

FIGURE 1 Total number of consultant surgeons by surgical specialty



Notes

These figures refer to consultant surgeons who practise in England, Wales and Northern Ireland as of April 2010. Surgeons classified as retired, temporarily not in practice, surgeons in training and non-consultant grades are not included.

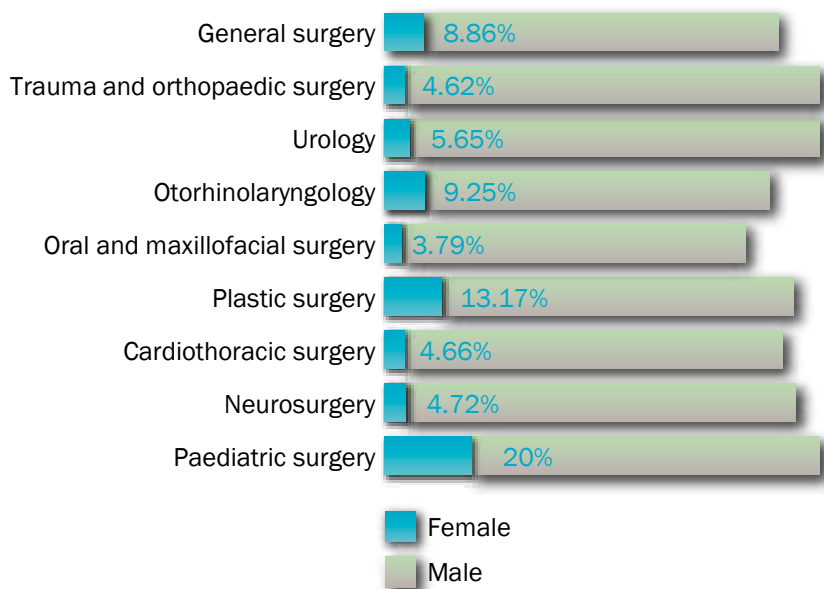
Source

Data from surgical specialty associations, RCS surgical database, RCS survey April 2010.

TABLE 2 Number and percentage of female consultant surgeons by surgical specialty

Specialty	Total	Number of females	Percentage of females
General surgery	2,087	185	8.8
Trauma and orthopaedic surgery	2,056	95	4.6
Urology	726	41	5.6
Otorhinolaryngology	638	59	9.2
Oral and maxillofacial surgery	369	14	3.8
Plastic surgery	334	44	13.1
Cardiothoracic surgery	279	13	4.6
Neurosurgery	254	12	4.7
Paediatric surgery	145	29	20
All specialties	6,888	492	7.1

FIGURE 2 Percentage of female consultant surgeons by surgical specialty



Notes

These figures refer to consultant surgeons who practise in England, Wales and Northern Ireland as of April 2010. Surgeons classified as retired, temporarily not in practice, surgeons in training and non-consultant grades are not included.

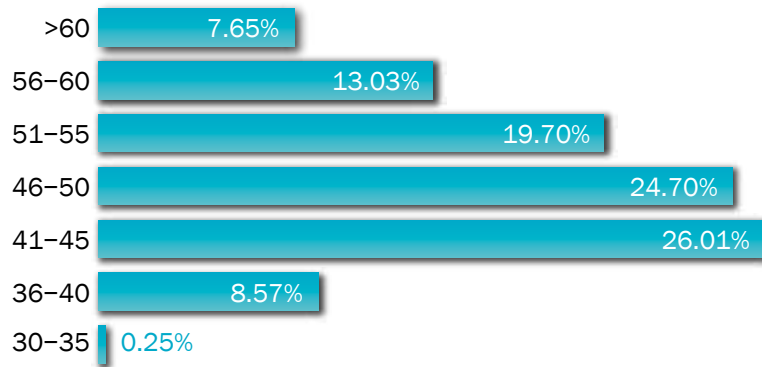
The percentages are based on the number of surgeons whose gender was known. Gender was unknown for 394 practising surgeons.

Source

Data from surgical specialty associations, RCS surgical database and RCS survey April 2010.

Age profile of consultant surgeons in all surgical specialties

FIGURE 3 Age profile (in years) of consultant surgeons in all surgical specialties



Notes

These figures refer to consultant surgeons who practise in England, Wales and Northern Ireland as of April 2010. Percentages represent a profile of the age of consultant surgeons based on responses to the RCS survey.

Source

RCS survey, April 2010.

Profile of workload for consultant surgeons in all surgical specialties

Data and figures in this section are based on the total number of responses to the RCS survey from consultant surgeons who practise in England, Wales and Northern Ireland as of April 2010.

FIGURE 4 Number of programmed activities (PAs) worked per week by consultant surgeons in all surgical specialties

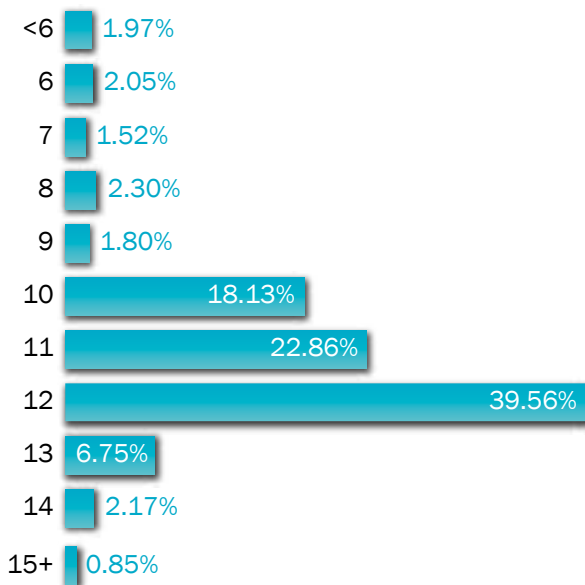
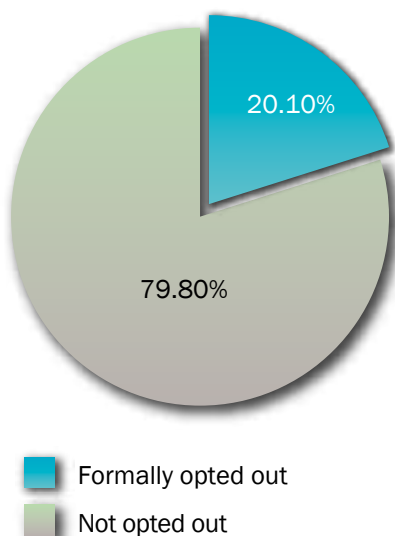


FIGURE 5 Percentage of consultant surgeons who have formally opted out of European Working Time Regulations (EWTR)



Notes

These figures show the number of PAs actually worked (not just contracted) by consultant surgeons in all surgical specialties. Guidance from NHS Employers in England* recommends that a job plan for a full-time consultant surgeon should consist of 10 PAs per week. However, more than two thirds of respondents indicated that their actual work rises above this threshold.

Source

RCS survey, April 2010.

* NHS Employers. *Guidance on supporting professional activities*. London: DH; 2007.

Notes

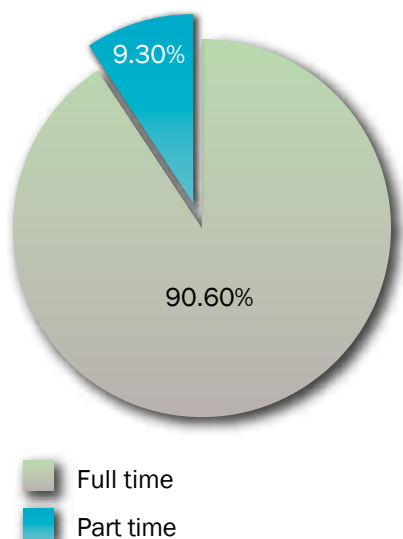
EWTR prescribes a 48-hour working week for all healthcare workers in the United Kingdom. It is possible to 'opt out' of the 48-hour working week in order to work longer hours but all other EWTR requirements must be met.

Although the majority of consultant surgeons work longer than the indicated 48 hours per week, only 20% have formally signed an 'opt out' statement with their employer.

Source

RCS survey, April 2010.

FIGURE 6 Percentage of consultant surgeons working part time



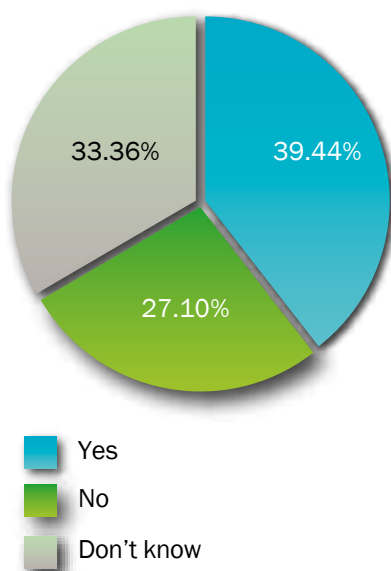
Notes

Approximately 9.3% of consultant surgeons described themselves as working part time.

Source

RCS survey, April 2010.

FIGURE 7 Percentage of consultant surgeons intending to work part time at some point in their career



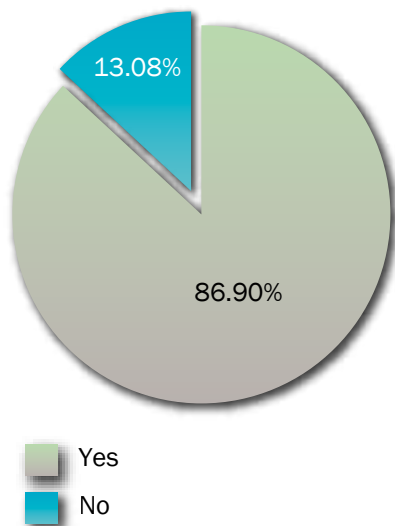
Notes

Figures based on consultant surgeons who currently work full time. 39.44% expressed the wish to work part time at some point in their career.

Source

RCS survey, April 2010.

FIGURE 8 Percentage of consultant surgeons with on-call commitment



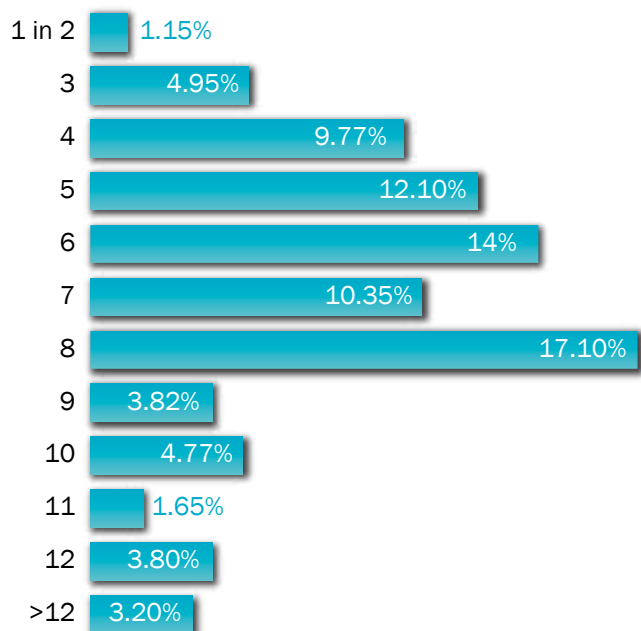
Notes

The great majority of consultant surgeons (86.9%) indicated that on-call commitment is part of their contracted workload.

Source

RCS survey, April 2010.

FIGURE 9 Frequency of on-call commitment required of consultant surgeons



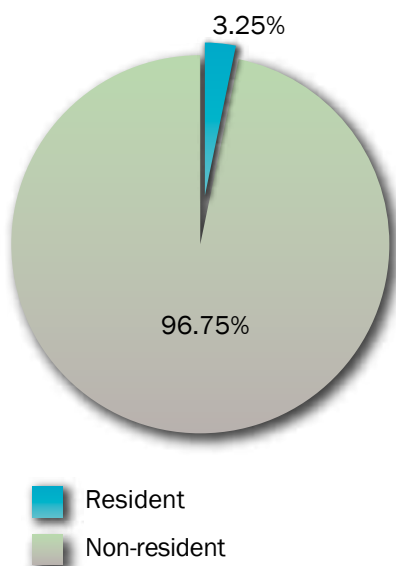
Notes

Figures based on consultant surgeons with on-call duties. Approximately 63.3% of respondents reported the frequency of their on-call commitment to be between 1 in 4 and 1 in 8. Approximately 6.1 % of respondents indicated that they are working on-call rotas of greater intensity than 1 in 4.

Source

RCS survey, April 2010.

FIGURE 10 Percentage of consultant surgeons who are resident while on call



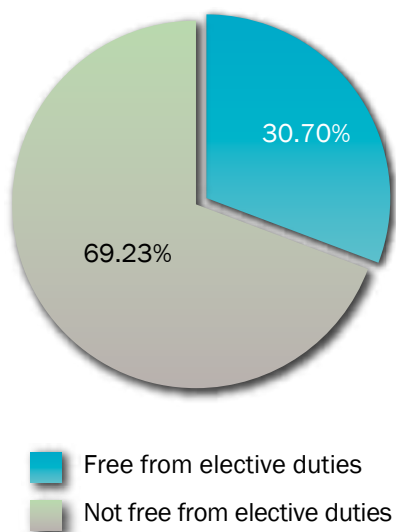
Notes

Figures based on consultant surgeons with on-call duties. Only 3.25% reported that they are resident while on call. Surgeons who are resident while on call are classified as working even when at rest, which needs to be taken into account when considering working patterns that will allow compliance with EWTR.

Source

RCS survey, April 2010.

FIGURE 11 Percentage of consultant surgeons who are free from elective duties while on call



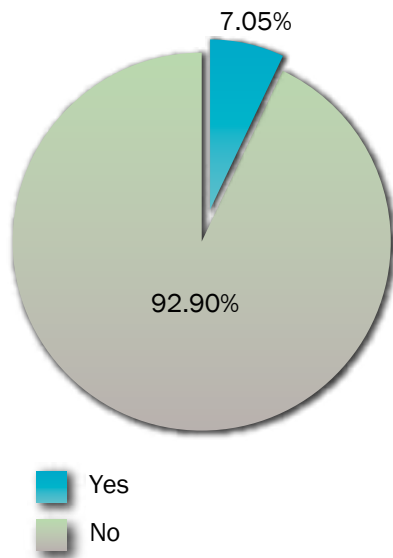
Notes

Less than one third (30.7%) of respondents indicated that they are free from elective duties while covering on-call responsibilities. As part of its policy for separating emergency and elective work streams in order to support the highest standards of surgical practice, the RCS recommends that surgeons are free of elective commitments during the time they spend on call.

Source

RCS survey, April 2010.

FIGURE 12 Percentage of consultant surgeons who intend to retire in the next two years



Notes

Approximately 7% of respondents suggested that they intend to retire within the next two years. An accurate account of retirement intentions is crucial for effective workforce planning. Potential trends for earlier retirement among consultant surgeons may have a profound effect on workforce numbers, particularly for smaller surgical specialties.

Source

RCS survey, April 2010.

PART TWO

Profile of surgical workforce by specialty

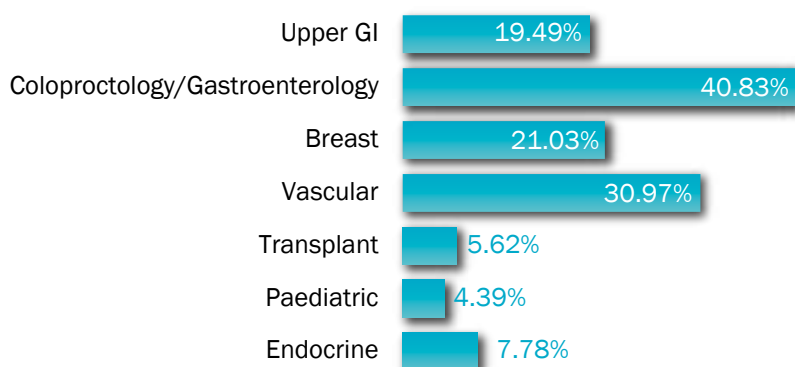
11	A. General surgery
15	B. Trauma and orthopaedic surgery
19	C. Urology
23	D. Otorhinolaryngology
27	E. Oral and maxillofacial surgery
31	F. Plastic surgery
35	G. Cardiothoracic surgery
39	H. Neurosurgery
43	I. Paediatric surgery

A. General surgery

A1. Specialty recommendations for England, Wales and Northern Ireland

The Association of Surgeons of Great Britain and Ireland (ASGBI) recommends a consultant workforce ratio of 1:25,000 population and an overall maintenance of current consultant surgeon numbers. These recommendations will vary depending on each sub-specialty. Currently, the Association of Breast Surgery (ABS) and the British Transplantation Society (BTS) require an increased amount of consultants in their specialties to meet public need, whereas the Vascular Society and the Association of Upper Gastrointestinal Surgeons of Great Britain and Ireland (AUGIS) recommend maintenance of their current consultant surgeon numbers.

A2. Percentage of consultant surgeons working in areas of special interest



Source

ASGBI, ABS, AUGIS, the Vascular Society and BTS.

Notes

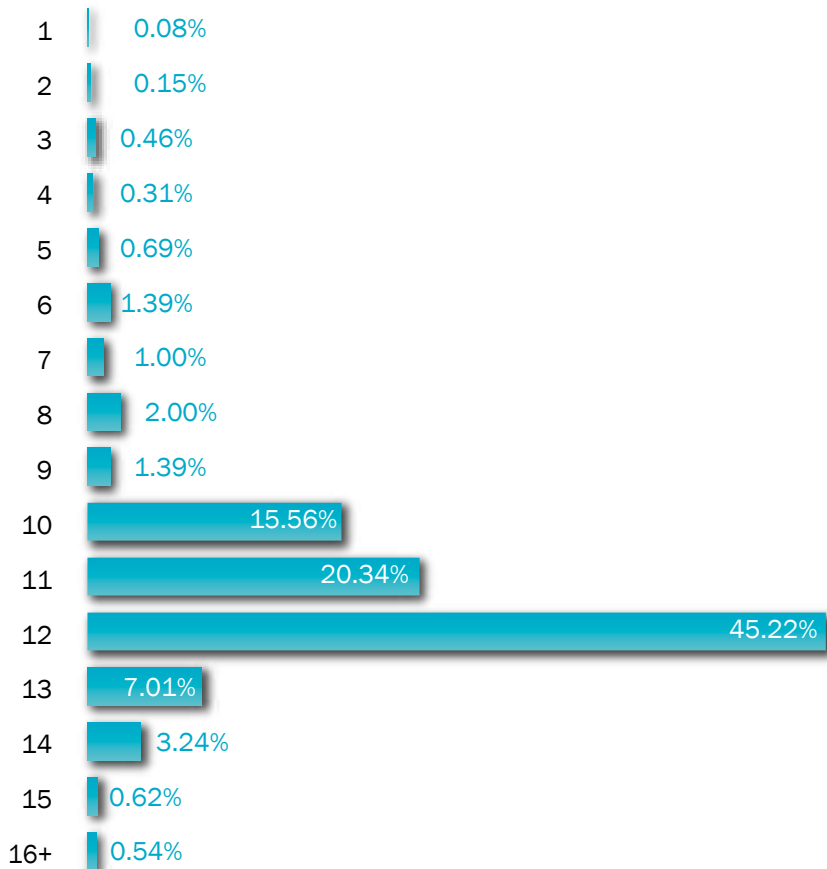
These figures show areas of special interest as specified by consultant general surgeons who responded to the RCS survey. Surgeons may have more than one area of special interest, therefore the above figures total more than the number of respondents.

Source

RCS survey, April 2010.

A. General surgery

A3. Number of programmed activities (PAs) worked per week by consultant surgeons



Notes

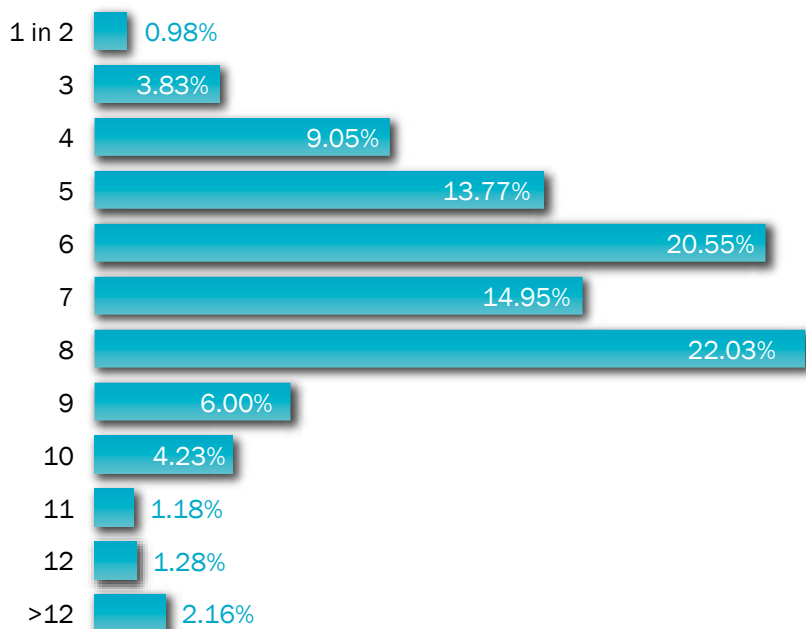
These figures show the number of PAs actually worked (not just contracted) by consultant general surgeons.

Source

RCS survey, April 2010.

A. General surgery

A4. Frequency of on-call commitment required of consultant surgeons



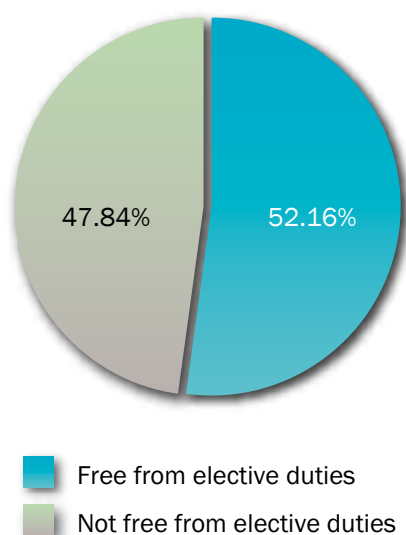
Notes

Figures based on consultant general surgeons with on-call duties. Approximately 80% of respondents recorded that the frequency of their on-call commitment is between 1 in 4 to 1 in 8, and 5% are working on-call rotas of greater intensity than 1 in 4.

Source

RCS survey, April 2010.

A5. Percentage of consultant surgeons who are free from elective duties while on call



Notes

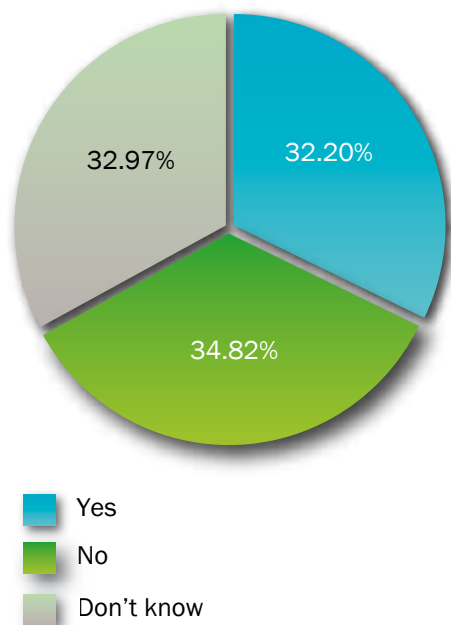
Slightly more than half of consultant general surgeons who responded to the RCS survey (52.16%) recorded that they are free from elective duties while covering on-call responsibilities.

Source

RCS survey, April 2010.

A. General surgery

A6. Percentage of consultant surgeons intending to work part time at some point in their career



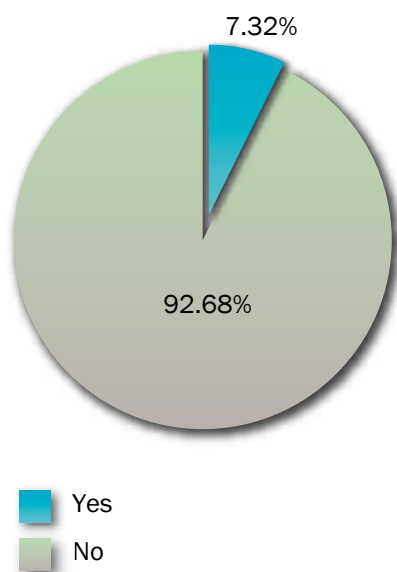
Notes

These figures show the percentage of full-time consultant general surgeons who expressed the wish to work part time at some point in their career.

Source

RCS survey, April 2010.

A7. Percentage of consultant surgeons who intend to retire in the next two years



Notes

Approximately 7% of consultant general surgeons who responded to the RCS survey suggested that they intend to retire within the next two years.

Source

RCS survey, April 2010.

B. Trauma and orthopaedic surgery

B1. Specialty recommendations for England, Wales and Northern Ireland

Source
BOA.

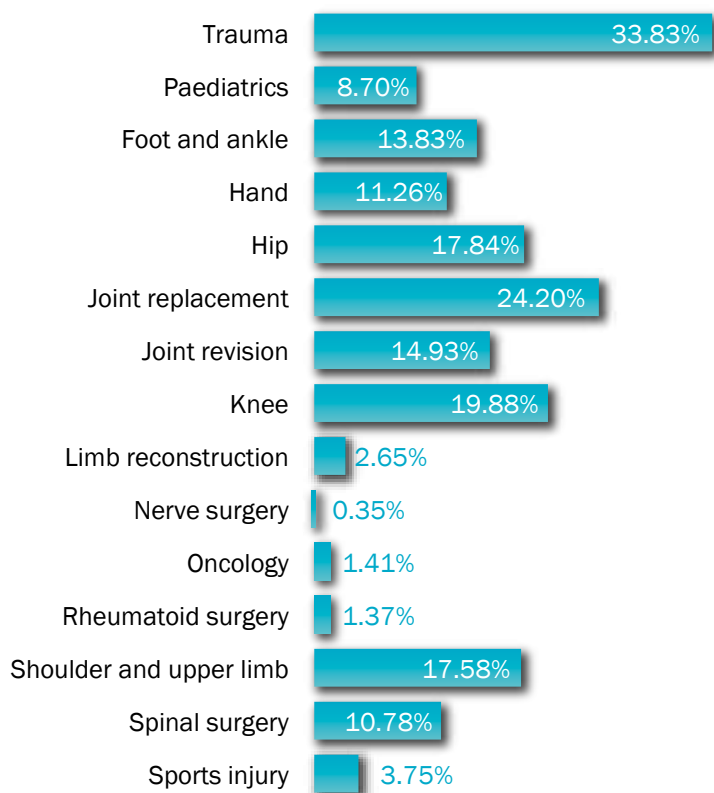
The British Orthopaedic Association (BOA) recommends a consultant workforce ratio of 1:15,000 population, to be achieved ideally by 2020, with an interim target of 1:20,000 by 2015. These figures match European mean workforce figures for orthopaedic surgery. In order to achieve this target an expansion of the size of the consultant workforce is recommended.

B2. Percentage of consultant surgeons working in areas of special interest

Notes

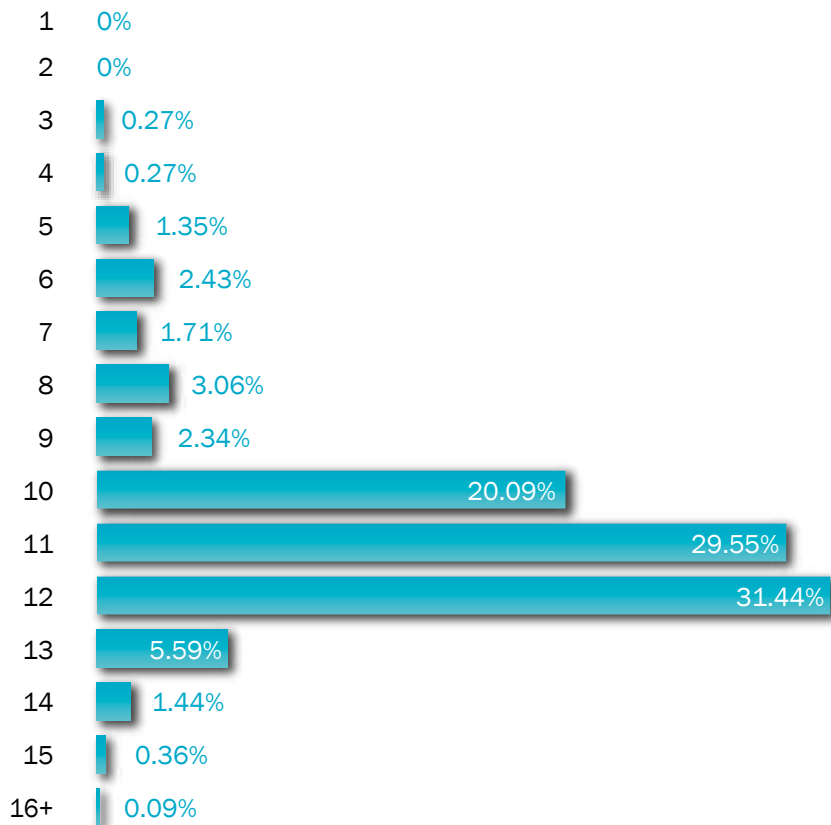
These figures show areas of special interest as specified by consultant trauma and orthopaedic surgeons. Surgeons may have more than one area of special interest, therefore the above figures total more than the number of surgeons.

Source
BOA.



B. Trauma and orthopaedic surgery

B3. Number of programmed activities (PAs) worked per week by consultant surgeons



Notes

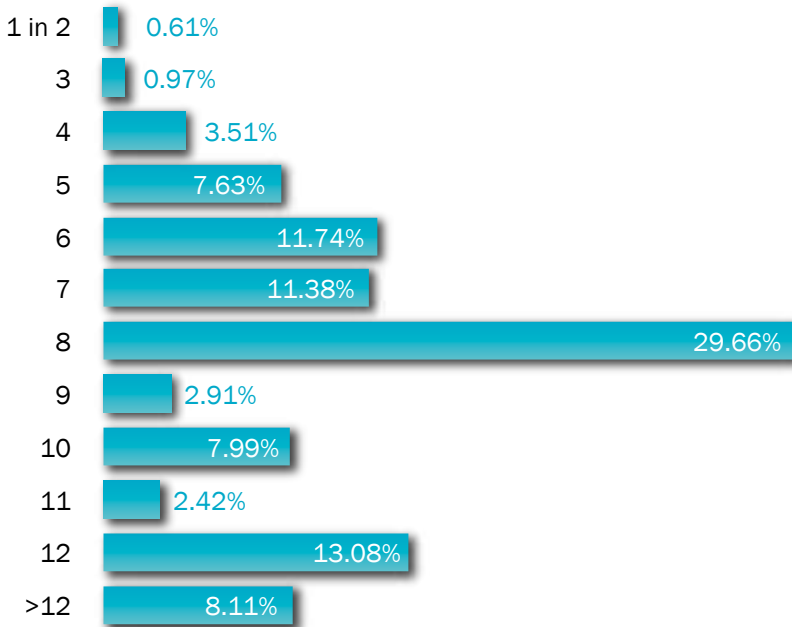
These figures show the number of PAs actually worked (not just contracted) by consultant trauma and orthopaedic surgeons.

Source

RCS survey, April 2010.

B. Trauma and orthopaedic surgery

B4. Frequency of on-call commitment required of consultant surgeons



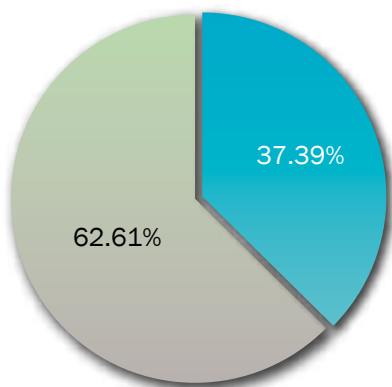
Notes

Figures based on consultant trauma and orthopaedic surgeons with on-call duties. Approximately 63.92% of respondents recorded that the frequency of their on-call commitment is between 1 in 4 to 1 in 8, and 1.57% are working on-call rotas of greater intensity than 1 in 4.

Source

RCS survey, April 2010.

B5. Percentage of consultant surgeons who are free from elective duties while on call

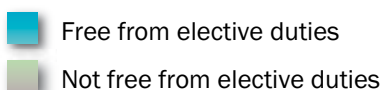


Notes

Approximately 37% of consultant trauma and orthopaedic surgeons who responded to the RCS survey recorded that they are free from elective duties while covering on-call responsibilities.

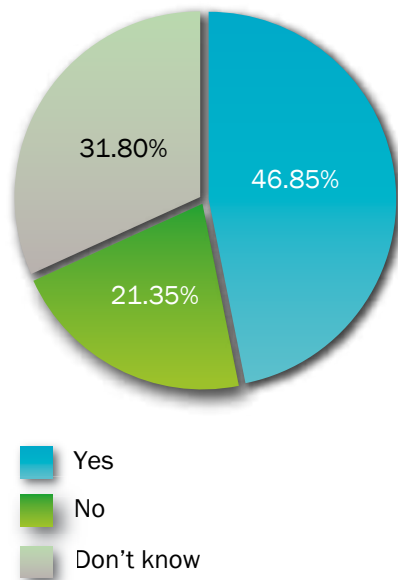
Source

RCS survey, April 2010.



B. Trauma and orthopaedic surgery

B6. Percentage of consultant surgeons intending to work part time at some point in their career



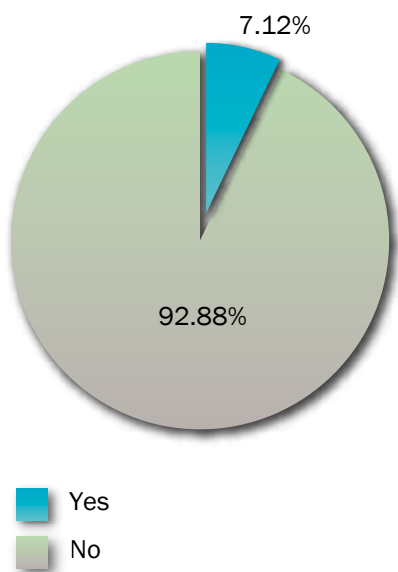
Notes

These figures show the percentage of full-time consultant trauma and orthopaedic surgeons who expressed the wish to work part time at some point in their career.

Source

RCS survey, April 2010.

B7. Percentage of consultant surgeons who intend to retire in the next two years



Notes

Approximately 7% of consultant trauma and orthopaedic surgeons who responded to the RCS survey suggested that they intend to retire within the next two years.

Source

RCS survey, April 2010.

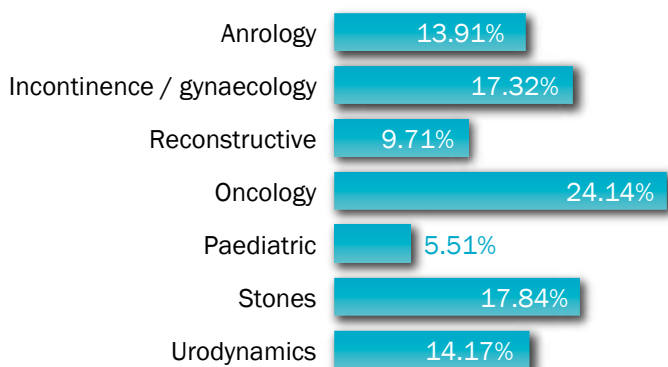
C. Urology

C1. Specialty recommendations for England, Wales and Northern Ireland

The British Association of Urological Surgeons (BAUS) recommends a consultant workforce ratio of 1:80,000 population. There is currently a need for more diagnostic and medical-style urologists. If the trend of an ageing population continues, the recommended ratio to meet public need will be 1:60,000. An expansion of the current consultant numbers is recommended.

Source
BAUS.

C2. Percentage of consultant surgeons working in areas of special interest



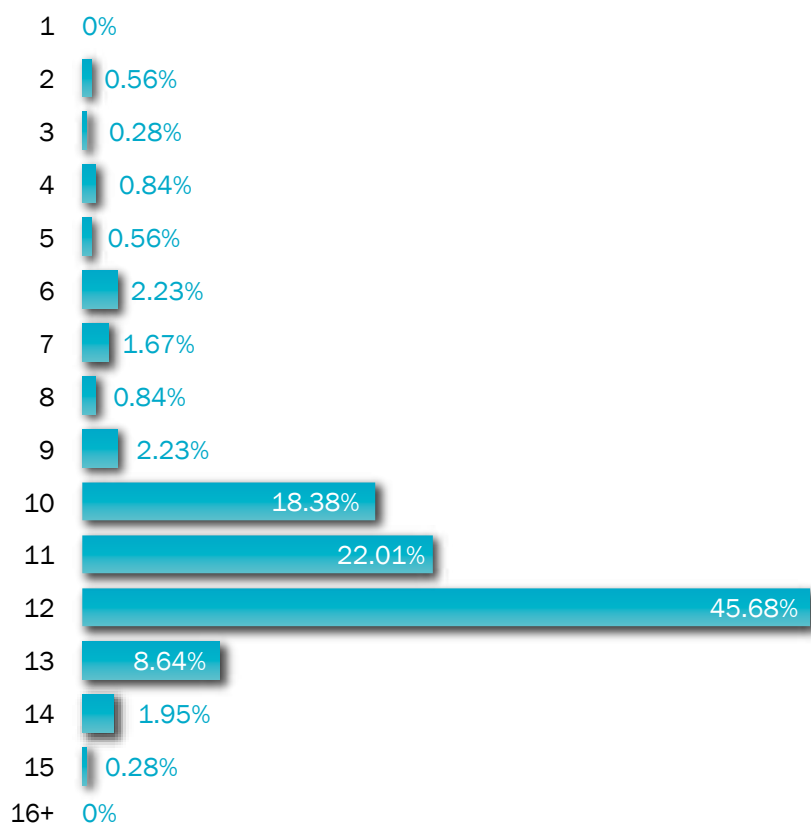
Notes

These figures show areas of special interest as specified by consultant urologists who responded to the RCS survey. Surgeons may have more than one area of special interest, therefore the above figures total more than the number of respondents.

Source
RCS survey, April 2010.

C. Urology

C3. Number of programmed activities (PAs) worked per week by consultant surgeons



Notes

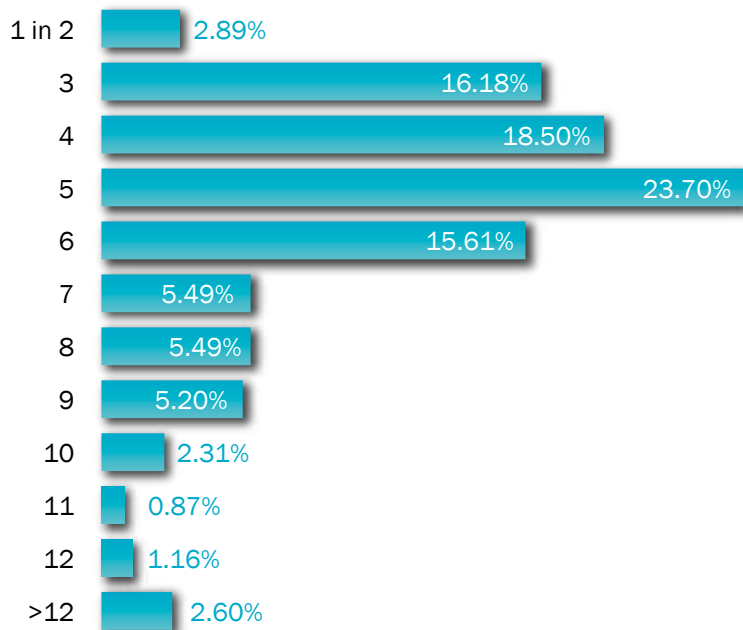
These figures show the number of PAs actually worked (not just contracted) by consultant urologists.

Source

RCS survey, April 2010.

C. Urology

C4. Frequency of on-call commitment required of consultant surgeons



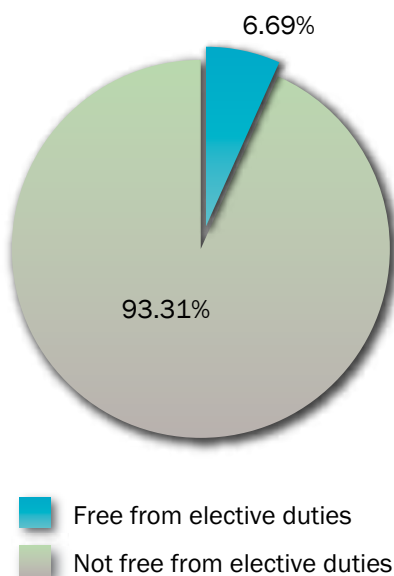
Notes

Figures based on consultant surgeons with on-call duties. Approximately 69% of respondents recorded that the frequency of their on-call commitment is between 1 in 4 to 1 in 8. Approximately 19% of respondents indicated that they are working on on-call rotas of greater intensity than 1 in 4.

Source

RCS survey, April 2010.

C5. Percentage of consultant surgeons who are free from elective duties while on call



Notes

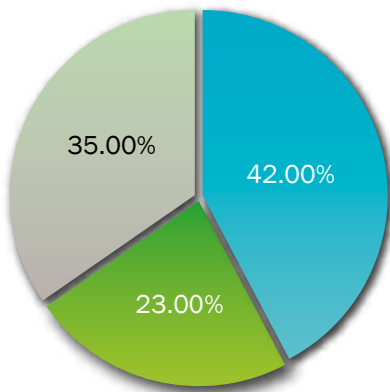
The great majority consultant urologists who respondents to the RCS survey (93.31%) recorded that they are not free from elective duties while covering on-call responsibilities.

Source

RCS survey, April 2010.

C. Urology

C6. Percentage of consultant surgeons intending to work part time at some point in their career



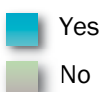
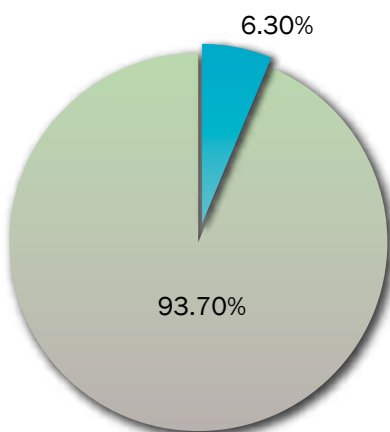
Notes

These figures show the percentage of full-time consultant urologists who expressed the wish to work part time at some point in their career.

Source

RCS survey, April 2010.

C7. Percentage of consultant surgeons who intend to retire in the next two years



Notes

Approximately 6 % of consultant urologists who responded to the RCS survey suggested that they intend to retire within the next two years.

Source

RCS survey, April 2010.

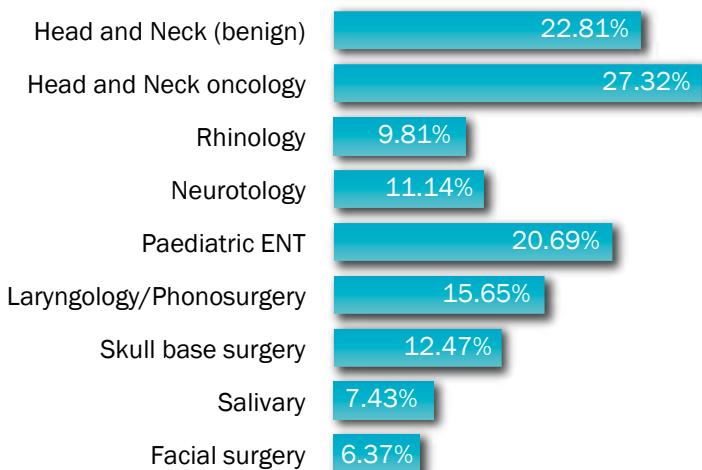
D. Otorhinolaryngology

D1. Specialty recommendations for England, Wales and Northern Ireland

The British Association of Otorhinolaryngologists (ENT UK) recommends a consultant workforce ratio of 1:50,000 population, and an expansion of current consultant numbers. It has noted that there is currently a sufficient number of trainees to support an expansion but consultant posts are not being made available by trusts.

Source
ENT UK.

D2. Percentage of consultant surgeons working in areas of special interest

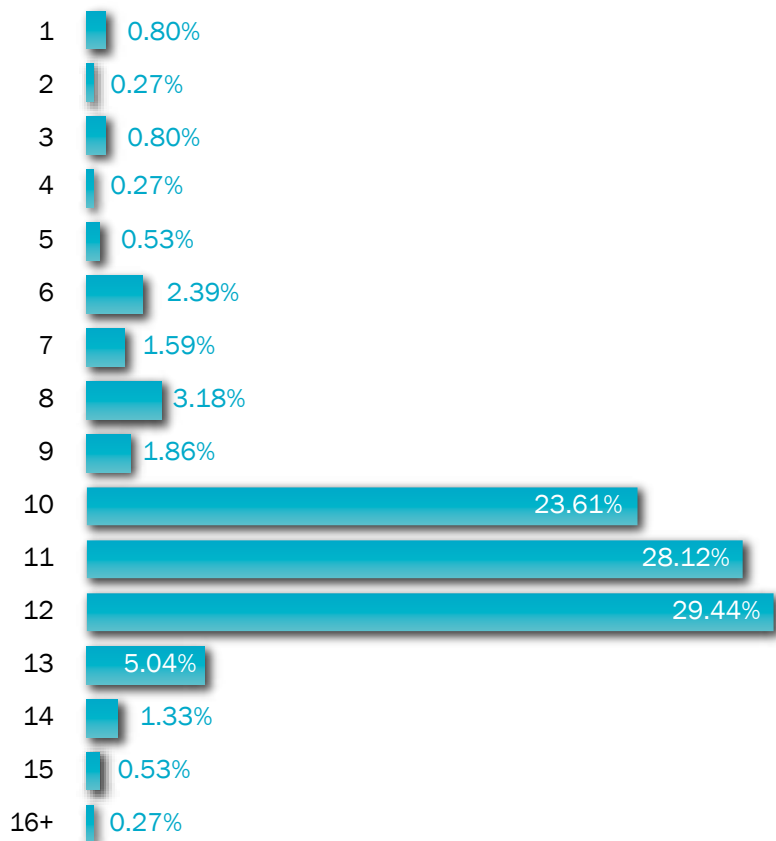


Notes
These figures show areas of special interest as specified by consultant otorhinolaryngologists who responded to the RCS survey. Surgeons may have more than one area of special interest, therefore the above figures total more than the number of respondents.

Source
RCS survey, April 2010.

D. Otorhinolaryngology

D3. Number of programmed activities (PAs) worked per week by consultant surgeons



Notes

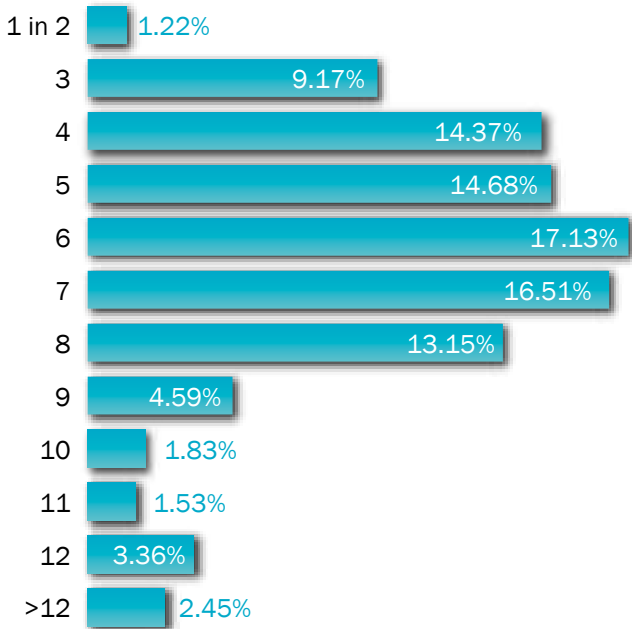
These figures show the number of PAs actually worked (not just contracted) by consultant otorhinolaryngologists.

Source

RCS survey, April 2010.

D. Otorhinolaryngology

D4. Frequency of on-call commitment required of consultant surgeons



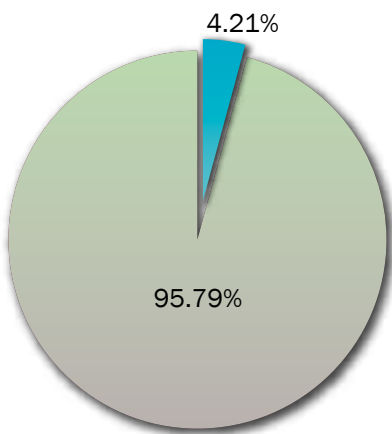
Notes

Figures based on consultant otorhinolaryngologists with on-call duties. Approximately 76% of respondents recorded that the frequency of their on-call commitment is between 1 in 4 to 1 in 8, and 10% are working on-call rotas of greater intensity than 1 in 4.

Source

RCS survey, April 2010.

D5. Percentage of consultant surgeons who are free from elective duties while on call



- Free from elective duties
- Not free from elective duties

Notes

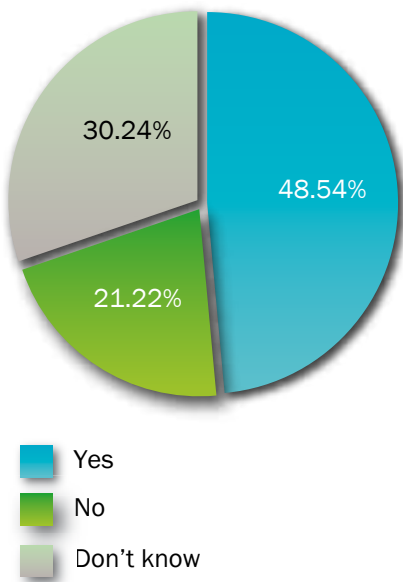
Only 4.21% of consultant otorhinolaryngologists who responded to the RCS survey recorded that they are free from elective duties while covering on-call responsibilities.

Source

RCS survey, April 2010.

D. Otorhinolaryngology

D6. Percentage of consultant surgeons intending to work part time at some point in their career



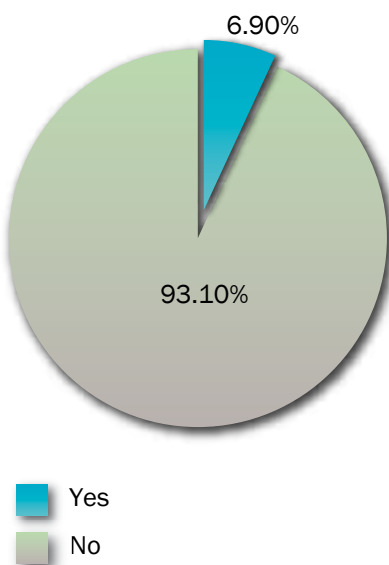
Notes

These figures show the percentage of full-time consultant otorhinolaryngologists who expressed the wish to work part time at some point in their career.

Source

RCS survey, April 2010.

D7. Percentage of consultant surgeons who intend to retire in the next two years



Notes

Almost 7% of consultant otorhinolaryngologists who responded to the RCS survey suggested that they intend to retire within the next two years.

Source

RCS survey, April 2010.

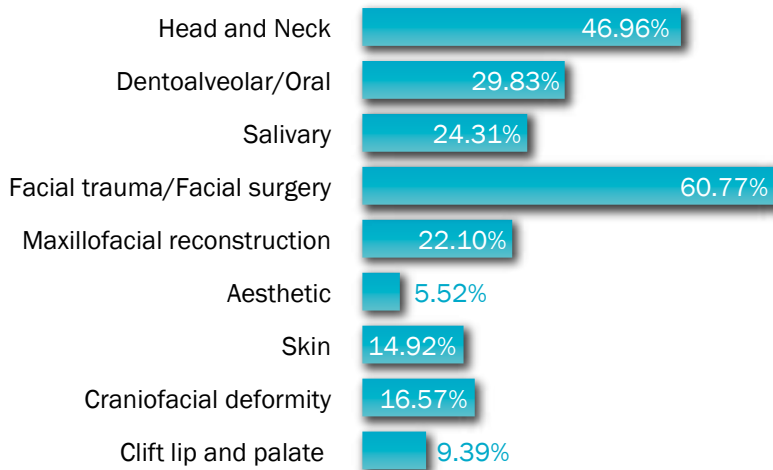
E. Oral and maxillofacial surgery

E1. Specialty recommendations for England, Wales and Northern Ireland

Source
BAOMS.

The British Association of Oral and Maxillofacial Surgeons (BAOMS) recommends a consultant workforce ratio 1:200,000 population and a slight expansion for maxillofacial consultant numbers to meet public need.

E2. Percentage of consultant surgeons working in areas of special interest



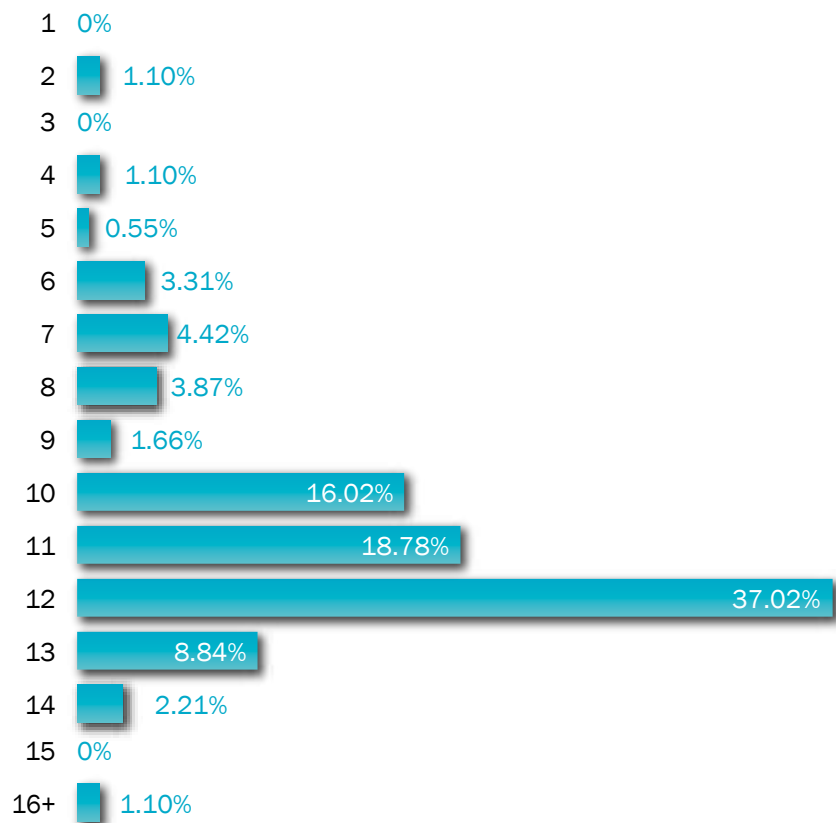
Notes

These figures show areas of special interest as specified by consultant oral and maxillofacial surgeons who responded to the RCS survey. Surgeons may have more than one area of special interest, therefore the above figures total more than the number of respondents.

Source
RCS survey, April 2010.

E. Oral and maxillofacial surgery

E3. Number of programmed activities (PAs) worked per week by consultant surgeons



Notes

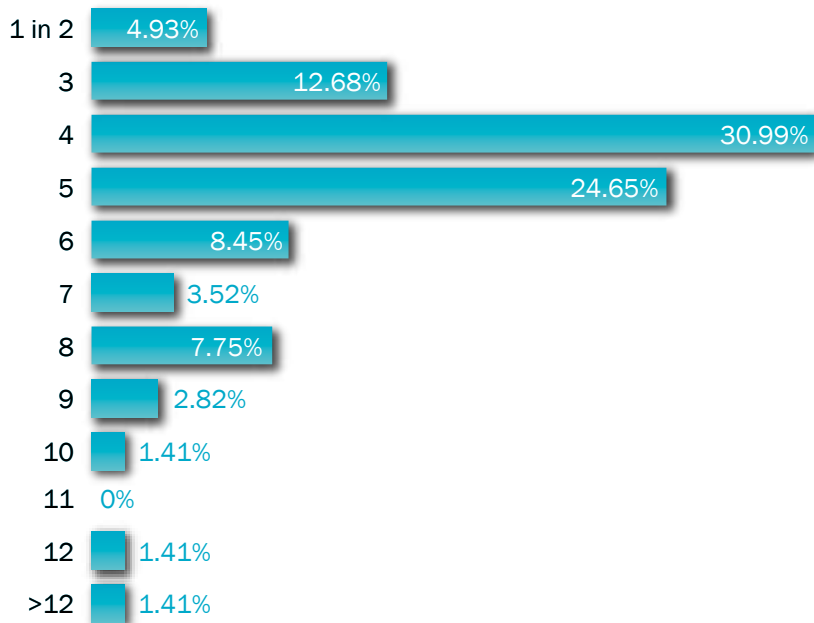
These figures show the number of PAs actually worked (not just contracted) by consultant oral and maxillofacial surgeons.

Source

RCS survey, April 2010.

E. Oral and maxillofacial surgery

E4. Frequency of on-call commitment required of consultant surgeons



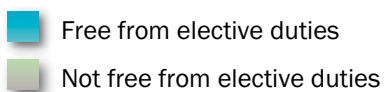
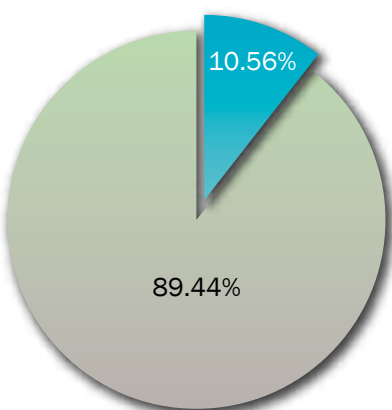
Notes

Figures based on consultant oral and maxillofacial surgeons with on-call duties. Approximately 75% of respondents recorded that the frequency of their on-call commitment is between 1 in 4 and 1 in 8, whereas 17.61% are working on-call rotas of greater intensity than 1 in 4.

Source

RCS survey, April 2010.

E5. Percentage of consultant surgeons who are free from elective duties while on call



Notes

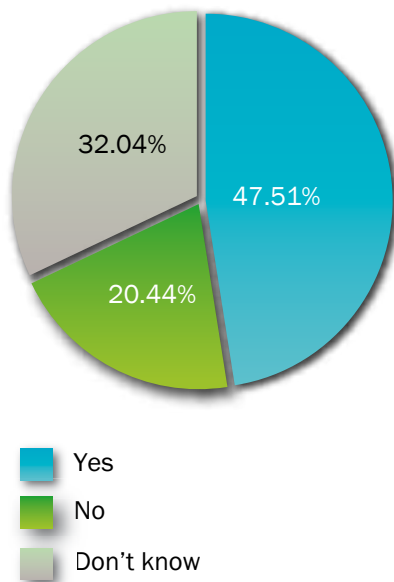
Approximately 10% of consultant oral and maxillofacial surgeons who responded to the RCS survey recorded that they are free from elective duties while covering on-call responsibilities.

Source

RCS survey, April 2010.

E. Oral and maxillofacial surgery

E6. Percentage of consultant surgeons intending to work part time at some point in their career



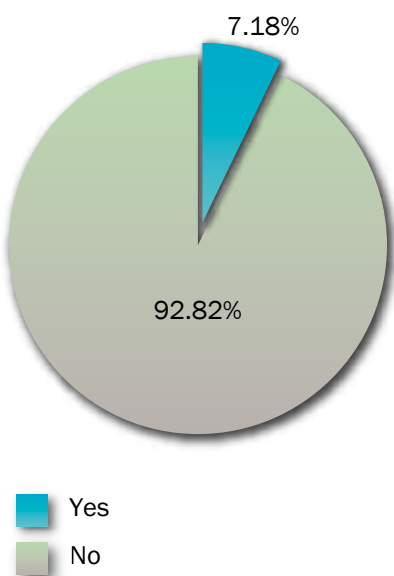
Notes

These figures show the percentage of full-time consultant oral and maxillofacial surgeons who expressed the wish to work part time at some point in their career.

Source

RCS survey, April 2010.

E7. Percentage of consultant surgeons who intend to retire in the next two years



Notes

Approximately 7% of consultant oral and maxillofacial surgeons who responded to the RCS survey suggested that they intend to retire within the next two years.

Source

RCS survey, April 2010.

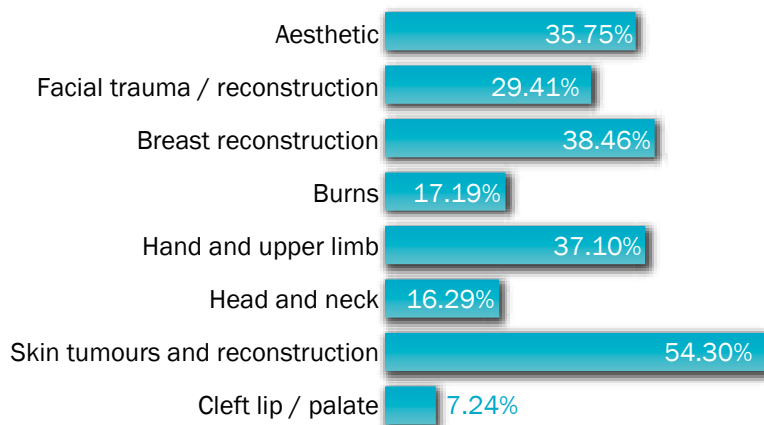
F. Plastic surgery

F1. Specialty recommendations for England, Wales and Northern Ireland

The British Association of Plastic, Reconstructive and Aesthetic Surgeons (BAPRAS) recommends a consultant workforce ratio of 1:100,000 population, to be achieved by 2018. In order to achieve this target an expansion of the size of the consultant workforce is recommended.

Source
BAPRAS.

F2. Percentage of consultant surgeons working in areas of special interest



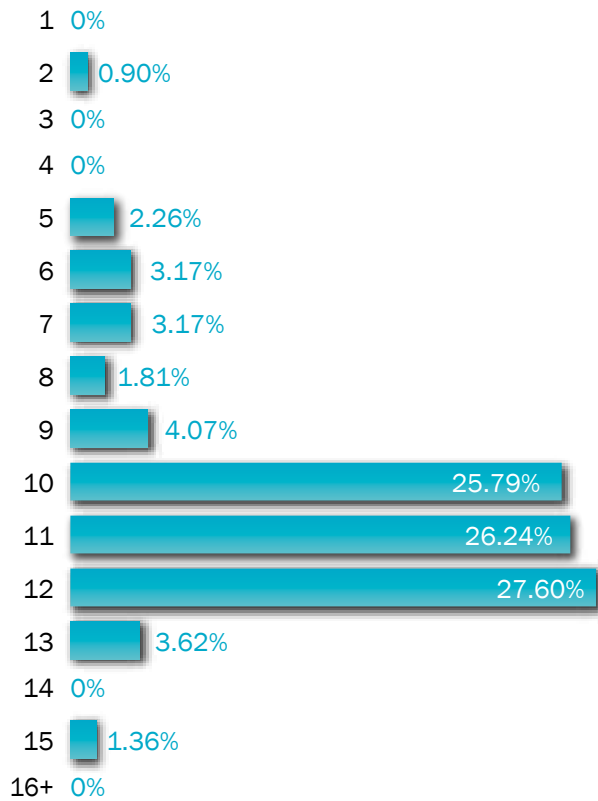
Notes

These figures show areas of special interest as specified by consultant plastic surgeons who responded to the RCS survey. Surgeons may have more than one area of special interest, therefore the above figures total more than the number of respondents.

Source
RCS survey, April 2010.

F. Plastic surgery

F3. Number of programmed activities (PAs) worked per week by consultant surgeons



Notes

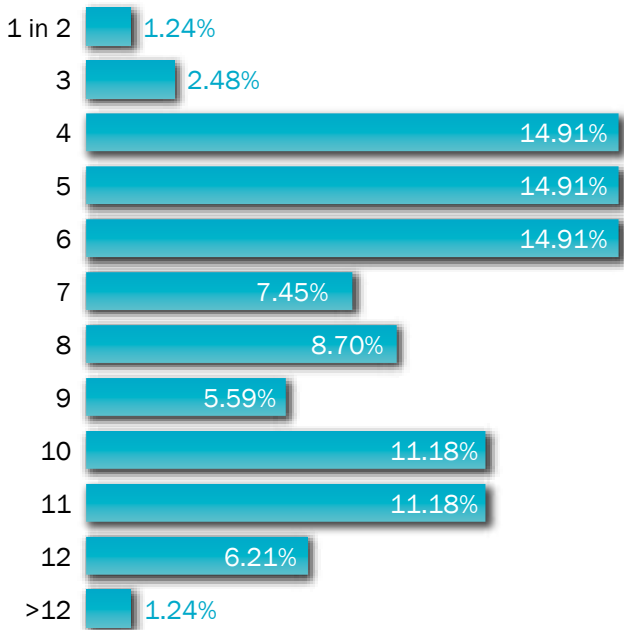
These figures show the number of PAs actually worked (not just contracted) by consultant plastic surgeons.

Source

RCS survey, April 2010.

F. Plastic surgery

F4. Frequency of on-call commitment required of consultant surgeons



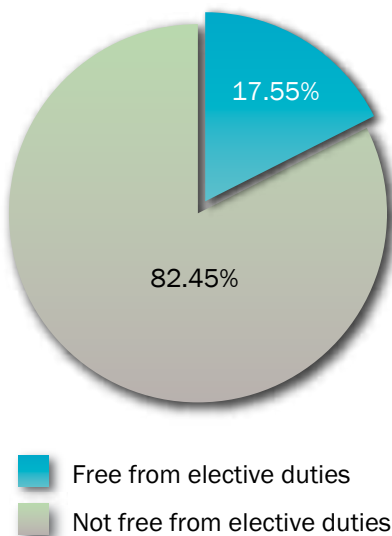
Notes

Figures based on consultant plastic surgeons with on-call duties. Approximately 61% of respondents recorded that the frequency of their on-call commitment is between 1 in 4 to 1 in 8, whereas approximately 4% are working on-call rotas of greater intensity than 1 in 4.

Source

RCS survey, April 2010.

F5. Percentage of consultant surgeons who are free from elective duties while on call



Notes

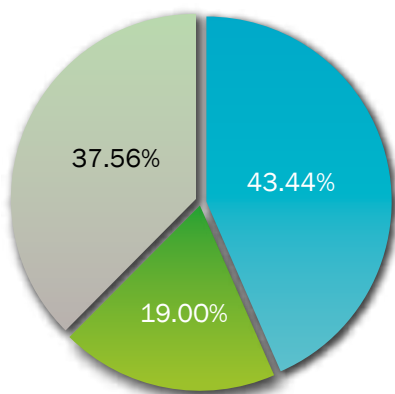
17.55% of consultant plastic surgeons who responded to the RCS survey recorded that they are free from elective duties while covering on-call responsibilities.

Source

RCS survey, April 2010.

F. Plastic surgery

F6. Percentage of consultant surgeons intending to work part time at some point in their career



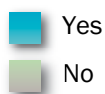
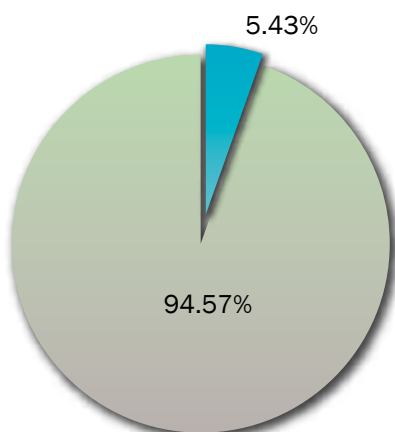
Notes

These figures show the percentage of full-time consultant plastic surgeons who expressed the wish to work part time at some point in their career.

Source

RCS survey, April 2010.

F7. Percentage of consultant surgeons who intend to retire in the next two years



Notes

Approximately 5.5% of consultant plastic surgeons who responded to the RCS survey suggested that they intend to retire within the next two years.

Source

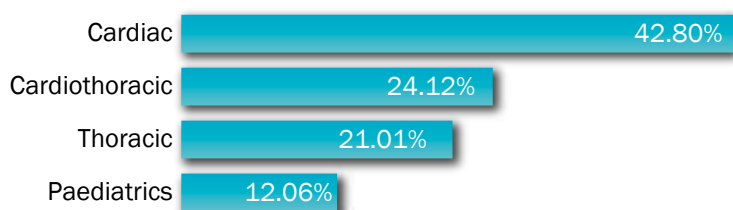
RCS survey, April 2010.

G. Cardiothoracic surgery

G1. Specialty recommendations for England, Wales and Northern Ireland

The Society for Cardiothoracic Surgery in Great Britain and Ireland (SCTS) recommends a total of 330 consultant cardiothoracic surgeons in England, Wales and Northern Ireland, to be achieved by 2015. In order to achieve this target an expansion of the size of the consultant workforce is recommended.

G2. Percentage of consultant surgeons working in areas of special interest



Source
SCTS.

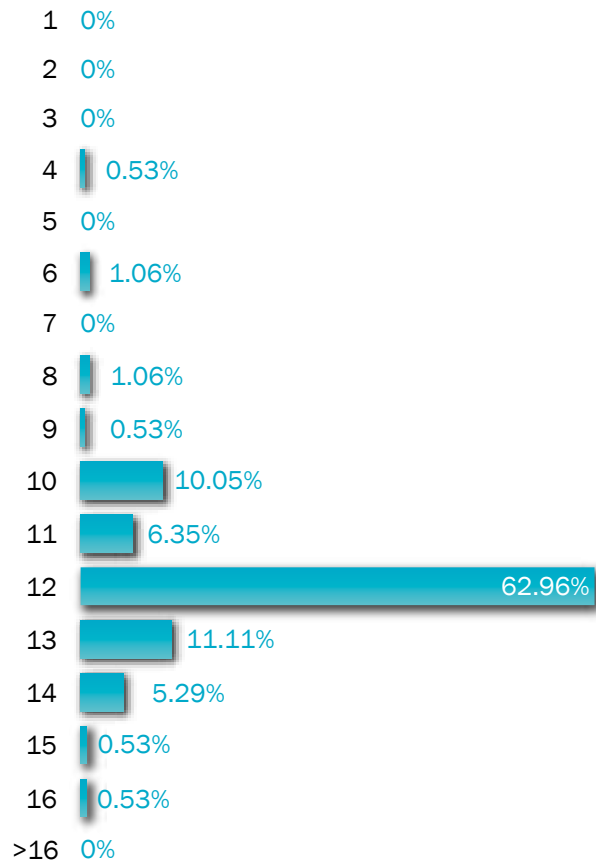
Notes

These figures show areas of special interest as specified by consultant cardiothoracic surgeons. Surgeons may have more than one area of special interest, therefore the above figures may total more than the number of surgeons.

Source
SCTS.

G. Cardiothoracic surgery

G3. Number of programmed activities (PAs) worked per week by consultant surgeons



Notes

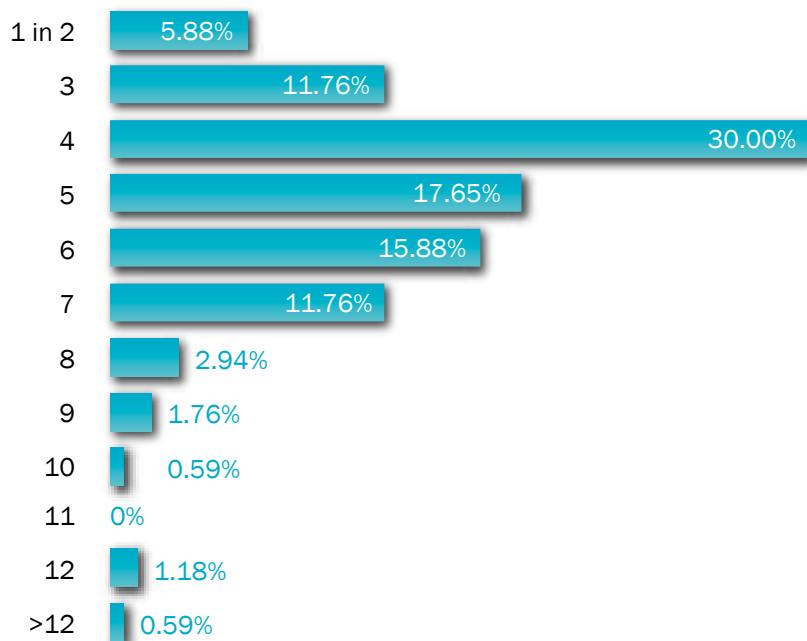
These figures show the number of PAs actually worked (not just contracted) by consultant cardiothoracic surgeons.

Source

RCS survey, April 2010.

G. Cardiothoracic surgery

G4. Frequency of on-call commitment required of consultant surgeons



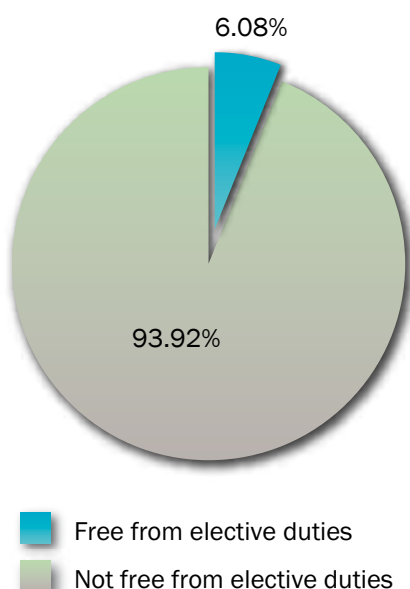
Notes

Figures based on consultant cardiothoracic surgeons with on-call duties. Approximately 78% of respondents recorded that the frequency of their on-call commitment is between 1 in 4 to 1 in 8, whereas 17.65% are working on-call rotas of greater intensity than 1 in 4.

Source

RCS survey, April 2010.

G5. Percentage of consultant surgeons who are free from elective duties while on call



Notes

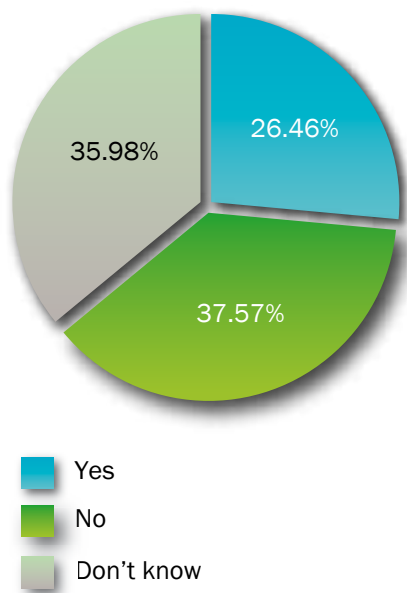
Approximately 6% of consultant cardiothoracic surgeons who responded to the RCS survey recorded that they are free from elective duties while covering on-call responsibilities.

Source

RCS survey, April 2010.

G. Cardiothoracic surgery

G6. Percentage of consultant surgeons intending to work part time at some point in their career



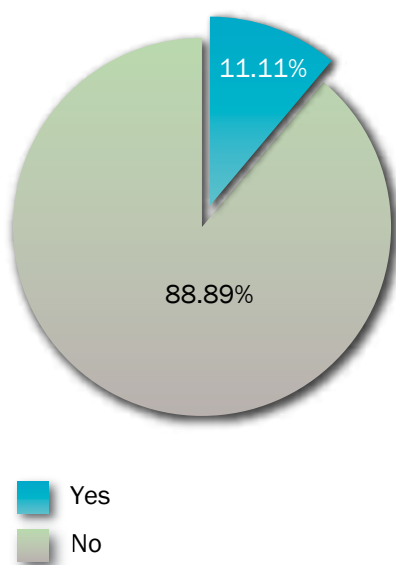
Notes

These figures show the percentage of full-time consultant cardiothoracic surgeons who expressed the wish to work part time at some point in their career.

Source

RCS survey, April 2010.

G7. Percentage of consultant surgeons who intend to retire in the next two years



Notes

Slightly more than 11% of consultant cardiothoracic surgeons who responded to the RCS survey suggested that they intend to retire within the next two years.

Source

RCS survey, April 2010.

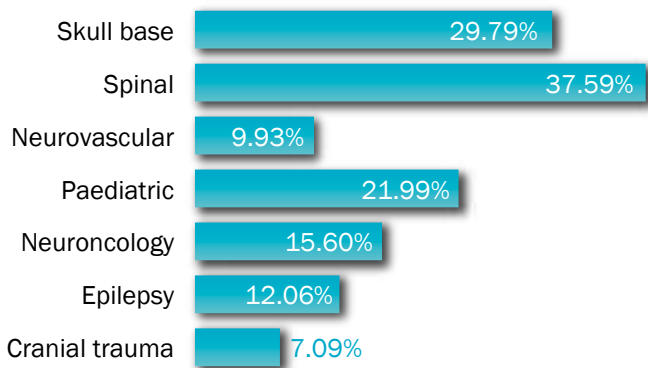
H. Neurosurgery

H1. Specialty recommendations for England, Wales and Northern Ireland

Source
SBNS.

The Society of British Neurological Surgeons (SBNS) recommends a consultant workforce ratio of 5:1,000,000 population, to be achieved by 2015. In order to achieve this target an expansion of the size of the consultant workforce is recommended.

H2. Percentage of consultant surgeons working in areas of special interest



Notes

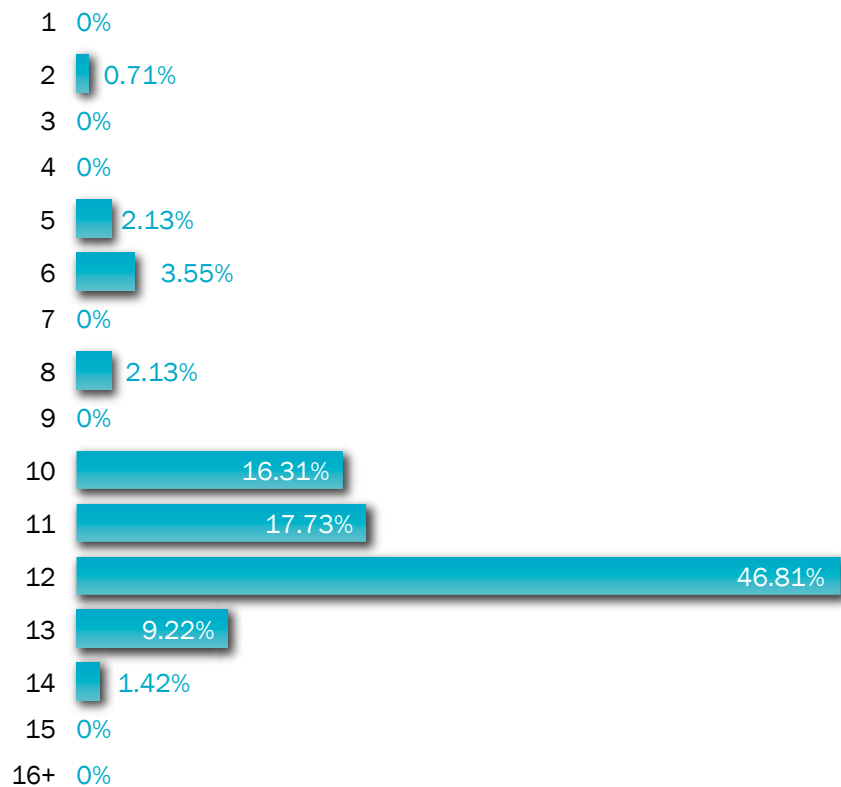
These figures show areas of special interest as specified by consultant neurosurgeons who responded to the RCS survey. Surgeons may have more than one area of special interest, therefore the above figures total more than the number of respondents.

Source

RCS survey, April 2010.

H. Neurosurgery

H3. Number of programmed activities (PAs) worked per week by consultant surgeons



Notes

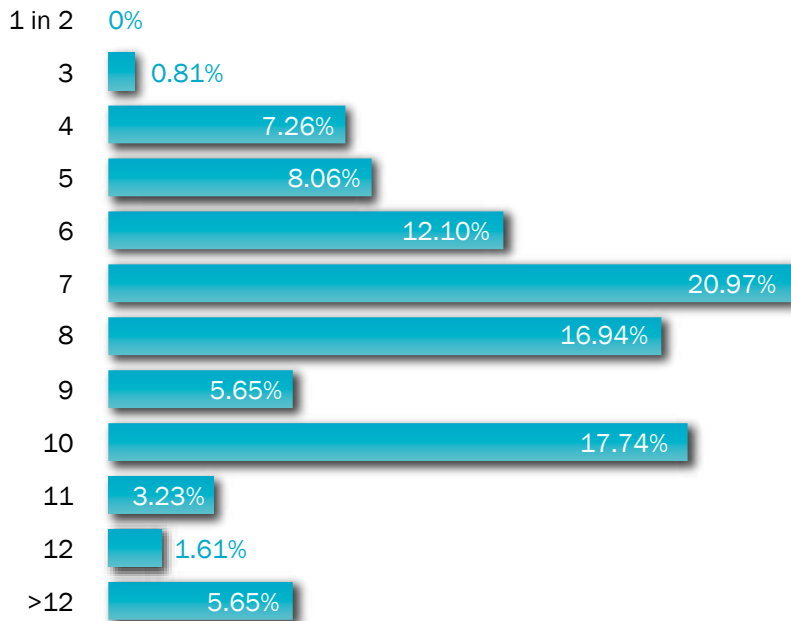
These figures show the number of PAs actually worked (not just contracted) by consultant neurosurgeons.

Source

RCS survey, April 2010.

H. Neurosurgery

H4. Frequency of on-call commitment required of consultant surgeons



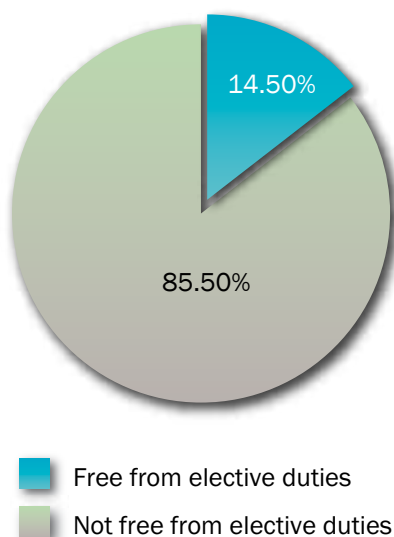
Notes

Figures based on consultant neurosurgeons with on-call duties. Approximately 65% of respondents recorded that the frequency of their on-call commitment is between 1 in 4 to 1 in 8, whereas approximately 1% have indicated that they are working on-call rotas of greater intensity than 1 in 4.

Source

RCS survey, April 2010.

H5. Percentage of consultant surgeons who are free from elective duties while on call



Notes

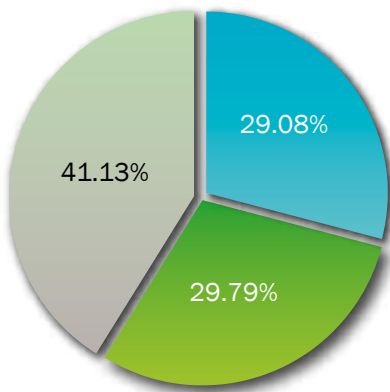
14.50% of consultant neurosurgeons who responded to the RCS survey recorded that they are free from elective duties while covering on-call responsibilities.

Source

RCS survey, April 2010.

H. Neurosurgery

H6. Percentage of consultant surgeons intending to work part time at some point in their career



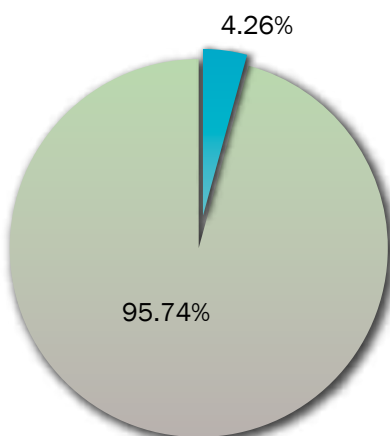
Notes

These figures show the percentage of full-time consultant neurosurgeons who expressed the wish to work part time at some point in their career.

Source

RCS survey, April 2010.

H7. Percentage of consultant surgeons who intend to retire in the next two years



Notes

Approximately 4% of consultant neurosurgeons who responded to the RCS survey suggested that they intend to retire within the next two years.

Source

RCS survey, April 2010

I. Paediatric surgery

I1. Specialty recommendations for England, Wales and Northern Ireland

The British Association of Paediatric Surgeons (BAPS) recommends a total of 218 consultant paediatric surgeons in England, Wales and Northern Ireland, and an expansion of the size of the consultant workforce to meet public need.

Source
BAPS.

I2. Percentage of consultant surgeons working in areas of special interest



Notes

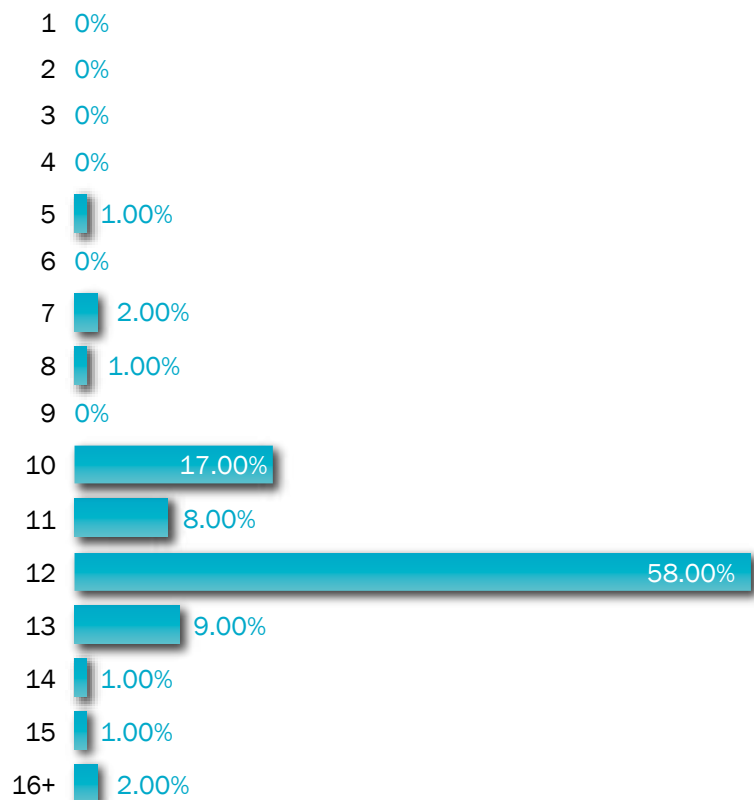
These figures show areas of special interest as specified by consultant paediatric surgeons who responded to the RCS survey. Surgeons may have more than one area of special interest, therefore the above figures total more than the number of respondents.

Source

RCS survey, April 2010.

I. Paediatric surgery

I3. Number of programmed activities (PAs) worked per week by consultant surgeons



Notes

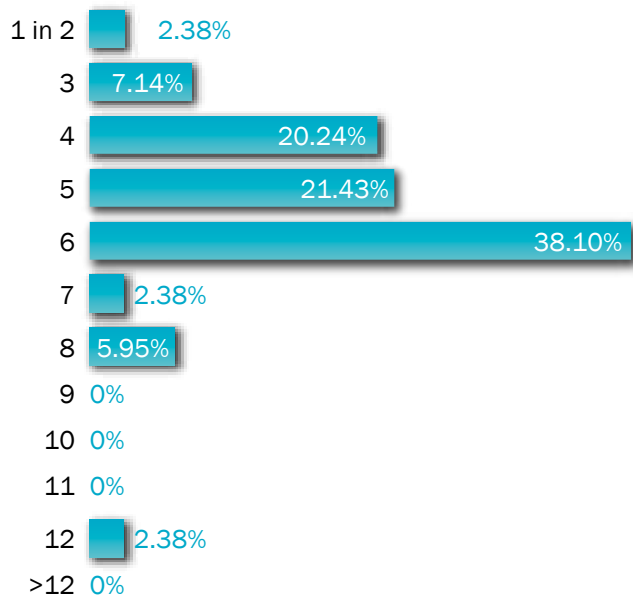
These figures show the number of PAs actually worked (not just contracted) by consultant paediatric surgeons.

Source

RCS survey, April 2010.

I. Paediatric surgery

14. Frequency of on-call commitment required of consultant surgeons



Notes

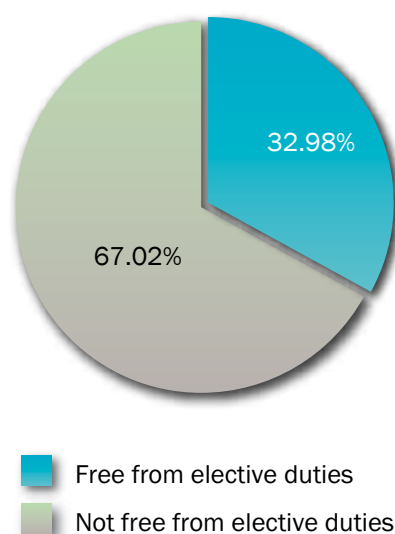
Figures based on consultant paediatric surgeons with on-call duties.

Approximately 88% of respondents recorded that the frequency of their on-call commitment is between 1 in 4 to 1 in 8, whereas slightly less than 10% (9.52%) are working on-call rotas of greater intensity than 1 in 4.

Source

RCS survey, April 2010.

15. Percentage of consultant surgeons who are free from elective duties while on call



Notes

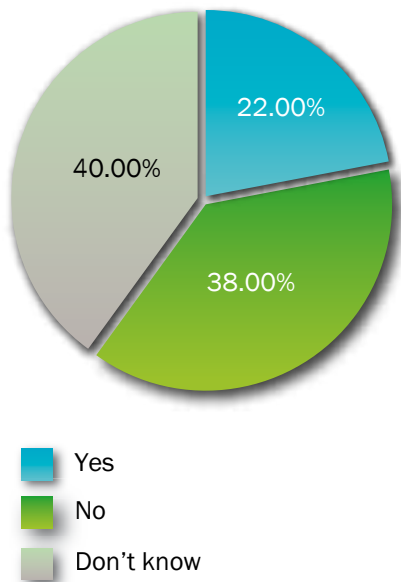
Approximately one third of consultant paediatric surgeons who responded to the RCS survey (32.98%) recorded that they are free from elective duties while covering on-call responsibilities.

Source

RCS survey, April 2010.

I. Paediatric surgery

16. Percentage of consultant surgeons intending to work part time at some point in their career



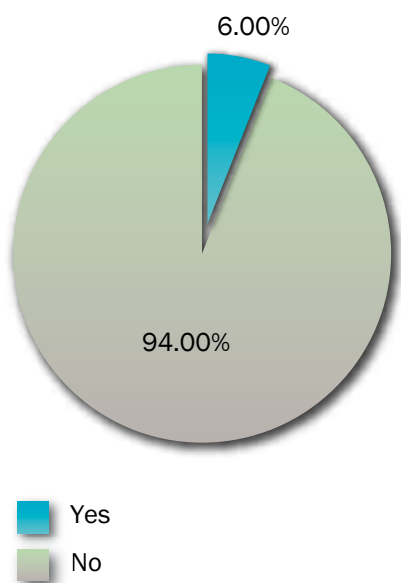
Notes

These figures show the percentage of full-time consultant paediatric surgeons who expressed the wish to work part time at some point in their career.

Source

RCS survey, April 2010.

17. Percentage of consultant surgeons who intend to retire in the next two years



Notes

6% of consultant paediatric surgeons who responded to the RCS survey suggested that they intend to retire within the next two years.

Source

RCS survey, April 2010.

