Royal College of Obstetricians & Gynaecologists

RCOG Workforce Census

2025

Contents

Foreword

As President of the Royal College of Obstetricians and Gynaecologists, I am proud to present the 2025 Workforce Census, a vital report that sheds light on the challenges and opportunities facing our dedicated obstetrics and gynaecology workforce across the UK. This report comes at a critical moment for the NHS, as we navigate increasing demands, evolving patient needs, and the publication of the 10-Year Health Plan for England. It is clear that the ambitions of this plan; shifting the focus from sickness to prevention, from hospital to community, and from analogue to digital, can only be realised if we prioritise workforce planning and the wellbeing of our healthcare professionals. I am also acutely aware of the significant pressure our workforce is facing due to the emerging maternity reviews and rising waiting lists.

At the RCOG, advocating for our members is at the heart of everything we do. This census provides invaluable insights into the demographics, workplace conditions, career development opportunities, job satisfaction, and future intentions of O&G doctors. It highlights the systemic pressures they face, including rota gaps, excessive administrative burdens, and insufficient time for career development. These challenges impact both the wellbeing of our members and the care they are able to provide to women and girls, because the two are inseparable.

As President, I am committed to ensuring that our members are supported at every stage of their careers. This report strengthens our calls for increased resources in women's healthcare. It provides recommendations to address the pressing issues of workforce retention, protected time for education and leadership, and improved working conditions. By advocating for these changes, we aim to create a resilient, well-supported workforce that can continue to deliver high-quality, safe care. This is what I have been advocating for during my presidency, and now we have robust evidence, evidence from you, our membership.

I urge policymakers, healthcare leaders, and all stakeholders in women's health to act on the findings of this report. No single leader can overcome this challenge; we must do it together. Together, we can build a sustainable future for O&G services, empowering our members to thrive in their roles and provide the exceptional care that women and girls expect and deserve.

Ranee Thakar MD PRCOG

President, RCOG

As Vice President for Membership and Workforce, I very much welcome this 2025 Workforce Census. I am hugely grateful to everyone who took the time to share their thoughts and experiences with us, enabling us to produce such a comprehensive report, full of rich detail about the O&G workforce.

This detail will underpin the College's ongoing work to support the O&G workforce and will strengthen our calls for additional resource in women's healthcare. We believe by creating an environment that empowers and supports clinicians, we enable them to deliver the safest, most compassionate care possible.

The Census builds on the work done in the College in recent years to better support our members. We have known for some time that our doctors are experiencing challenges in delivering increasingly complex care in high-pressure environments, with inadequate resources. In response, we have developed resources to support Educational Supervisors, created a hub to support International Medical Graduates joining the NHS, refreshed our return-to-work toolkit to support retention, and updated our job plan approval guidance to support fairness in recruitment. But we know there is always more we can do, and more governments and health leaders must do.

This report gives us a much greater understanding of who our doctors are and how they are working, which is invaluable for future workforce planning. It gives us more detailed information on how the ever-growing pressure of service delivery is manifesting, the impact it is having on doctors' wellbeing and how it is influencing their decisions about the future.

The findings in this report will be familiar to many of you, with reported rota gaps, doctors working over contracted hours and over a third of the workforce unable to take the annual leave they need to rest and restore a work–life balance. It is also evident if we want doctors to continue to deliver the highest standards of care, they need protected time in their roles for education, training and leadership responsibilities. Good leadership is essential for good patient care, and this aspect of training should not be neglected, even in the face of extreme service pressures. Indeed, there is a compelling case to be made that it is even more important in the context of current challenges and those that undoubtedly lie ahead.

As we look forward to a new long-term workforce plan for England, we hope this report will be used to inform thinking around the current and future needs of O&G services, to ensure we have a resilient, well-supported, fully staffed workforce to provide women and girls with the care and support they need.

Laura Hipple, FRCOG

Vice President for Membership and Workforce, RCOG

Executive summary

Supporting the O&G workforce to deliver the highest levels of care to women and girls is a key strategic priority for the RCOG.

The 2025 workforce census aimed to capture a detailed snapshot of the current O&G workforce across all career stages and all four nations of the UK. The findings will help to shape the RCOG's work to further support the O&G workforce and strengthen advocacy efforts to call for additional resources in women's healthcare.

The census included five key domains:

- Demographics
- Career development
- Workplace conditions
- Job satisfaction and wellbeing
- Job planning and leadership roles.

The census was conducted online between 24 March and 2 May 2025 and was open to all O&G doctors working in the UK. It included a mixture of closed and open-ended questions. A total of 1,589 valid responses were received. Enventure Research supported the development of the census questionnaire, led the analysis and prepared a report on behalf of the RCOG.

Responses were received from a mix of consultants (59%); Specialty, Associate Specialist and Specialist (SAS) doctors (7%); trainees (27%); Locally Employed Doctors (LEDs) (5%) and doctors working in other roles within O&G (3%).

The respondents predominantly identified as female (70%). This proportion of females was higher for trainees (79%) than other career grades. By age (in years), the largest groups were 41–45 (18%) and 36–40 (16%), followed by 31–35 and 51–55 (both 13%). The workforce is ethnically diverse, with four in ten respondents (41%) identifying as Asian or Asian British (24%), Black or Black British (8%), Mixed (4%) or other ethnic groups (6%); just over half of respondents (52%) identified as white. Almost four in ten (37%) respondents received their primary medical qualification outside of the UK. This was highest for LEDs (84%) and SAS doctors (77%).

A total of 24% of respondents were working less than full time (LTFT) on completion of the census. This was highest for trainees (43%). The most cited reason for respondents working LTFT was work–life balance (55%). Among those on programmed activities (PAs) job plans, six in ten (60%) reported that they are contracted to work more than 10 PAs each week (consultants, 62%; SAS, 47%), with 78% reporting at least one PA allocated to out-of-hours work. The most common frequency of on-call work was working between 1 in 11 and 1 in 15 (28%) shifts, followed by 1 in 8 (18%). Across the wider workforce, two-thirds (68%) said

they always or often worked beyond their contracted hours because of reasons such as the increase in amount of administrative work (68%), staff shortages (56%), and the increase in the number of cases with complex comorbidities (52%).

The census explored what doctors working in O&G feel they need to develop and progress in their careers. Findings reflect the wide spectrum of career stages and development aims within the specialty. Nearly half of consultants (46%) cited a need for protected Supporting Professional Activities (SPAs) time in order to develop. In addition to protected SPAs, SAS doctors also said that they need greater recognition of contributions and experience (43%) to progress. Developing surgical skills was the most common development priority for trainees (70%) and LEDs (52%). To meet this priority, access to the operating theatre was the most cited need (trainees, 75%, LEDs, 67%).

Across all career grades, over half of respondents (58%) reported that they do not have a sufficient amount of time for their career or personal development within their contracted hours. The overwhelming reason cited was service provision pressures (86% of all affected respondents). This lack of time is emphasised by the 63% of doctors holding clinical leadership roles who felt that the allocated PAs were not sufficient for them to carry out the responsibilities of their role. In addition, 67% reported that there were gaps in the rota at their level, and 35% reported not being able to take their full annual leave entitlement, further highlighting the impact of staffing issues on the O&G workforce.

Overall, 13% of respondents plan to retire in the next five years. This included a fifth of all consultants (20%), 18% of those who hold a clinical leadership role and 18% of those in educational roles. These figures underline the need to support those approaching retirement with succession planning and flexible working, and provide opportunities for these senior clinicians to mentor and train colleagues.

Wellbeing in the workplace and job satisfaction were other key areas the census considered. Across the workforce, 68% of respondents said that they were satisfied with their day-to-day work. This was highest for consultants (71%). When asked what they enjoyed about their role, almost nine in ten respondents (88%) said they most enjoyed the delivery of care, consistently the top response across all roles. The census also provided valuable insight into the drivers to improve job satisfaction, including feeling more valued in the workplace (60%), increased time for administrative tasks (58%), improved workforce levels (56%), more recognition of good practice (53%), improved IT systems (53%) and improved workplace culture (49%).

Around one in five (19%) respondents were categorised as being at a high risk of burnout (moderate risk, 46%; low risk, 35%). LEDs and trainees were most likely to be at high risk (29% and 23%, respectively). The most commonly suggested interventions to improve the wellbeing of those working in the specialty were to improve staffing levels, enhance staff recognition and appreciation, and improve work–life balance.

It is crucial that staff feel valued. This is a key driver to both increased job satisfaction and positive wellbeing. Those who often or always felt valued were significantly more likely to be satisfied in their jobs (90%), suggesting a strong link between workplace culture and job satisfaction. Despite this, respondents who felt consistently recognised for their contributions were in the minority. LEDs were particularly vulnerable to this, as they were the least likely to feel always or often valued in the workplace (36%), and the most at risk of burnout.

The O&G workforce is highly motivated and the passion for our specialty is evident, but the workforce is under-resourced, with many working beyond contracted hours and feeling undervalued. Obstetric care is becoming increasingly complex and gynaecology waiting lists are growing, the current workforce is under-resourced to meet evolving population demands and greater patient expectations.

It is important that obstetricians and gynaecologists are supported to meet the current and future population and service needs, but we must also put an emphasis on protecting the wellbeing and development of our dedicated clinicians. Providing a work environment that is adequately resourced and supportive of the whole workforce, at every career stage, is crucial to reducing the risk of burnout, increasing job satisfaction and helping our doctors to deliver the highest levels of care to women and girls.

Key messages

- **Increased resource and investment in women's healthcare is needed.** Having a motivated, well-trained and adequately staffed and resourced workforce underpins all our members do to provide the best-quality care for women, patients and families.
- **Doctors need protected time for education, training and leadership responsibilities.** It is vital that senior clinicians are enabled to fulfil their responsibilities within contracted time, to support the development of the whole workforce.
- **The medical workforce approaching retirement need to be supported to work flexibly if they choose to.** This is fundamental to their wellbeing and the retention of valued skills and expertise in the workforce. Opportunities for them to support mentorship and succession planning should be provided.
- **All doctors needed to be supported.** The wellbeing of O&G professionals must be prioritised through improved working conditions, flexible working options, support after adverse events and role-modelling of positive workplace behaviours.
- **All doctors, including doctors working outside of formal training pathways, need to be recognised and valued, with access to career progression opportunities.**

List of abbreviations

BMA	British Medical Association
CCT	Certificate of Completion of Training
CESR	Certificate of Eligibility for Specialist Registration
DCC	Direct Clinical Care
GMC	General Medical Council
IMG	International Medical Graduate
LED	Locally Employed Doctors
LTFT	Less Than Full Time
MTI	Medical Training Initiative
NHS	National Health Service
O&G	Obstetrics and Gynaecology
PAs	Programmed Activities
PMQ	Primary Medical Qualification
PTSS	Post-traumatic stress symptoms
RCOG	Royal College of Obstetricians and Gynaecologists
SAS	Specialty, Associate Specialist and Specialist
SITMs	Special Interest Training Modules
SPAs	Supporting Professional Activities
UK	United Kingdom

Within this document we use the terms woman and women's health. However, it is important to acknowledge that it is not only women for whom it is necessary to access women's health and reproductive services in order to maintain their gynaecological health and reproductive wellbeing. Gynaecological and obstetric services and delivery of care must therefore be appropriate, inclusive and sensitive to the needs of those individuals whose gender identity does not align with the sex they were assigned at birth.

Introduction

The Royal College of Obstetricians and Gynaecologists (RCOG) commissioned this workforce census to gain comprehensive, up-to-date insight into the composition, experiences and challenges faced by doctors working in obstetrics and gynaecology (O&G) across the UK. The census was inclusive of doctors in all career grades, regardless of whether they held any form of RCOG membership. This initiative aligns with the College's strategic objective to support and advocate for its members and the broader O&G workforce, supporting them to deliver high-quality care to women and girls.

The census provided a valuable opportunity for those on the frontline of O&G to share their views, experiences and perceptions of their role and work environment. The census captures individual-level data on workforce pressures and working conditions, career and personal development needs, job satisfaction and workplace wellbeing.

Key drivers for the census included:

- Understanding the current composition of the O&G workforce by role, region and demographic characteristics
- Gaining insight into career development pathways, job planning and training needs
- Exploring the factors contributing to workforce pressures, rota gaps and burnout.

The census was delivered by the RCOG in partnership with the independent research agency Enventure Research, who supported the development of the questionnaire, led the analysis and prepared this report.

O&G teams are working incredibly hard while contending against a host of challenges, including decades of underinvestment, staffing shortfalls, estates no longer fit for purpose and a lack of time to train, reflect or recharge. O&G doctors are navigating increasingly complex obstetric care, growing gynaecology waiting lists, evolving population demands and greater patient expectations, leading to increased workloads and pressure on an already stretched workforce.

The census findings reflect these challenges. The passion for our speciality is evident, but further underlines that the O&G workforce is under resourced, with many working beyond contracted hours and feeling undervalued. Respondents report staff shortages, increased administrative work and a lack of protected time in job plans for educational and leadership roles. These findings will help shape the RCOG's work to further support the O&G workforce and strengthen advocacy efforts to call for additional resources in women's healthcare.

Career development

The census explored what doctors working in O&G feel they need to develop and progress in their careers. Findings reflect the wide spectrum of career stages and development aims within the specialty, and have been analysed by career grade clinicians (consultants, Specialty, Associate Specialist and Specialist (SAS) doctors, trainees and Locally Employed Doctors (LEDs)).

Consultants

Consultants play a critical leadership role within the specialty, and are expected to engage in lifelong learning and continuous professional development to maintain high standards of clinical care, deliver training and contribute to service improvement.

When asked about their current career or personal development needs, most consultants stated a need to gain or improve leadership skills (41%), followed by quality improvement (35%) and planning for retirement (31%). Other needs included the development of educational roles (25%) and surgical skills (25%).

When asked what else they needed to progress in their careers, nearly half of consultants (46%) cited a need for protected Supporting Professional Activities (SPAs) time and protected time for leadership roles (41%). This barrier to career development due to a lack of protected time is reinforced by the 54% of consultants who said that they do not have sufficient time for their own career or personal development within their contracted hours. Service provision was the most commonly cited reason for this (84%), followed by patient-related administration (70%) and a lack of administrative support (47%). Not having a sufficient amount of SPA time was particularly high in Scotland, where this challenge was reported by six in ten consultants (60%). This may reflect the direct clinical care (DCC)/SPA split in consultant job plans in Scotland (9:1 DCC:SPA).

Three in ten consultants (29%) also highlighted the need for greater recognition of their contributions and experience, and this was higher among those who had been in post longer (30%) than those who had been in post for less than five years (23%), suggesting that despite seniority, some feel undervalued or overlooked within their organisations.

Another commonly cited development need was access to theatre (18%), and this was more common among those who had been in post for a shorter period of time (31%) compared with those who had been in post for five or more years (14%).

Consultants were the most positive of all career stage groups regarding access to professional development:

- 90% agreed they were given sufficient independence (autonomy) and clinical responsibility appropriate to their level of practice.

- 74% agreed they had access to management and leadership skill development.
- 78% agreed that they had opportunities to develop and practise teaching skills.
- 59% agreed that they have a team structure that adequately supports their development and practice needs.
- 64% agreed they received a sufficient induction into their current role (17% disagreed).

However, this still leaves a significant minority of consultants who do not feel supported in their development, particularly in regard to their team structure.

SAS doctors

SAS doctors are experienced clinicians working in permanent posts on nationally agreed contracts and have the same appraisal and revalidation requirements as consultants. SAS doctors as a cohort have a wide range of experience from early career to senior clinicians working autonomously.

Although there are existing associate specialist doctors contributing to the workforce, this grade was closed to new entrants in 2008, meaning senior specialty doctors had nowhere to progress to within the SAS grade until the new specialist (senior SAS) role was created in 2021. To be eligible for a specialist grade post, doctors must have a minimum of 12 years medical work (10 years in Scotland), at least six of which should have been in a relevant specialty since obtaining their primary medical qualification (PMQ). They also need to meet a set of generic capabilities.[1] In response to local service needs, specialist posts can be appointed internally, allowing career progression for eligible local senior specialty doctors.

A total of 115 SAS doctors, with a broad range of experience, completed the census. Four in ten (42%) had worked in an SAS role for less than five years, while half had been in post for longer. One in five had worked as a SAS doctor for 15 years or more, indicating that a significant proportion of these doctors are very experienced in their SAS roles.

These SAS doctors followed many different career pathways. For example, just over a fifth (22%) reported having held a UK National Training Number before pursuing an SAS career, and 17% of SAS doctors had been on the RCOG Medical Training Initiative (MTI) Scheme.

Overall, SAS doctors reported greater barriers to accessing development opportunities than their consultant colleagues:

- 65% agreed they had sufficient autonomy and clinical responsibility appropriate to their level (versus 90% of consultants). In addition, of those working autonomously in clinics and/or theatres, only 41% said the clinics/theatre lists were coded in their own name.

- Only 48% agreed they had access to management and leadership skill development (74% for consultants)
- 57% agreed they had opportunities to develop and practise teaching skills (78% for consultants)
- Just 44% agreed they had a team structure that supported their development (59% for consultants)
- 57% agreed they received a sufficient induction into their current role (64% for consultants).

Although many SAS doctors feel they can develop and practise teaching skills and are working with reasonable autonomy, access to structured leadership and management development opportunities is more variable, highlighting significant gaps in career development support.

Nearly half of SAS doctors (48%) said that they had an insufficient amount of time for their own career or personal development within contracted hours. This reinforces the consultant findings, and indicates that time pressures and service commitments are a significant barrier to development within the O&G workforce.

The most common reason cited for this lack of time was service provision requirements (80%), followed by a lack of administrative support (43%). These findings suggest that systemic pressures are limiting SAS doctors' ability to access development, regardless of their personal aspirations.

When asked about their current development goals, SAS doctors most frequently cited a desire to gain or improve surgical skills (35%) and work towards the Portfolio Pathway (35%). These were more commonly selected by those who had been working as an SAS doctor for less than five years (both 50%) than those working in post for longer (26% and 24%, respectively).

A third cited a desire to gain or improve their leadership skills, 30% planned to pursue formal accredited training in specialist skills and 30% were working towards a specialist (senior SAS) post.

Just over a quarter (27%) wanted to gain independent practice and recognition, and 26% cited education role development. The latter was more commonly selected by those who had been working as an SAS doctor for less than five years (42%) than those who had been in post longer (16%).

In terms of support needed to progress, the most commonly cited needs were greater recognition of contributions or experience and protected SPA time (both 43%), followed by a need for access to theatre (39%) and scan training (38%). A total of 36% of SAS doctors cited the need for more structured alternative career pathways. This likely reflects the

barrier to progression from 2008 until the new specialist (senior SAS) contract was created in 2021.

Those newer to the role were more likely to seek access to theatre opportunities (60%) and scan training (56%) than those who had been SAS doctors for five or more years (28% and 29%, respectively).

Trainees

Trainees make up a vital and dynamic part of the workforce, and the census captured a wide range of perspectives from those at different stages of training. The UK O&G specialty training programme requires a minimum of seven years of specialty training (ST1–ST7). Of the 424 trainees who responded to the census, 19% were at stage one (ST1-2), 43% were at stage two (ST3–5) and 29% were at stage three (ST6–7). A smaller group (9%) were currently out of programme.

Trainees were more likely to work less than full time (LTFT) than other groups, suggesting that LTFT working is becoming an established working pattern. Among trainees working LTFT, the most frequently cited reasons were work–life balance and caring commitments (both 60%), highlighting the significant role of family and dependent care in shaping working patterns.

Of the trainees who completed the 2025 Training Evaluation Form survey, 39.5% responded that they work LTFT; this includes 24.2% working at 80% and 11.4% at 60% hours. Working as a trainee at 80% hours is equivalent to 40 hours per week, which is considered full-time (10 PAs) on a consultant or SAS contract.

Overall, trainees reported better access to development opportunities than their SAS and LED colleagues:

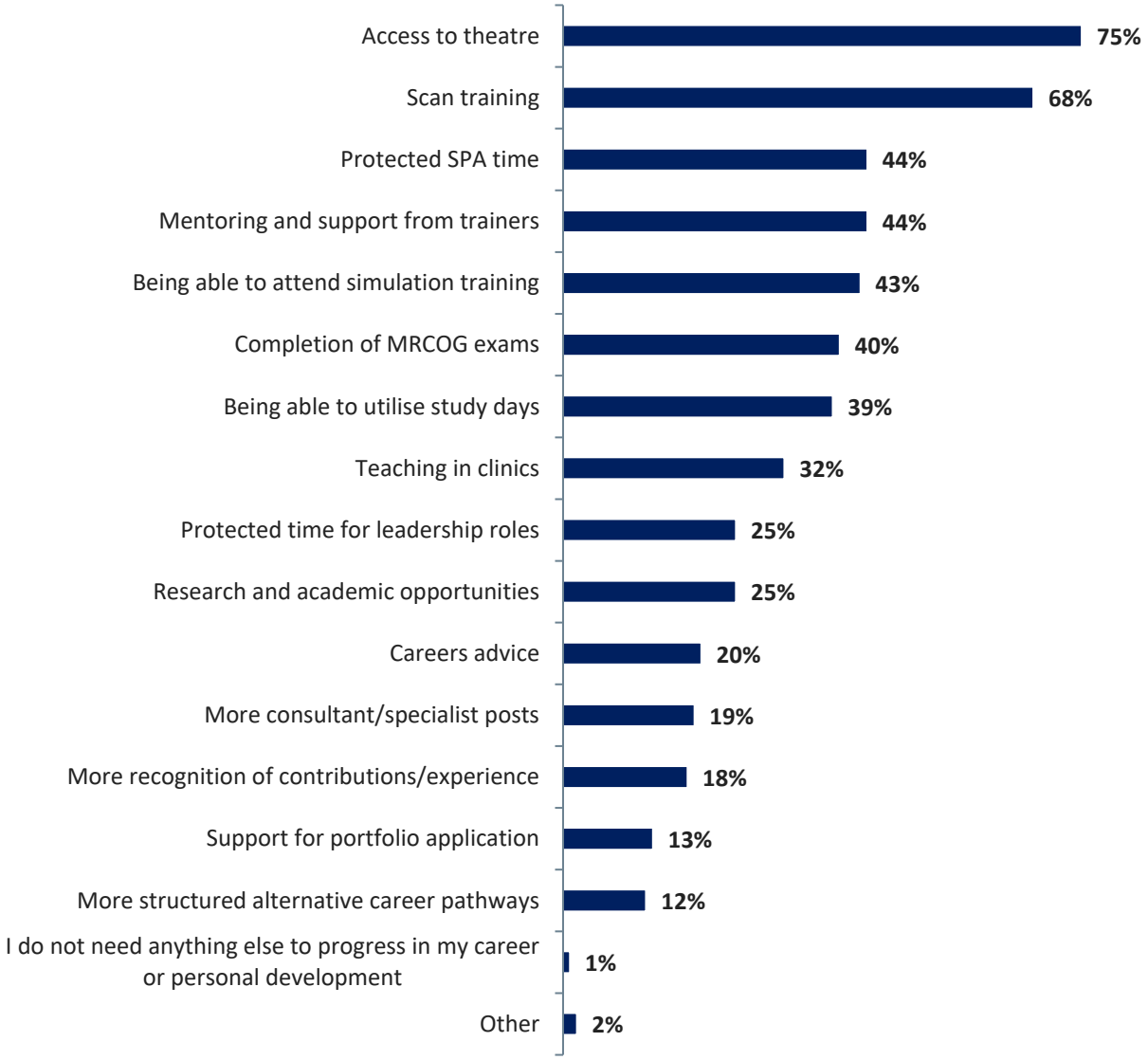
- 82% agreed they were given sufficient independence and clinical responsibility appropriate to their level of practice, indicating that most trainees feel well-supported in terms of autonomy (versus 65% of SAS doctors and 67% of LEDs)
- 63% agreed they had sufficient opportunity to develop or practise management and leadership skills (versus 48% of SAS doctors and 42% of LEDs)
- 71% agreed they had the opportunity to develop or practise their teaching and training skills (versus 57% of SAS doctors and 55% of LEDs), suggesting teaching opportunities are generally accessible and recognised as part of trainee development.
- 58% agreed that their team structure adequately supported their development and practice needs (versus 44% of SAS doctors and 41% of LEDs)

- 71% agreed they were sufficiently inducted into their current post (versus 57% of SAS doctors and 52% of LEDs).

Trainees reported a wide range of current career and personal development needs. The most common was to gain or improve surgical skills (70%), followed by working towards their Certificate of Completion of Training (53%), gaining independent practice and recognition (44%), and leadership skills (41%). Over a third (38%) said they needed support with exam preparation, while 30% said they need support with quality improvement work and transitioning to a senior role. Other needs included formal accredited training in specialist skills (26%), specialty training guidance (22%), and education role development (18%).

As illustrated in Figure 1, trainees highlighted a number of practical and developmental needs to support their career or personal progression, which most commonly included access to theatre (75%) and scan training (68%).

Figure 1 – What else do you need to progress in your career or personal development (trainees)?



LEDs

LEDs are the fastest-growing part of the UK medical workforce[2] and are employed by NHS Trusts and health boards on local terms and conditions, usually on fixed-term contracts. Unlike other doctor groups, they do not have nationally agreed contracts or terms and conditions. Consequently, opportunities for training and development are at the discretion of the employer.

There are a wide range of experiences and job titles that are included under the umbrella term LED. For example, the development needs of a UK graduate gaining additional

experience as an FY3 doctor will be very different from an experienced International Medical Graduate (IMG) who is new to UK practice. Nonetheless, it is important that all doctors within this diverse cohort are supported to meet their career aspirations.

There was a small base size for LEDs (*n* = 82) in the census, and so findings regarding LEDs should be interpreted with some degree of caution. This section of the report includes LEDs only and does not include MTI trainees.

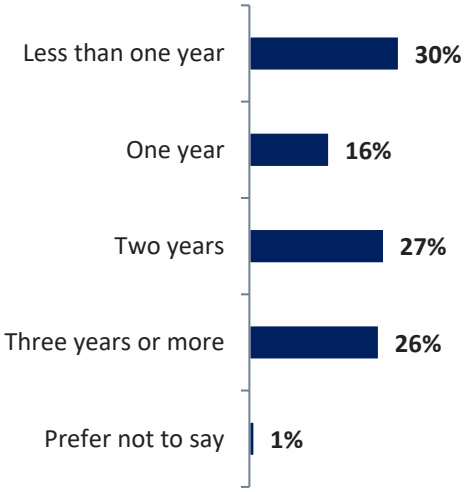
Perceptions of development support among LEDs were mixed, which is to be expected given the wide range of roles and experiences in this category:

- 67% agreed they had sufficient autonomy and clinical responsibility appropriate to their level of practice, and 21% disagreed.
- 43% agreed they had sufficient opportunity to develop and/or practice their management and leadership skills, and 33% disagreed.
- 60% agreed they had opportunities to develop and practise teaching skills, and 29% disagreed.
- 40% felt their team structure supported their development and practice needs, and 33% disagreed.
- 51% agreed they had received a sufficient induction into their current post, and 26% disagreed.

These results suggest that although many LEDs feel engaged, a significant minority lack structure or formal support, particularly with access to management and leadership opportunities.

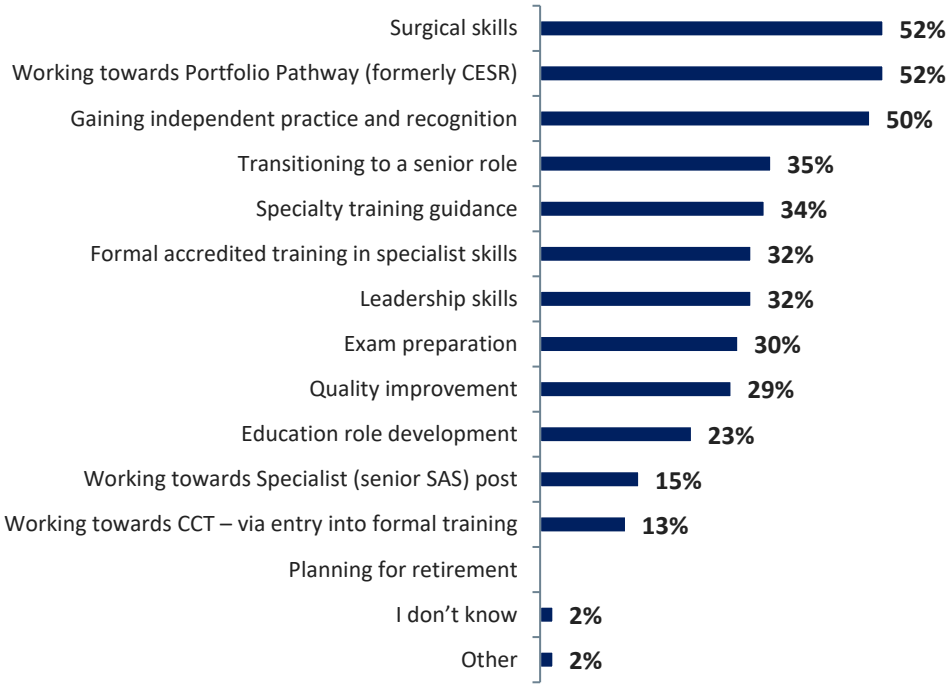
Three-quarters of LED respondents were IMGs – the highest of any career grade – and one in four had been in an LED post for three years or more (Figure 2). It is important that all LEDs, especially those new to UK practice, are supported with their career development.

Figure 2 – How long have you been working as an LED?



When asked about their current development goals, LEDs highlighted a range of aspirations (Figure 3). The most common needs were to gain or improve surgical skills and working towards inclusion on the GMC Specialist Register via the Portfolio Pathway (both 52%). These were closely followed by gaining independent practice and recognition (50%).

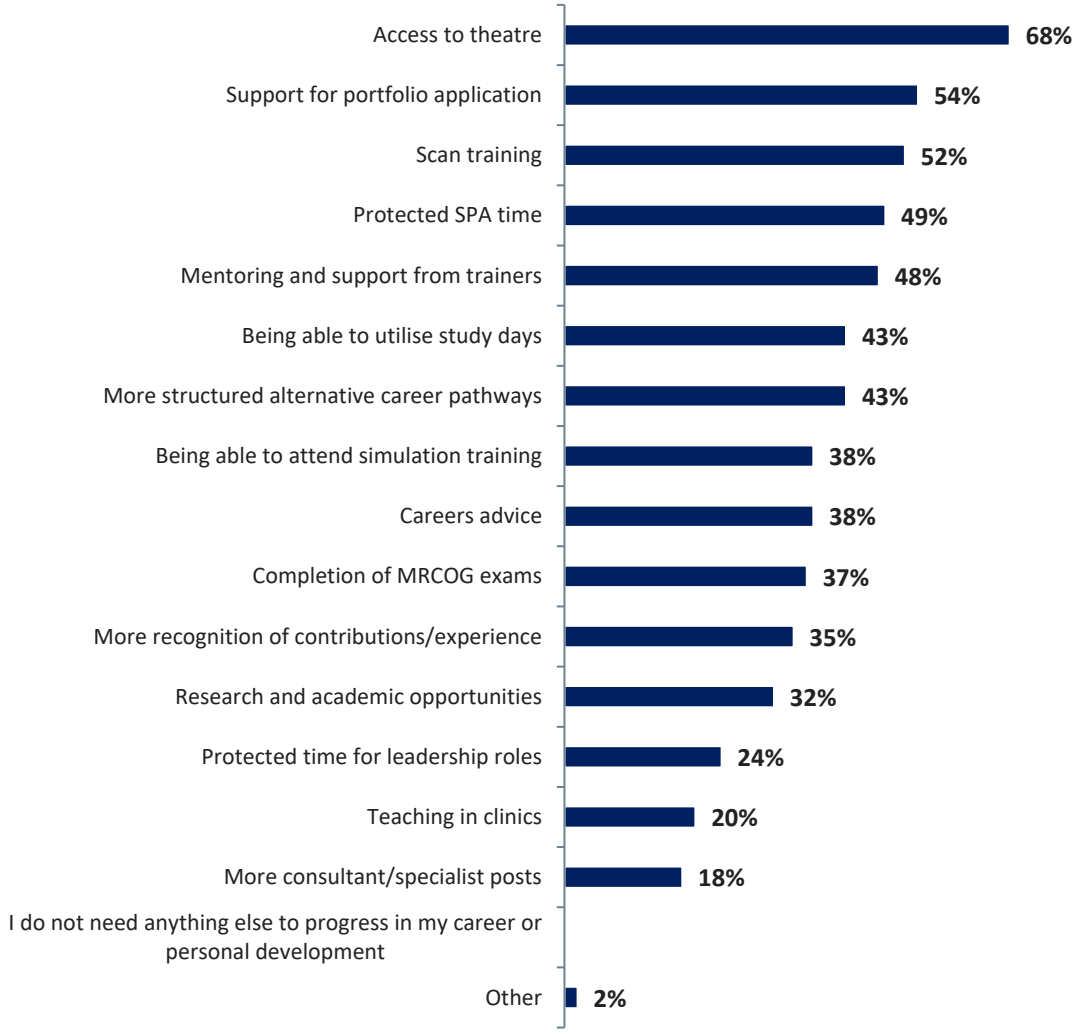
Figure 3 – What are your current career or personal development needs (LEDs)?



In terms of support needed to progress, LEDs most commonly cited access to time in theatre (68%) (Figure 4), followed by support for their portfolio application (54%) and scan training (52%). Half (49%) said they required protected SPA time, and a similar proportion (48%) suggested mentoring and support from trainers.

A total of 43% identified more structured alternative career pathways as a developmental need. Despite usually being employed on fixed-term contracts, 26% of LEDs had been in their post for three years or more. NHS Employers guidance outlines that doctors on local terms and conditions who wish to move to the 2021 SAS contracts do not have an automatic right to do so, but may wish to discuss this with their employer if they have been in post for 24 months or more.[3] Being offered the opportunity to progress into a SAS contract would support LEDs to develop within a more structured career pathway.

Figure 4 – What else do you need to progress in your career or personal development (LEDs)?



Encouragingly, the vast majority of LEDs reported they had an educational supervisor (88%). However, the small base size means that these figures should be interpreted with some degree of caution. LEDs were the most likely of all career stages to respond that they need careers advice to develop (38%), identifying a gap in their current support. It is important for

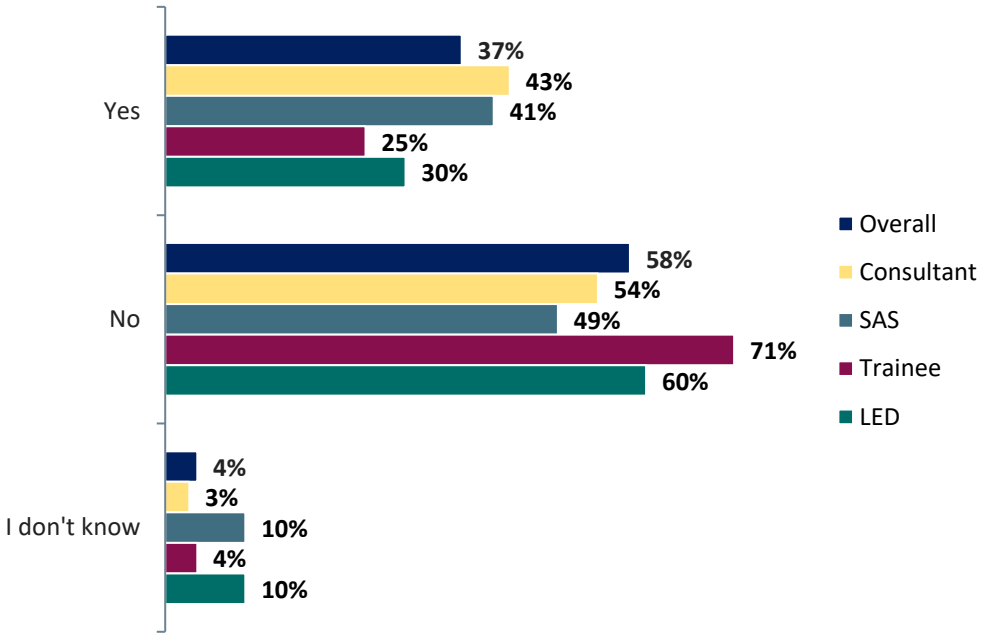
all LEDs to have an educational supervisor to support their learning and career aspirations and who understands alternative career pathways in our specialty.[4]

Time for development

A challenge that spanned all career stages was the lack of time for development. The census found that 58% of respondents do not have a sufficient amount of time for their own career or personal development within their contracted hours, indicating a shortfall in how career and personal development is supported across the O&G workforce (Figure 5).

Each career role was more likely to say they did not have sufficient time for development, but this was particularly acute for trainees, at 71%.

Figure 5 – Do you have a sufficient amount of time for your own career or personal development within your contracted hours (by career role)?



By far, the most common reason given was service provision pressures, selected by 86% of respondents (Table 1). This was particularly acute for trainees (93%), but the vast majority of consultants (84%), SAS doctors (80%) and LEDs (80%) also cited this issue, underscoring pressures across the workforce.

Overall, half of those who said they had insufficient time for career development cited patient-related administration as a reason; this was higher in the consultant cohort, with 70% affected by an increased administration requirement.

These findings suggest that systemic pressures are limiting doctors' ability to access development, regardless of their personal career aspirations. They highlight the need for

protected time for development opportunities, support with administration and an increased workforce.

Table 1 – Please indicate why you do not have a sufficient amount of time for your own career or personal development within your contracted hours (by career role)

Response	Overall %	% of consultants	% of SAS doctors	% of trainees	% of LEDs
Service provision	86%	84%	80%	93%	80%
Patient-related administration	50%	70%	32%	28%	9%
Lack of administration support	41%	47%	43%	31%	35%
I don't know	2%	1%	5%	2%	7%
Other	8%	10%	7%	4%	4%

Recommendations

It is fundamental that O&G doctors are supported to meet their career aspirations. This is crucial for retention, improved morale and increased satisfaction among the workforce. Career development is vital to ensure the workforce can meet the needs of the population and deliver the highest-quality care to women, patients and families.

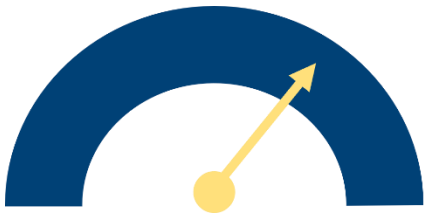
- Doctors with educator and leadership responsibilities need protected time in their job plans to fulfil these roles alongside service provision commitments. This requires retention and expansion of the senior O&G workforce.
- Employers need to recognise the time clinicians are required to spend on administrative tasks in job plans and ensure appropriate support is available.
- NHS organisations need to support the development needs of doctors at every career stage.
- Trainees and LEDs need to have access to time in theatre to develop surgical skills. This is crucial to ensure the future workforce is capable of managing increased surgical complexity.
- NHS Trusts and Health Boards should enable autonomously working senior SAS doctors to have their clinics and theatre lists coded in their own name, to recognise their experience and contribution, and more accurately attribute service provision within the department and for national reports such as Getting It Right First Time.
- NHS Trusts and Health Boards should support SAS doctors and LEDs with structured career development and career advice:

  - Early career SAS doctors and LEDs should have an educational supervisor familiar with alternative pathways to support their professional development.[4]
  - Post-foundation LEDs who have been in post for 24 months or more should be given the opportunity to apply for a permanent SAS doctor post at the equivalent level of experience.
  - NHS Trusts and Health Boards should consider the creation of specialist posts for senior specialty doctors. As well as providing a career progression pathway for specialty doctors, specialist posts offer opportunities to strengthen workforce stability and expertise, and increase the number of senior decision makers within departments.
- NHS Trusts and Health Boards should provide IMGs with a local induction, as outlined in the NHS resource: Welcoming and Valuing International Medical Graduates: A Guide to Induction for IMGs.[5]
- NHS Trusts and Health Boards should consider facilitating mentoring opportunities to support the development of the future workforce. Mentoring would be particularly beneficial for trainees, LEDs and newly appointed consultants or specialist (senior SAS) doctors. Senior clinicians approaching retirement can offer valuable skills, expertise and advice.

Workplace conditions

The census explored key aspects of working conditions across the workforce, including working beyond contracted hours, taking annual leave and the frequency and impact of gaps in rotas. These issues offer insight into the day-to-day pressures faced by the workforce and how operational challenges affect workload, wellbeing and service delivery.

Working beyond contracted hours



68% said they **always** or **often worked beyond their contracted hours**

Figure 6 – How often do you work beyond your contracted hours?

Working beyond contracted hours was a routine experience for almost all respondents: 68% said they always (28%) or often (40%) worked beyond their contracted hours (Figure 6). A further quarter (25%) said they sometimes worked beyond their hours, with only 7% saying they rarely or never did.

By career role, consultants were most likely to say they always or often worked beyond their contracted hours (75%). However, significant proportions of trainees (58%), SAS doctors (51%) and LEDs (57%) also reported this, reflecting the pressures the entire O&G workforce are experiencing.

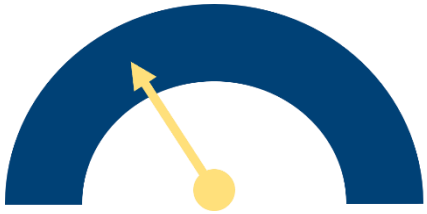
Reasons for working beyond contracted hours

The most common reason for working beyond contracted hours was an increase in the administrative requirements, cited by 68% of respondents. This was followed by staff shortages (56%) and increases in the number of cases with complex comorbidities (52%). Over a third (36%) pointed to backlog pressures, and a similar proportion (34%) said they stayed late to fulfil leadership responsibilities. These findings reflect both system-wide capacity issues and growing complexity in clinical care.

There were some notable differences by career role:

- Consultants (77%) were the likeliest to cite an increase in administrative work as a reason for working beyond contracted hours, but this was a common theme across all roles.
- Staff shortages was the most common reason for working beyond contracted hours for SAS doctors (57%), trainees (61%) and LEDs (56%), indicating there is some reliance on these groups to fill shortfalls in rota cover.

Taking annual leave



35% reported **not** being able to take their **full annual leave entitlement**

Figure 71 – Did you take your full annual leave entitlement in the last year?

Six in ten respondents reported that they were able to take their full annual leave entitlement in the last year, but a substantial minority were not (35%) (Figure 7).

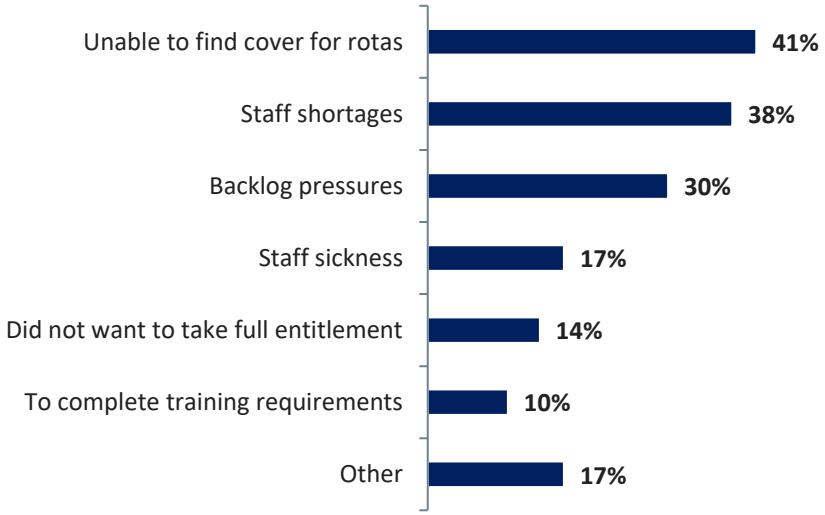
This was particularly acute for consultants, 43% of whom said they did not take their full entitlement, but large minorities of SAS doctors (28%), trainees (21%) and LEDs (30%) also encountered this challenge.

Those working LTFT were more likely to say they were able to take their full annual leave entitlement (70%) than those who worked full time (59%).

Reasons for not taking annual leave

The most commonly cited reason for not taking full annual leave entitlement was being unable to find cover for rotas, reported by 41% overall (Figure 8). This was closely followed by staff shortages (38%) and backlog pressures (30%). These results suggest systemic service pressures are the main barrier to taking annual leave.

Figure 8 – What are the main reasons you would give for not taking your full annual leave entitlement in the last year?



Gaps in rotas

67% reported that there were **gaps** in the rota at their level

Figure 9 – Are there any gaps in the rota at your level in your current unit?

Two-thirds (67%) of respondents reported that there were gaps in the rota at their level in their current unit (Figure 9). Only a quarter (26%) of respondents overall said there were no rota gaps, and 7% were unsure.

Impact of rota gaps

Rota gaps undermine both the functioning of services and staff development and wellbeing.

As outlined in Table 2, almost three-quarters (72%) of those reporting rota gaps felt they had an impact on job satisfaction, and this was very closely followed by an impact on service

improvement (71%). Two-thirds (67%) felt rota gaps had an impact on patient care, and 64% said they had an impact on the supervision and training of others. Six in ten (60%) felt that gaps had an impact on their own career development.

Those who reported rota gaps were more likely to not have taken their annual leave entitlement in the last year (38%) than those who reported no gaps (31%). Staff taking their full leave entitlement is crucial for maintaining good physical and mental health, promoting positive work–life balance, reducing the risk of burnout and increasing productivity. Being unable to take this due to inadequate staffing can have a negative impact on the wellbeing of the workforce.

There was some variation by career role:

- 79% of trainees felt rota gaps affected job satisfaction, the highest of any career role; of this group, 71% felt these gaps had an impact on the supervision and training of others
- The vast majority of affected trainees and LEDs felt rota gaps had an impact on their own career development (86% and 82%, respectively)
- Consultants who reported rota gaps were most likely to report that it affected service improvement (76%) and patient safety (71%).

Table 2 – Does having gaps in your rota impact on any of the following (by career role)?

Response	Overall %	% of consultants	% of SAS doctors	% of trainees	% of LEDs
Your job satisfaction	72%	69%	71%	79%	71%
Service improvement	71%	76%	64%	66%	53%
Patient care	67%	71%	64%	64%	53%
Supervision and training of others	64%	64%	41%	71%	49%
Own career development	60%	46%	66%	86%	82%
Other	4%	4%	–	2%	5%

Workplace challenges

Respondents were given an opportunity to share any additional comments related to challenges in their workplace. These open-text responses, coded thematically, provide a rich and candid insight into the persistent and systemic pressures experienced by O&G doctors. The themes are presented below in Table 3.

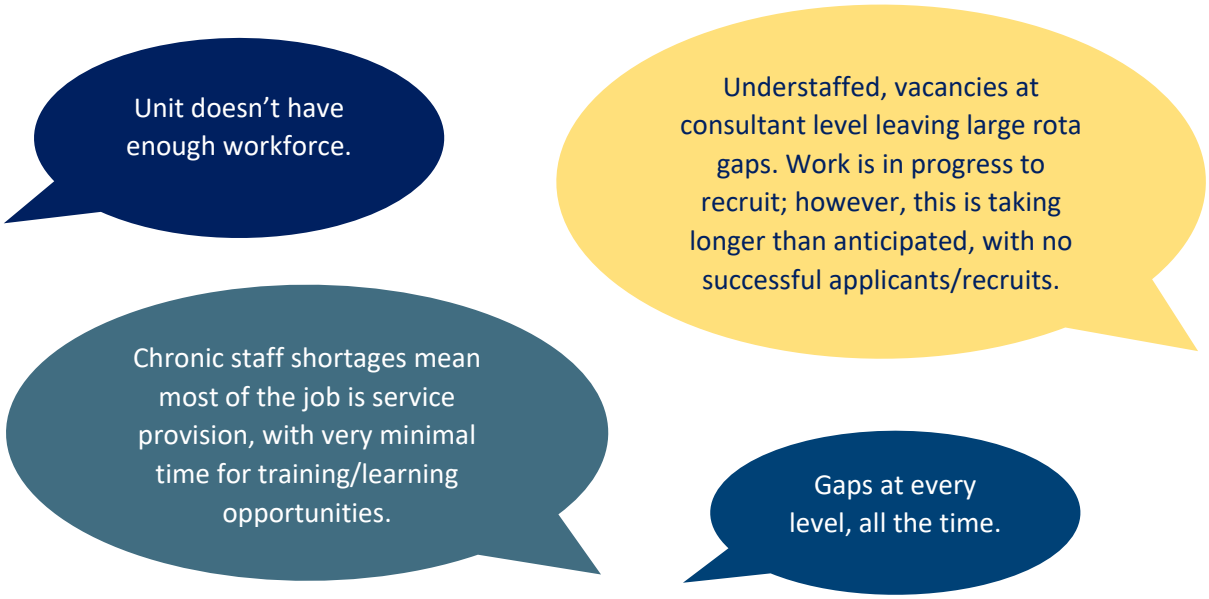
One of the most frequently raised themes was a lack of workforce capacity, particularly the need for more consultants. Other very common themes were staff burnout, high sickness rates and being overworked (grouped together as one theme). This echoes widespread concerns about wellbeing, which are evident throughout the census responses. The need for better rota planning and fewer rota gaps was also one of the most common themes.

Many comments also related to a need for training and development to be prioritised, especially access to scanning.

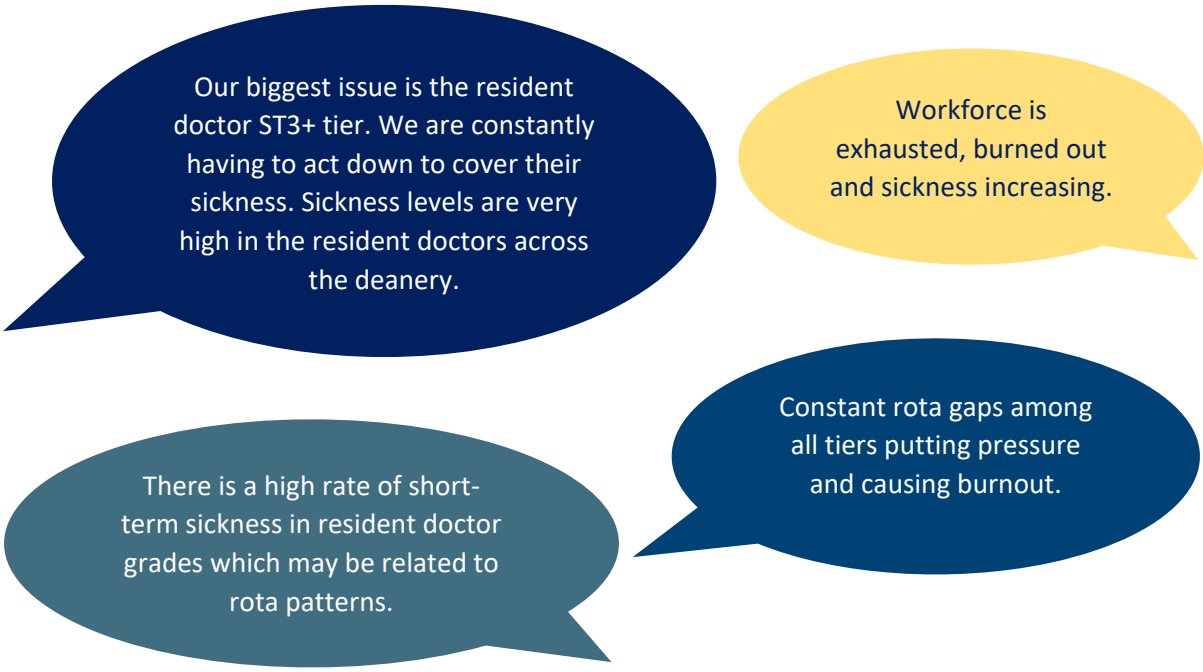
Table 3 – Do you have any additional comments you would like to make about workplace challenges and how you think they could be addressed? (Themes with 40+ comments)

Theme	Number of respondents
Lack of workforce/more consultants needed	76
Staff burnout/high levels of sickness/overworked	76
Fewer rota gaps/better rota planning	62
Training should be prioritised, including scanning	48
Put the patient first, no continuity of care, all about saving money/patient care and safety is suffering	40

Lack of workforce/more consultants needed – example comments



Staff burnout/high levels of sickness/being overworked – example comments



Recommendations

Working conditions impact job satisfaction, patient care and service improvement. Across all career grades, over half of respondents reported that they do not have a sufficient amount of time for their career or personal development within their contracted hours. The overwhelming reason cited was service provision pressures (86% of all affected respondents). In addition, 67% reported that there were gaps in the rota at their level, and 35% reported not being able to take their full annual leave entitlement.

- Increased resources in women's healthcare are needed to provide an adequately staffed workforce and reduce rota gaps.
- The Government's next 10 Year Workforce Plan must ensure doctors have adequate time for training alongside service provision requirements, to enable doctors to take on leadership roles and drive improvements in care.
- NHS workforce planning must evolve and adapt to support flexible working, to ensure rotas are adequately staffed and retain experienced doctors in the workforce.
- Employers need to support staff to take their full annual leave entitlement. This is crucial for maintaining staff wellbeing and increasing productivity.

- NHS Trusts and Health Boards should seek to increase productivity by reducing the administrative burden on clinicians and ensuring adequate time in job plans for necessary administrative tasks.
- NHS organisations need improved IT systems and estates to ensure clinicians have the equipment and resources they need to provide the highest-quality care for women, patients and families.
- NHS staff need to have access to adequate rest facilities, refreshments and staff parking spaces. All these things combined contribute to staff feeling valued in the NHS.

Job satisfaction and wellbeing

Job satisfaction levels

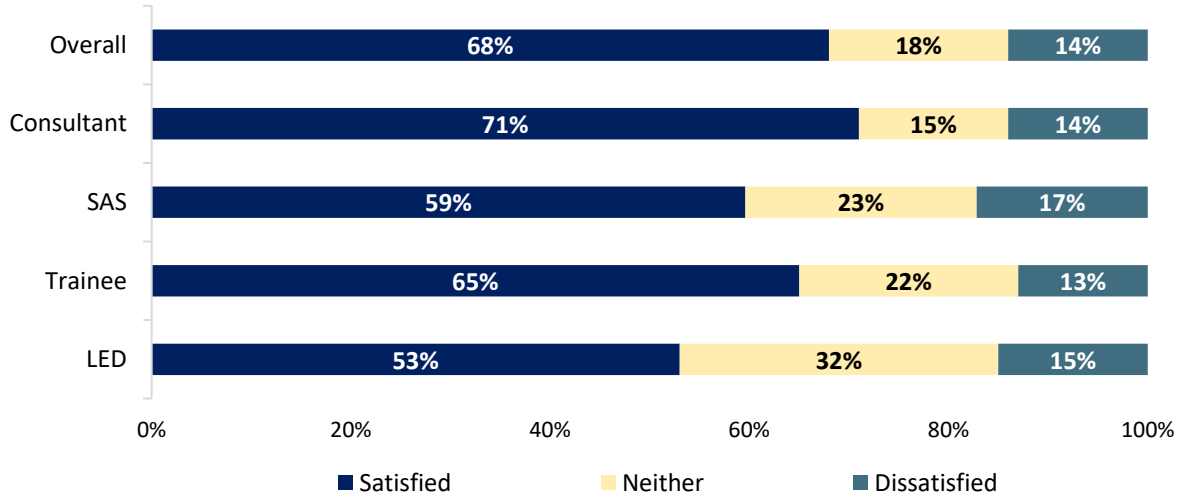
Overall job satisfaction

Despite all the above concerns and challenges, 68% of respondents said that they were satisfied with their day-to-day work (Figure 10). Just over one in six respondents (14%) said they were dissatisfied, of which 4% were very dissatisfied. The remaining 18% were neither satisfied nor dissatisfied.

Job satisfaction by career role

Job satisfaction varied significantly across role types, with consultants reporting the highest (71%) and LEDs reporting the lowest (53%) levels of satisfaction with their day-to-day work (Figure 10). The 2024 GMC Workplace Experiences report found that across specialties, SAS doctors were the most positive overall and the most likely to be satisfied.[6] However, within our census findings, SAS doctor satisfaction levels (59%) were lower than the average across all roles (68%). Since the introduction of the new specialist (senior SAS) contract in 2021, only a small number of these posts have been in established in O&G. The satisfaction levels in this census may reflect the lack of opportunities for career progression within the specialty doctor role. These lower satisfaction levels also demonstrate the need for greater recognition and support for SAS doctors working in O&G.

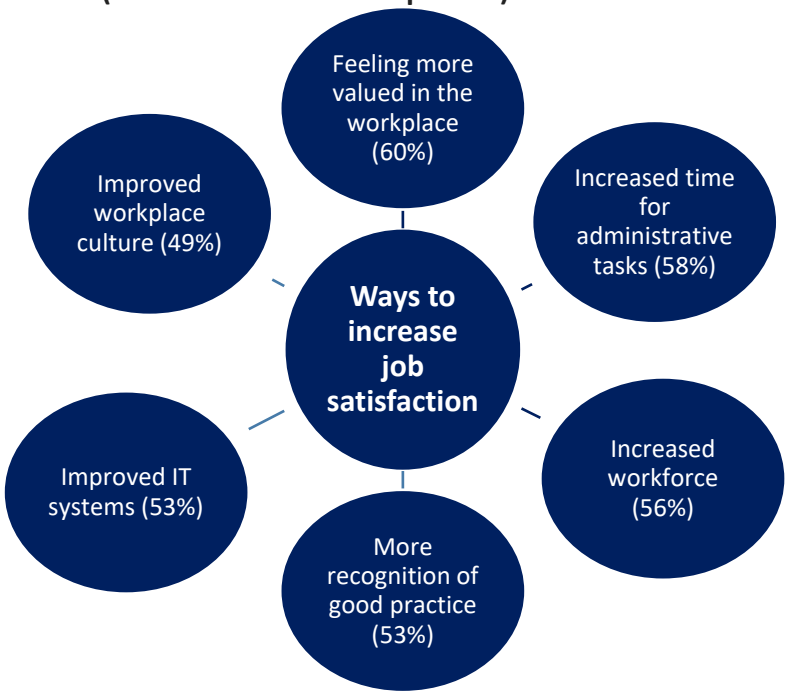
Figure 10 – To what extent are you satisfied or dissatisfied with your day-to-day work as an O&G doctor (by career role)?



Drivers to improve job satisfaction

Those who did not feel very satisfied in their day-to-day work identified a number of factors that would most improve their satisfaction (Figure 11). The most frequently selected across all roles were feeling valued in the workplace, closely followed by increased time for administrative tasks and increased workforce numbers. Just over half cited more recognition of good practice and the same proportion suggested improved IT systems would improve their satisfaction. Half also suggested an improved workplace culture would help.

Figure 11 – What, if anything, are the main things that would increase your job satisfaction? (The most common responses)



Other suggestions included improved estates (32%), more time for leadership (31%), reduced clinical workload (31%) and more time to teach (29%).

By career role

There were some notable differences by career role.

- For trainees, the main drivers were feeling more valued (65%), increased time for administrative tasks (64%) and increased workforce numbers (62%).
- Trainees (65%) and LEDs (71%) were more likely to say they wanted to feel more valued than consultants were (58%), and to suggest increased workforce numbers (62% and 61%, respectively, compared with 55% of consultants).
- Trainees were most likely to cite increased time for administrative tasks (64%)
- Key drivers for consultants were increased time for administrative tasks (59%) and improved IT systems (59%), closely followed by feeling more valued (58%) and increased workforce numbers (55%).
- Feeling more valued was key for SAS doctors (58%), followed by more recognition (57%) and improved workplace culture (50%).
- Feeling more valued was by far the biggest driver to improve job satisfaction for LEDs (71%), and six in ten (61%) cited increased workforce numbers.

What O&G doctors enjoy about their role

Census respondents were asked to identify the aspects of their role they enjoyed most. The responses, outlined in Figure 12, show a strong sense of professional commitment, centred on clinical care, teamwork and supporting others. This question complements the findings on job satisfaction and reveals the deeper motivations that sustain doctors in O&G, even amidst significant pressures.

The most frequently mentioned source of enjoyment was delivering care, cited by 88% of respondents overall. This includes both direct patient interaction and the fulfilment of helping women and families through key moments in their lives, and was the top reason across all career roles and locations.

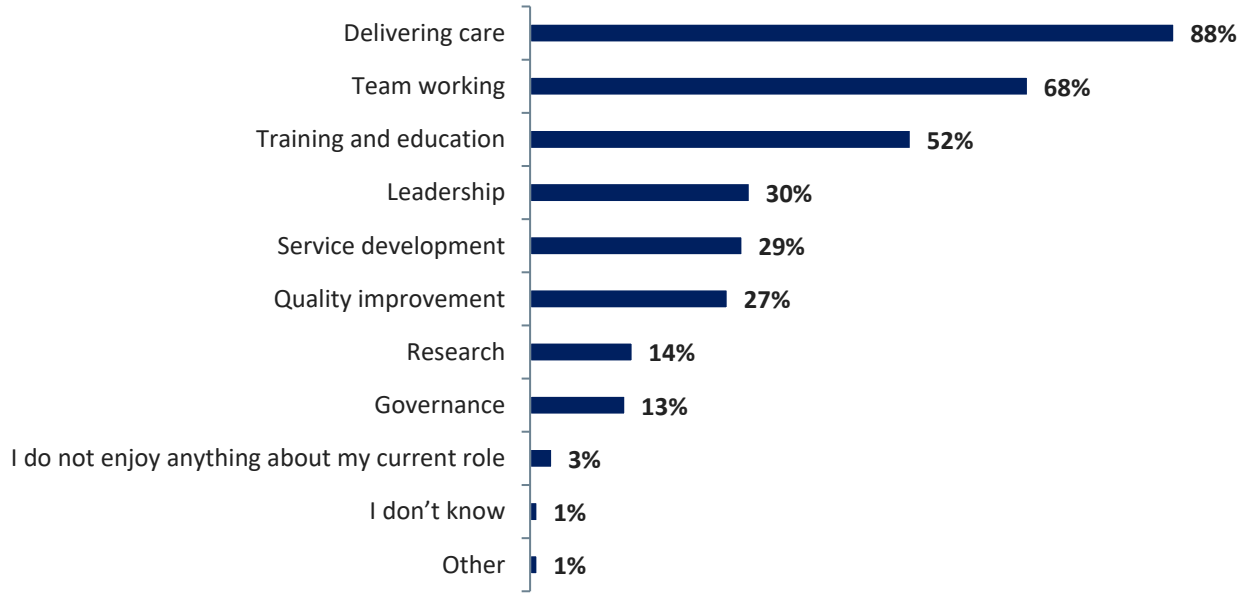
Following this, team working was cited by 68%, underlining the importance of working relationships in sustaining morale. Training and education were valued by 52%, suggesting that teaching and mentoring also play a central role.

Leadership (30%), service development (29%), and quality improvement (27%) were also recognised as enjoyable by significant minorities, highlighting that many respondents take pleasure in shaping and improving the systems around them.

Other areas, such as research (14%) and governance (13%), were less commonly selected, but still important for some.

Only 3% said they do not enjoy anything about their current role, and 1% said they did not know.

Figure 12 – What are the main things you enjoy about your current role?



Workplace culture and support

A positive workplace culture is essential for staff wellbeing and retention, and the delivery of high-quality care. The census explored how supported respondents feel in their day-to-day roles, focusing on feelings of being valued, the sense of community within their units and support received following adverse events.

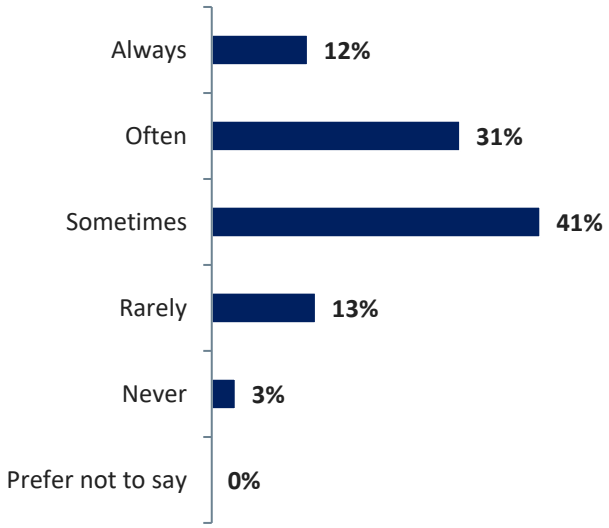
Feeling valued in the workplace

As seen previously, feeling valued in the workplace is a key driver of job satisfaction.

Despite this, only a minority of respondents felt consistently recognised for their contributions – just 12% said they always feel valued, and a further 31% said they often do (Figure 13). The most common response was only sometimes feeling valued (41%), while 13% said rarely and 3% felt they were never valued. This signals there are widespread perceptions of feeling underappreciated across the workforce.

These findings directly reflect earlier results in the census, where the most frequently cited factor for improving job satisfaction was feeling more valued in the workplace.

Figure 13 – Feel valued in the workplace



Feelings of value varied by career role, with consultants (48%) somewhat more likely to say they always or often feel valued than trainees (36%) and LEDs (32%) (Table 4).

Table 4 – Feel valued in the workplace, by career role

Response	Overall %	% of consultants	% of SAS doctors	% of trainees	% of LEDs
Always or often	43%	48%	42%	36%	32%
Sometimes	41%	37%	42%	48%	45%
Rarely or never	16%	15%	17%	16%	22%
Prefer not to say	0%	0%	-	0%	1%

Sense of community and belonging

Perceptions of community were more positive than feeling valued, but still mixed (Table 5): only 17% said they always feel their unit has a sense of community, 36% said often, 31% said sometimes and 15% said rarely or never.

Consultants were the most positive, with 57% saying they felt their unit always or often had a sense of community. In comparison, this fell to 43% for SAS doctors and 48% for trainees.

Table 5 – Feel your unit has a sense of community and belonging by career role

Response	Overall %	% of consultants	% of SAS doctors	% of trainees	% of LEDs
Always or often	53%	57%	43%	48%	49%
Sometimes	31%	28%	37%	36%	30%
Rarely or never	15%	14%	20%	16%	21%
Prefer not to say	1%	1%	–	0%	–

Support after an adverse event

Working in O&G is usually rewarding, but can prove challenging. Any doctor, in any specialty, can have times when they need support either professionally or personally. Staff within women's health services are commonly exposed to psychologically traumatic events at work.[7]

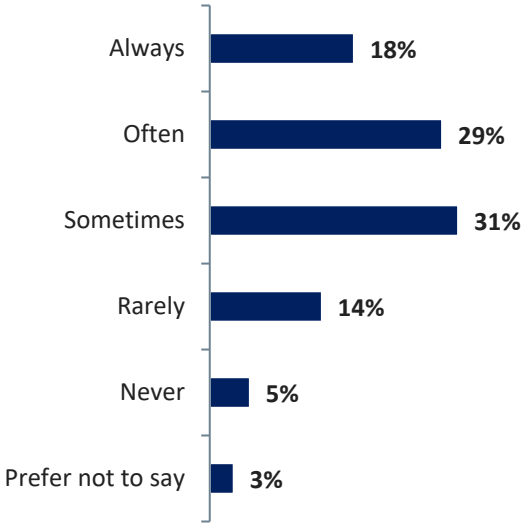
In addition, GMC data outlines that, based on data from 2012 to 2023, O&G had the fifth highest complaint rate. Further, 40% of complaints warranted an investigation, the highest conversion rate across all specialties. However, only 14% of the investigations into O&G specialists went on to result in a sanction or warning, which was the lowest conversion for any specialty.[2]

Being involved in an adverse event, an inquest or being part of a complaint process is incredibly challenging; it is normal to need support when events such as these occur. This is fundamental to preventing staff from developing post-traumatic stress symptoms (PTSS).

However, the census findings show that support following adverse events is not consistent (Figure 14): 18% said they always feel well supported, 29% said often, 31% said only

sometimes and 19% said rarely or never. This suggests that much of the O&G workforce do not feel consistently backed in difficult situations.

Figure 14 – Feel well supported after an adverse event at work (such as a complaint, serious untoward event, conflict with a colleague)



Consultants were most likely to report regular support (52% always or often), but still with notable proportions saying they rarely, never or sometimes feel supported. Trainees (38%), SAS doctors (42%), and LEDs (45%) were less likely to say they always or often felt supported (Table 6). This highlights a gap in current routine practice. All doctors need to be consistently supported after adverse events.

Table 6 – Feel well supported after an adverse event at work by career role

Response	Overall %	% of consultants	% of SAS doctors	% of trainees	% of LEDs
Always or often	47%	52%	42%	38%	45%
Sometimes	31%	28%	35%	37%	31%
Rarely or never	19%	19%	20%	19%	21%
Prefer not to say	3%	1%	3%	5%	3%

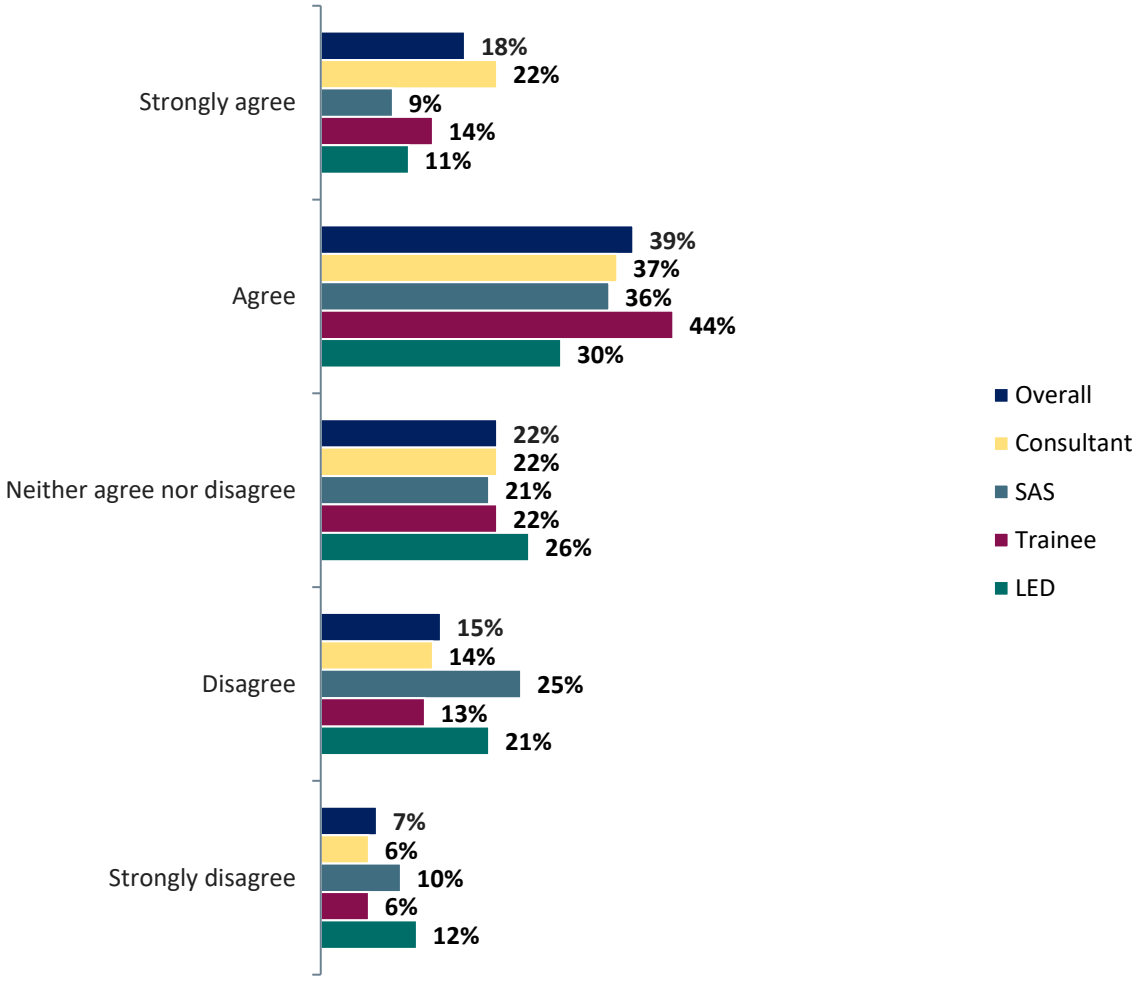
Support from team structure

Just over half (56%) of respondents agreed that their team structure adequately supports their development and practice needs, 18% strongly agreed, 39% agreed, 22% neither agreed nor disagreed, and 22% disagreed (including 7% who strongly disagreed) (Figure 15). This indicates that a large portion of the O&G workforce lack confidence that their team structure allows them to develop professionally.

Perceptions of support through team structures varied by role:

- Consultants (59%) and trainees (58%) were more likely to agree that their team structure supported their development and practice needs than SAS doctors (44%) and LEDs (41%).
- Just over a third of SAS doctors (35%) and LEDs (33%) disagreed that their team structure adequately supports their development and practice needs.

Figure 15 – I have a team structure that adequately supports my development and practice needs (by career role)

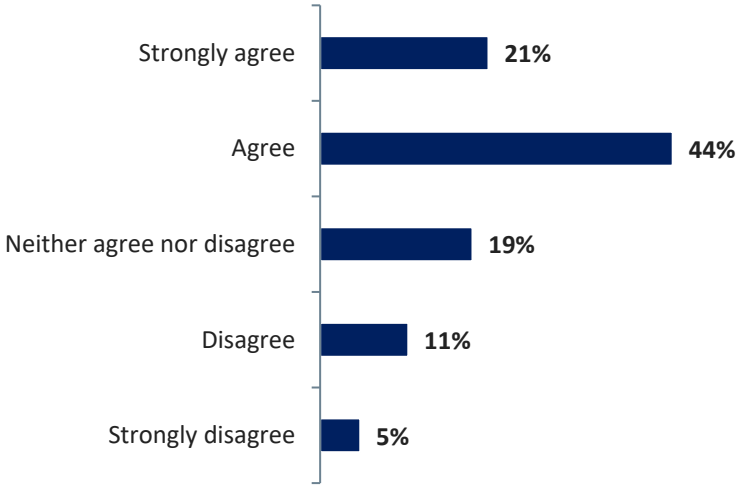


There was also a difference seen by hospital size, with those working in small units with fewer than 3,000 births more likely to feel that their team structure did not adequately support their development and personal needs (27%) than those working in medium and large hospitals (21% and 20%, respectively).

Induction

Overall, 65% of respondents agreed that they had been sufficiently inducted into their current post (21% strongly agreed and 44% agreed) (Figure 16). One in five (19%) neither agreed nor disagreed, and 17% disagreed in total, including 5% who strongly disagreed. These findings suggest that structured support at the start of a role is inconsistent.

Figure 16 – I was inducted sufficiently into my current post



Once more, there were notable differences by career role, with consultants and trainees more likely to agree (64% and 71%, respectively), and SAS doctors and LEDs more likely to disagree (22% and 25% respectively), highlighting inconsistencies by role (Table 7).

Table 7 – I was inducted sufficiently into my current post by career role

Response	Overall %	% of consultants	% of SAS doctors	% of trainees	% of LEDs
Agree	65%	64%	57%	71%	52%
Neither agree nor disagree	19%	19%	22%	16%	23%
Disagree	17%	17%	22%	14%	25%

Risk of burnout

As seen earlier in the report, burnout and the resulting levels of sickness were frequent themes in the comments related to workplace challenges.

To quantitatively measure the risk of burnout, the census included seven work-related statement questions that were adapted from the established and widely used Copenhagen Burnout Inventory (Table 8).

Calculating the risk of burnout

The seven statements below were scored using a scoring system on a scale from 0 to 100.

Table 8 – Scoring for the burnout questions and response options

Statement	0	25	50	75	100
Your work is emotionally exhausting	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
You feel burnt out because of your work					
Your work frustrates you					
You feel worn out at the end of the working day	Always	Usually	Sometimes	Rarely	Never
You are exhausted in the morning at the thought of another day at work					
You feel that every working hour is tiring for you					
You have enough energy for family and friends during leisure time	Never	Rarely	Sometimes	Usually	Always

Respondents' mean scores across all seven questions were then categorised into one of three levels of burnout (Table 9).

Table 9 – Burnout risk categories score ranges

Burnout level	Score range
Low	>50
Moderate	26–50
High	≤25

Across the overall sample, 35% were categorised as low risk of burnout, 46% were moderate risk and 19% were high risk (Table 10). These figures highlight a substantial risk of burnout across the workforce.

Risk of burnout by career role

There were marked variations in burnout risk by career role. LEDs were most likely to be at high risk of burnout (29%), followed by trainees (23%). By comparison, SAS doctors were most likely to be classified as low risk (42%), followed by consultants (37%).

Table 10 – Burnout risk categories, by career role

Response	Overall %	% of consultants	% of SAS doctors	% of trainees	% of LEDs
Low	35%	37%	42%	26%	31%
Moderate	46%	45%	43%	50%	41%
High	19%	18%	15%	23%	29%

Vicious cycle

The GMC outlined a vicious cycle of unmanageable workloads, low workplace satisfaction, high levels of burnout and doctors changing their working patterns or even leaving the workforce.[6] The RCOG census findings support the relationship between these factors, and substantiate the need to implement interventions to break this cycle.

Unmanageable workloads

Insufficient time for development, working beyond contracted hours, rota gaps and service provision pressures all point to a workforce that is enduring unmanageable workloads. O&G doctors are navigating increasingly complex obstetric care, growing gynaecology waiting lists, evolving population demands and greater patient expectations, leading to increased workloads and pressure on an already stretched workforce.

Within the census, the impact of these unmanageable workloads on job satisfaction can be demonstrated by the correlation between satisfaction in day-to-day work and whether respondents had sufficient time for career or personal development:

- Among those who said they had sufficient time for development, 84% were satisfied in their day-to-day work and only 4% were dissatisfied.
- Among those who did not have enough time, satisfaction dropped to 57% and dissatisfaction rose to 21%.

Related to not having sufficient time for development, the presence of rota gaps seems to be another important factor. Almost a fifth (18%) of those who reported rota gaps in their unit said they were dissatisfied with their day-to-day work, higher than those who did not report any gaps (6%).

These correlations show the impact that unmanageable workloads can have on job satisfaction and highlight the importance of implementing interventions – such as protected time for education, training and leadership responsibilities – not only for career progression, but also for day-to-day morale. Without this protected time, respondents report lower workplace satisfaction.

Job satisfaction

As well as unmanageable workloads, work environment can also affect job satisfaction. Respondents who reported often or always feeling valued in the workplace were much more likely to be satisfied in their jobs (90%). Among those who said they never or rarely feel valued, satisfaction was significantly lower (28%), and dissatisfaction notably higher (45% compared with 4%).

Similarly, those who reported a sense of community always or often had higher job satisfaction (85%), whereas 43% of those who rarely or never felt a sense of community were dissatisfied in their day-to-day work. This suggests that feeling connected with others within their team is an important driver of morale.

Rarely or never feeling supported after adverse events correlated with higher dissatisfaction in day-to-day work (37%), whereas 87% of those who felt always or often supported said they were satisfied.

These findings suggest that a culture of recognition, a sense of belonging to a team and perceptions of support after adverse events are essential to morale and are core drivers of job satisfaction.

Burnout

There was a clear link between job satisfaction and burnout. Among those who said they were satisfied with their current job, nearly half (46%) had a low risk of burnout, and just 8% were in the high-risk category. In contrast, among those who were dissatisfied, 58% were classified as high risk, and only 6% had a low burnout score.

Burnout also appears to be linked to whether respondents feel they have sufficient time for career or personal development within their contracted hours. Of those who said they did have sufficient time, 51% were low risk and just 8% were high risk. Among those who said they did not have sufficient time, 24% were low risk and 27% were high risk.

Furthermore, where rota gaps were reported, 23% were at high risk for burnout. Conversely, where no gaps were reported, 12% were at high risk, again underscoring the impact of staffing shortfalls on wellbeing.

This highlights the importance of increasing job satisfaction and reducing workload pressures to mitigate the risks of burnout.

Intention to leave the specialty

In addition, the findings show that dissatisfied doctors are more likely to report that they intend to leave the specialty in the next five years (excluding retirement).

Of those intending to leave the specialty in the next five years, 53% were at a high risk of burnout, compared with 14% of those who were not intending to leave.

Doctors leaving the specialty perpetuates workforce pressures and demonstrates how the cycle needs to be broken in order to increase job satisfaction, reduce risk of burnout and retain valued clinicians within the workforce.

Workforce wellbeing

Respondents were asked to share their thoughts on how the health and wellbeing of those working in the specialty can be improved. Respondents shared a wide range of suggestions, outlined in Table 11, reflecting both the personal toll of current working conditions and a clear appetite for systemic change.

The most commonly suggested intervention, raised by 22% of those who left a comment, was to improve levels of staffing. The second most common theme (16%) was a desire to feel more valued, supported, appreciated and recognised. These themes link strongly with other findings from the census.

Work–life balance improvements were another common theme, including improved rota design and more predictable shift patterns to allow time for rest and recovery. In a related theme, many called for fewer hours, more realistic workloads or working contracted hours only.

Respondents also highlighted the importance of camaraderie and a positive workplace culture, including teamwork and better interpersonal relationships.

Development-related suggestions were also raised, with a call for better access to training (including scan training and access to theatre) and time for development activities with support. Meanwhile, one in ten respondents identified the need for administrative support and protected time in job plans for non-clinical duties.

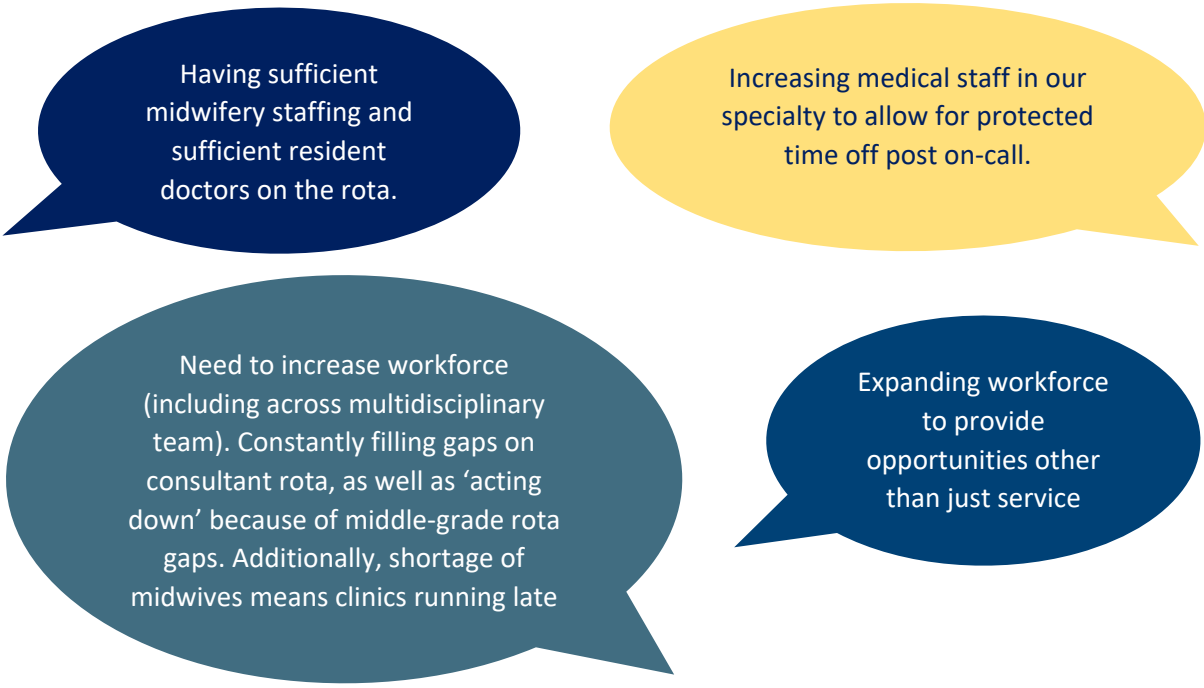
Smaller but significant proportions of respondents mentioned the need for stronger organisational support (8%), fewer rota gaps (7%), improved management and supportive leadership (6%), and access to psychological or pastoral care (6%).

Although individual suggestions varied, a consistent theme was the need for greater structural and cultural support to allow obstetrics and gynaecology professionals to thrive, both in terms of personal wellbeing and professional sustainability.

Table 11 – What, if anything, do you think would make a difference to the health and wellbeing of doctors working in our specialty? (Themes with 50+ comments)

Theme	Number of respondents
More staff/improve staffing levels	143
Feeling valued, appreciated, recognised, supported	104
Work–life balance/better rota patterns/protected time off	88
Fewer hours/realistic workloads/working contracted hours only	82
Improved cohesion with colleagues, comradery, less toxic environment	82
More training/development opportunities, time in theatre, scanning, supported and accommodated training	75
Administrative support/time for admin	67
More support from Trust/we're under constant scrutiny in the press/shout about the good we do (including references to Ockenden report)	56

More staff/improve staffing levels – example comments



Feeling valued, appreciated, recognised, supported – example comments

Recommendations

It is crucial that staff feel valued and supported. This is a key driver to both increased job satisfaction and positive wellbeing. Those who often or always felt valued were significantly more likely to be satisfied in their jobs (90%), suggesting a strong link between workplace culture and job satisfaction. Despite this, only a minority of respondents felt consistently recognised for their contributions.

- Employers need to recognise good practice and contributions; this is key to making staff feel more valued and appreciated, particularly among SAS doctors and LEDs, who were most likely to report feeling undervalued.
- Poor workplace culture can lead to defensive practice, high stress, burnout and sickness. Employers should foster a positive workplace culture to support the wellbeing of doctors, allow them to feel valued and respected in the workplace and deliver high-quality care for patients.
- Two-thirds of obstetricians and gynaecologists have encountered a traumatic work-related event during their career, which can trigger PTSS. Each organisation delivering maternity and/or gynaecology services should commit to a programme to prevent and provide early intervention for work-related PTSS in all staff members, as set out in the Prevention and Treatment of Work-Related Post-

Traumatic Stress Symptoms in the Maternity and Gynaecology Workforce (Good Practice Paper No. 19).[7]

- Employers should provide clinical psychologist input and time for senior clinicians to upskill and be able to offer teams suitable support after adverse events.
- Doctors being called to give evidence at an inquest should be signposted to suitable external sources of support, as well as that provided by their NHS Trust/Health Board and their educational supervisor, if they have one.[8]
- Employers need to take a preventative approach to burnout by upskilling the workforce, including senior clinicians and managers, to identify early symptoms of burnout and how to manage these.[9]
- Individuals need to be empowered to take steps that support their own wellbeing, through the cultivation of a positive workplace environment. This should be role-modelled by all senior clinicians.[10]

Job planning

Job plans

The census asked respondents detailed questions about their programmed activities (PAs), which form the basis of NHS job planning for consultants and SAS doctors. A full-time contract is generally considered to be 10 PAs per week (equivalent to 40 hours), typically split between Direct Clinical Care (DCC), Supporting Professional Activities (SPA), and other agreed responsibilities. However, contractual guidance and expectations vary across the devolved nations.[11]

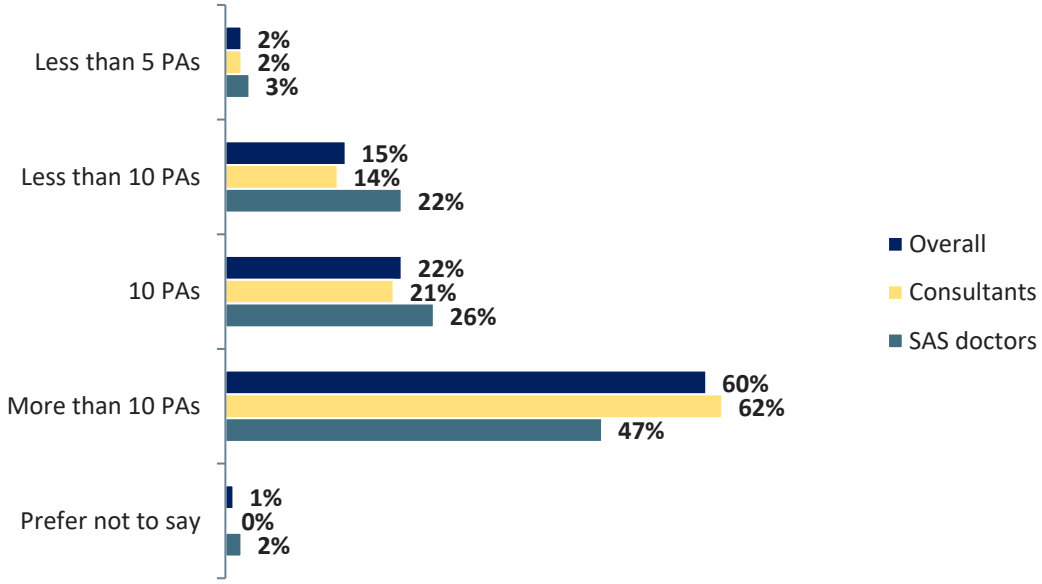
Working on a Programmed Activities (PA) job plan

Almost two-thirds of all census respondents reported that they were working a formal PA job plan.

Among those on PA job plans, six in ten reported they are contracted to work more than 10 PAs each week (Figure 17). Ten PAs is equivalent to 40 hours, which is considered full-time in consultant and SAS doctor contracts.

62% of consultants and 47% of SAS doctors were contracted to work more than 10 PAs per week. This means that a significant proportion of our workforce are contracted to work more than full time to maintain our services. Furthermore, 68% of respondents report working longer than their contracted hours.

Figure 17 – What is the total number of Programmed Activities (PAs) you are contracted to work per week in your job plan (by career role)?



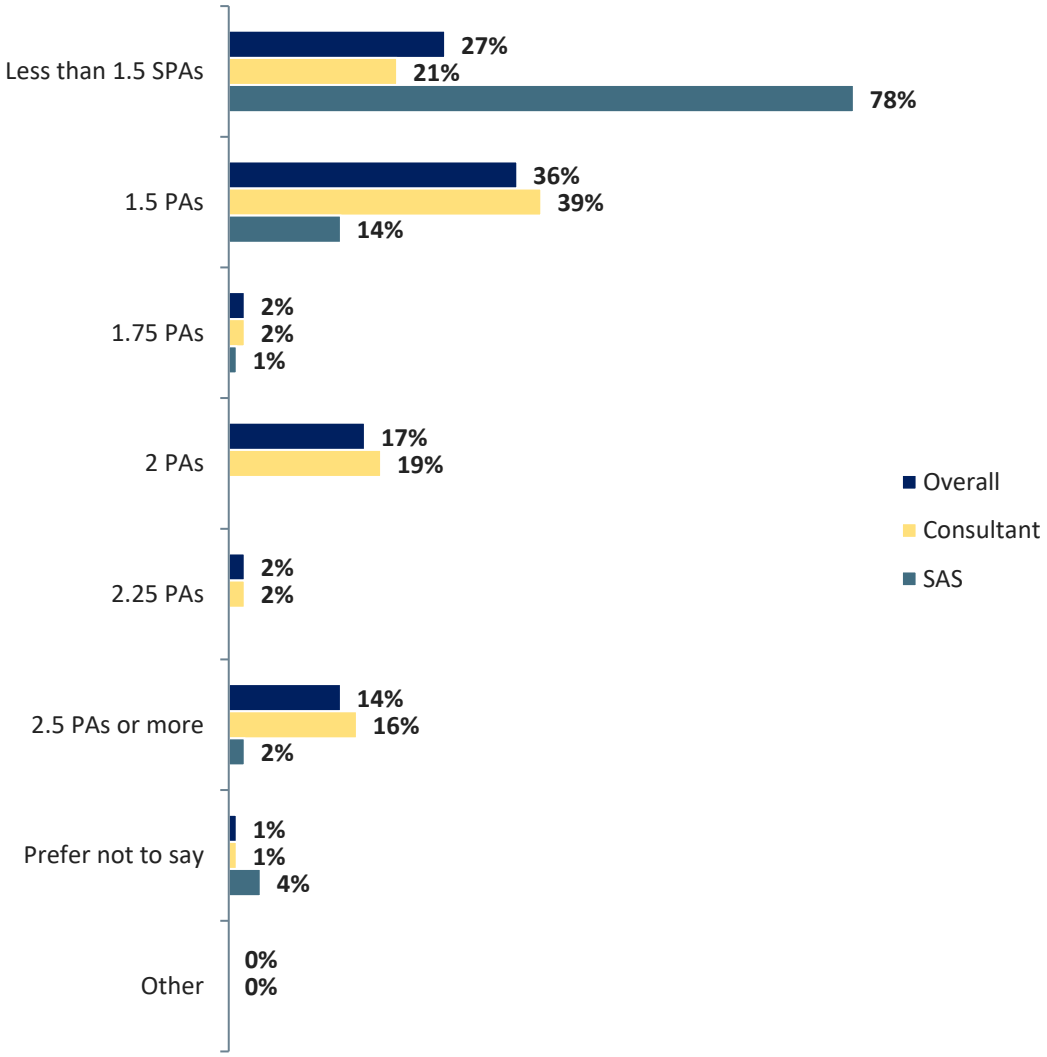
Allocation of time within job plans

The census explored how time is allocated within job plans by asking respondents to detail the number of PAs they were allocated each week for DCC, SPAs, additional NHS responsibilities, external duties and academic work. This breakdown provides valuable insight into how clinical and non-clinical responsibilities are balanced within contracted hours, and how closely these align with national expectations and contractual guidance across the UK.

Supporting Professional Activities (SPAs)

Census respondents who were on PA job plans were asked how many SPAs they were contracted to work per week (Figure 18). This allocation may be adjusted in job plans for those working less than full time, and the minimum SPA time required in full-time contracts varies across the devolved nations. The most common response was 1.5 SPAs per week (36%), but there was some notable variation: 17% reported having only one SPA, 6% had less than one SPA, 17% had two SPAs and 14% reported 2.5 or more SPAs. This shows that a substantial number of doctors may not have adequate protected time for education, audit, leadership, governance and other key non-clinical activities. This reflects other findings in the census, which suggest that many O&G doctors do not have time for their career or personal development.

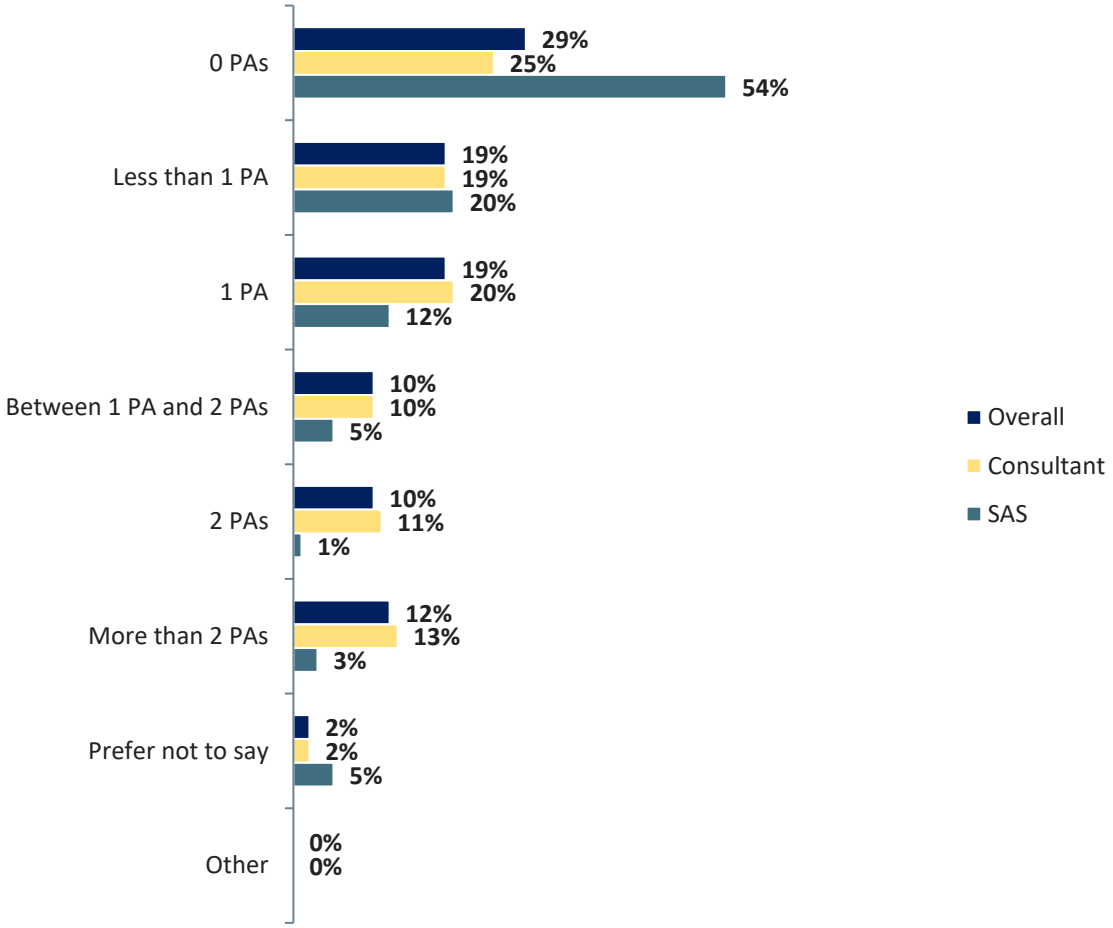
Figure 18 – What is the total number of Supporting Professional Activities (SPAs) you are contracted to work per week in your job plan (by career role)?



Additional NHS responsibilities

Figure 19 indicates time allocated to additional NHS responsibilities in job plans. This could include being a Medical Director, Director of Public Health, Clinical Director or lead clinician, or acting as a Caldicott guardian, clinical audit lead, clinical governance lead, undergraduate dean, postgraduate dean, clinical tutor or regional education adviser. This is not an exhaustive list (definition from NHS Employers, consultant contract (2003)).[12] These findings suggest that while most respondents have some allocation for additional NHS responsibilities, only a minority have more than one PA formally recognised for this work.

Figure 19 – What is the total number of Programmed Activities allocated to additional NHS responsibilities per week in your job plan (by career role)?

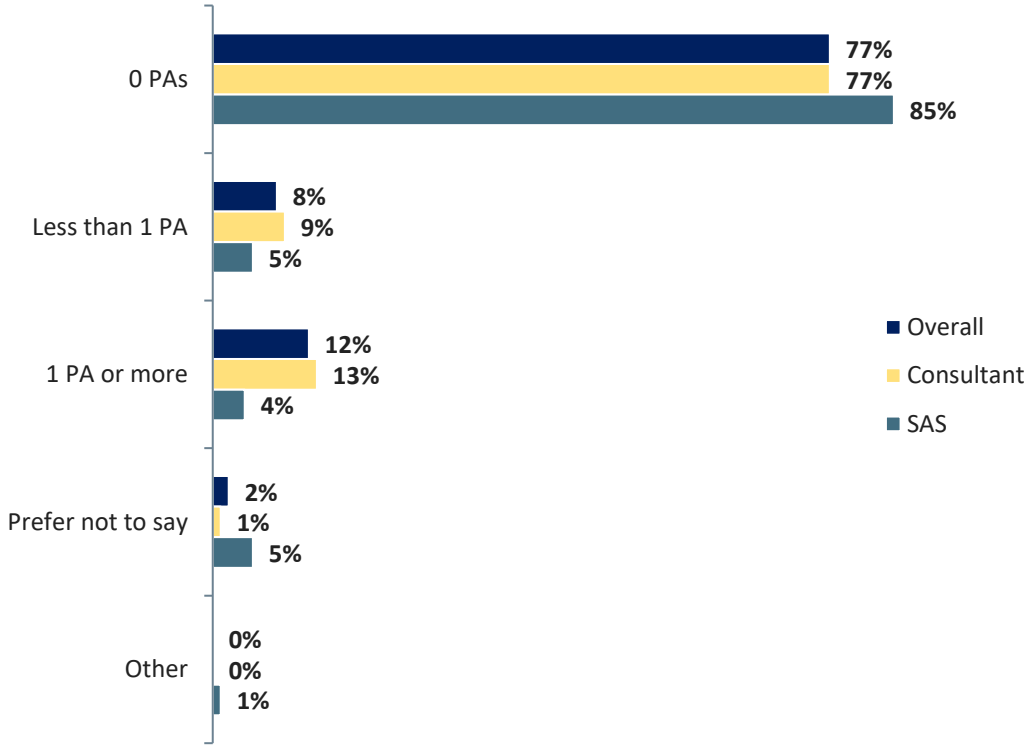


External duties

Figure 20 indicates time allocated in job plans to external duties, such as work for Royal Colleges or national bodies. The responses indicate that contributions to external professional roles are largely undertaken without formal recognition in job plans.

By role, consultants were more likely to have PAs for external duties, with 13% saying they had one or more, compared with 4% of SAS doctors.

Figure 20 – What is the total number of Programmed Activities allocated to external duties per week in your job plan (by career role)?



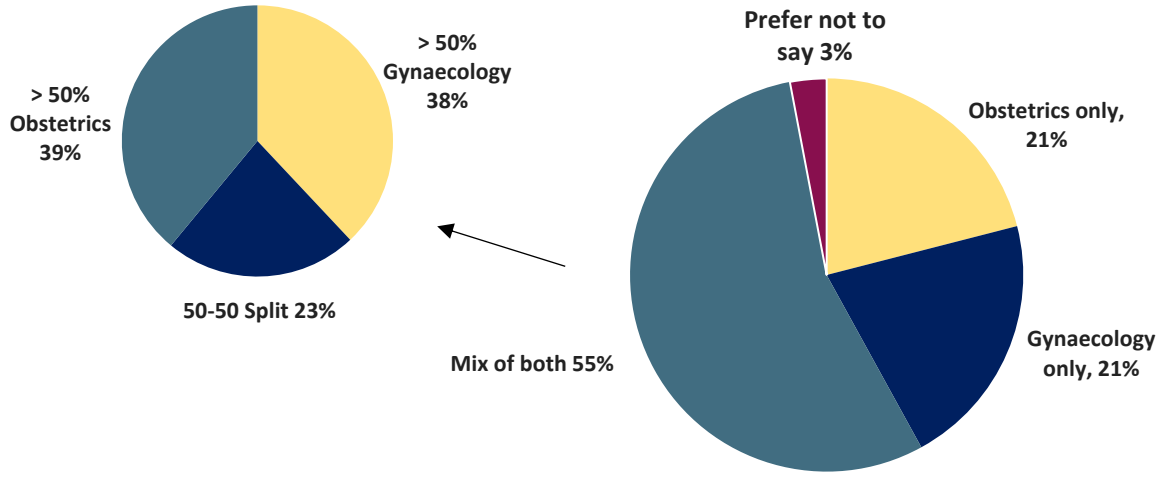
Allocations of Programmed Activities between obstetrics and gynaecology

The census asked those respondents who were on PA job plans about the approximate split of their daytime PAs between obstetrics and gynaecology. The results revealed a wide range of working patterns, with no dominant distribution for either gynaecology or obstetrics.

Figure 21 indicates that 21% work in gynaecology, 21% work in obstetrics and the majority (55%) work across both obstetrics and gynaecology.

Of those working in obstetrics only, 98% were consultants and 2% were SAS doctors. This is compared with 95% of consultants and 5% of SAS doctors working in gynaecology only.

Figure 21 – What is the approximate split of your daytime Programmed Activities across obstetrics and gynaecology?



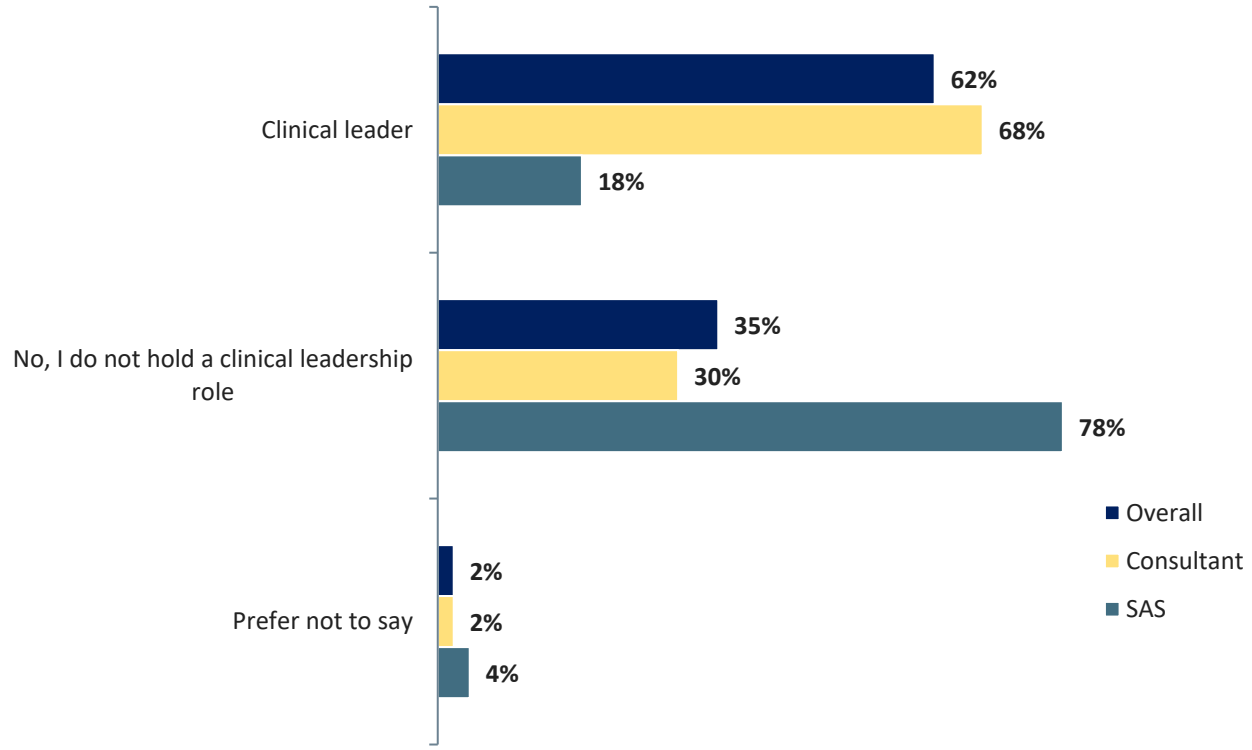
Clinical leadership roles

Holding clinical leadership roles

Figure 22 indicates time allocated for clinical leadership roles. Out of those on a PA job plan, six in ten said they held some sort of clinical leadership role. This was most common among consultants, reflecting their seniority and typical placement within leadership structures.

It also suggests a potential underutilisation of suitably experienced and competent senior SAS doctors.

Figure 22 – Holding a clinical leadership role, by career role

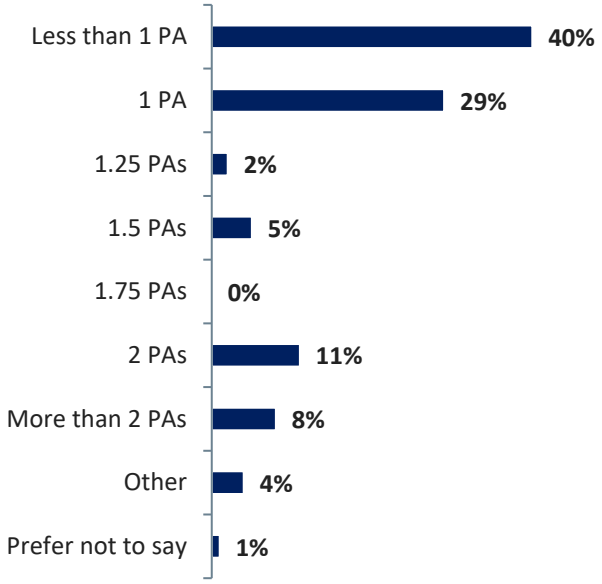


The most common clinical leadership role was Clinical Lead, held by 2% of SAS doctors and 17% of consultants. One in ten doctors working on a PA job plan worked as either a Risk or Governance Lead. Other clinical leadership roles included labour ward lead, fetal monitoring lead, audit lead, and acute gynaecology and early pregnancy lead.

Programmed Activities allocation for clinical leadership responsibilities

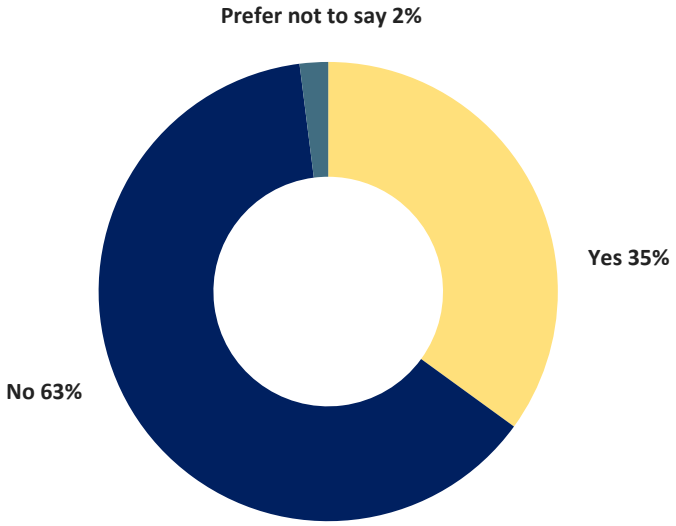
Figure 23 shows that among those who held a clinical leadership role, the allocation of PAs varied widely. Two in five said they were allocated less than one PA per week for their leadership duties. Three in ten reported they were allocated exactly one PA, and one in ten had two PAs.

Figure 23 – How many Programmed Activities are allocated for clinical leadership roles in your job plan?



Over six in ten (63%) of those holding leadership roles felt that the allocated PAs were not sufficient for them to carry out the responsibilities of their role (Figure 24).This suggests a widespread concern that leadership is being undertaken without adequate formal resourcing, consistent with other census findings about insufficient time for SPA responsibilities, working beyond contracted hours and reduced time for non-clinical responsibilities.

Figure 24 – Are the PAs allocated sufficient for your clinical leadership role(s)?

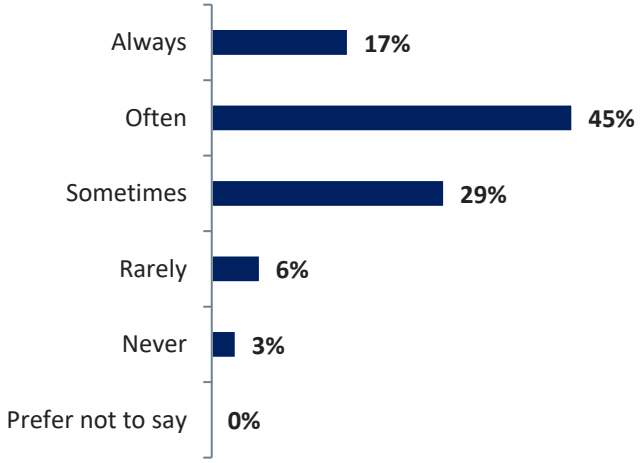


Enjoyment of clinical leadership roles

Despite concerns around time allocation, enjoyment of clinical leadership roles was generally high (Figure 25). Among those who held such a role, 17% said they always enjoyed it and 45% said they often enjoyed it. Only 3% said they never enjoyed the role and 6% said rarely, with the remaining 29% stating they sometimes did.

This finding suggests that clinical leadership remains a valued and rewarding aspect of work for many, even in the context of limited time. It also complements the census findings around the drivers of job satisfaction, where opportunities for development and influence were highlighted as positive aspects of the role.

Figure 25 – Do you enjoy your clinical leadership role(s)?

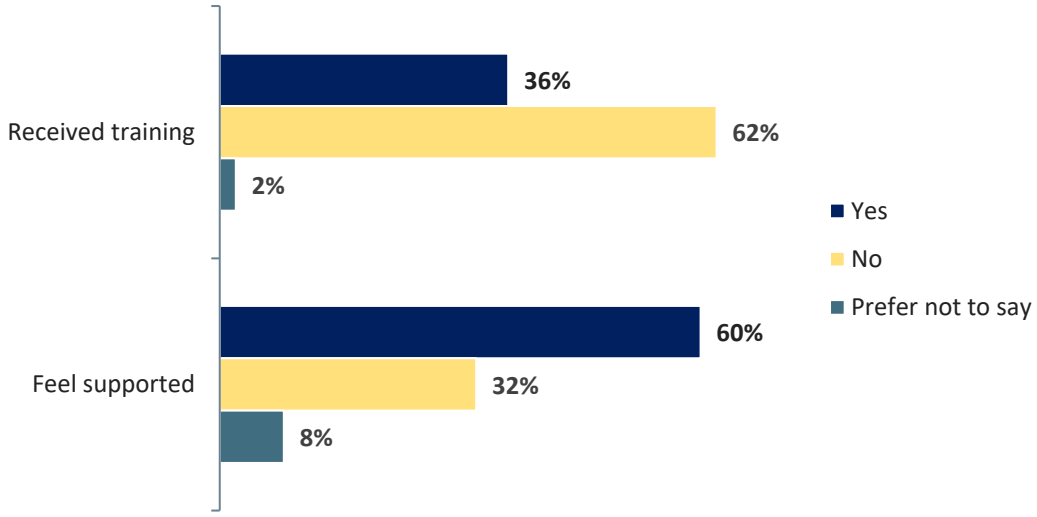


Training and support for clinical leadership roles

Notably, only 36% of those in clinical leadership roles had received formal training, whereas 62% had not received any (Figure 26). This gap suggests that many are stepping into significant leadership responsibilities without the structured preparation to support them. This is echoed in previous findings about unmet development needs and limited access to leadership training opportunities.

When asked whether they feel supported in their leadership roles, 60% said they did. While this indicates that a majority do feel supported, a substantial one in three did not, reinforcing earlier workplace challenges cited.

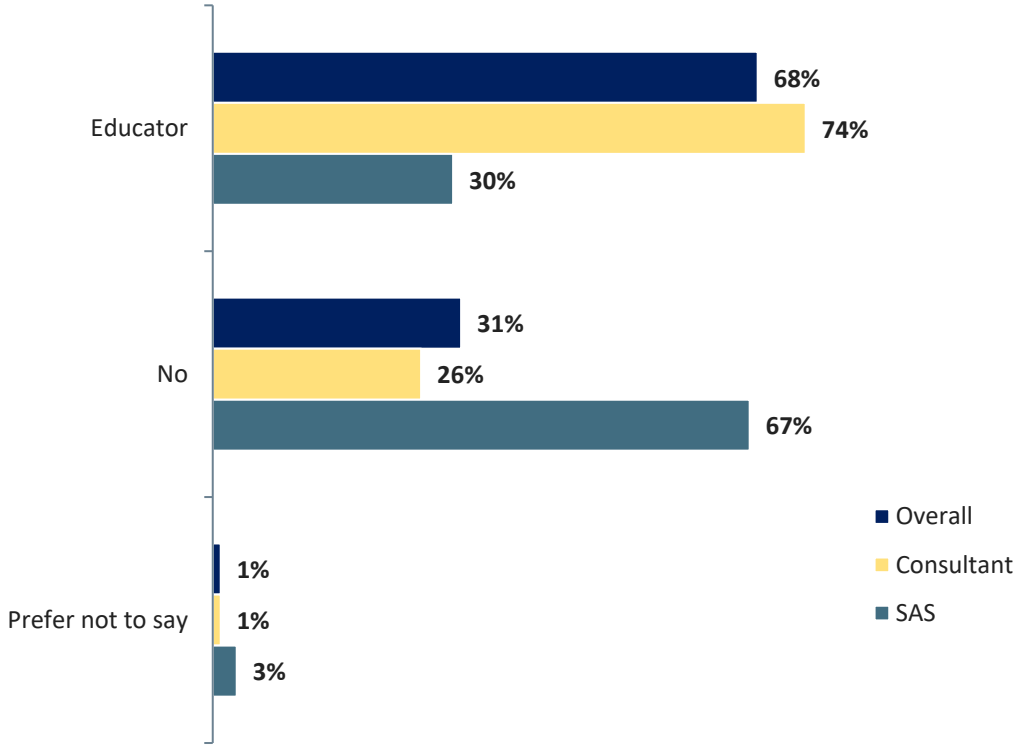
Figure 26 – Did you receive any training for your clinical leadership role(s)?/Do you feel supported in your clinical leadership role(s)?



Educator roles

Figure 27 indicates time allocated in PAs dedicated to educator roles and Table 12 details the type of educator role.

Figure 27 – Holding an educator role by career role



As shown in Table 12, the most common educator role held was Educational Supervisor (48%), which included 52% of consultants on PA job plans. A further 36% were Clinical Supervisors, including 39% of consultants. These roles are vital for the development of the next generation of doctors in the specialty.

Table 12 – Do you hold any of the following educator roles (by career role)?

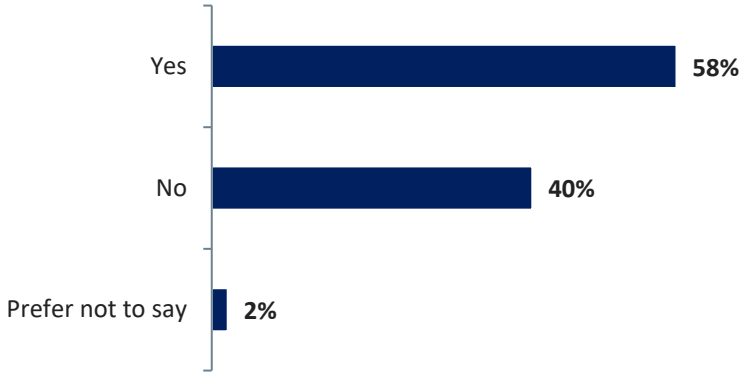
Response	Overall %	% of consultants	% of SAS doctors
Educational Supervisor	48%	52%	9%
Clinical Supervisor	36%	39%	13%
College Tutor	6%	7%	–
Lead for medical students	6%	6%	6%
Training Programme Director	4%	5%	–
Subspecialty Director	2%	2%	–
Special Interest Training Modules (SITM) Director	2%	2%	–
Associate Dean	1%	1%	–
Director of Medical Education/Associate Director of Medical Education	1%	1%	–
Head of School/Deputy Head of School	1%	1%	–
Teaching Fellow	1%	0%	4%
SAS Tutor	1%	0%	4%
LED Tutor	0%	0%	–
No, I do not hold an educational role	31%	26%	67%
Prefer not to say	1%	1%	3%
Other	6%	7%	4%

67% of SAS doctors indicated they do not currently hold any role as educators. With the expansion of medical schools in the UK, the number of Foundation Doctors who will require an Educational Supervisor is likely to increase. Early career doctors working outside of formal training also require an Educational Supervisor. The census findings suggest that senior SAS doctors may be underutilised as educators.[13]

Figure 28 indicates if the time allocated for educator roles is sufficient. When asked whether the allocated PA time was sufficient for their educator role, 40% thought it was insufficient. This contrasts with PA time for clinical leadership roles, where 63% said their PA allocation were not sufficient.

This echoes other findings around the lack of protected time for career development and pressures on doctors to work beyond contracted hours.

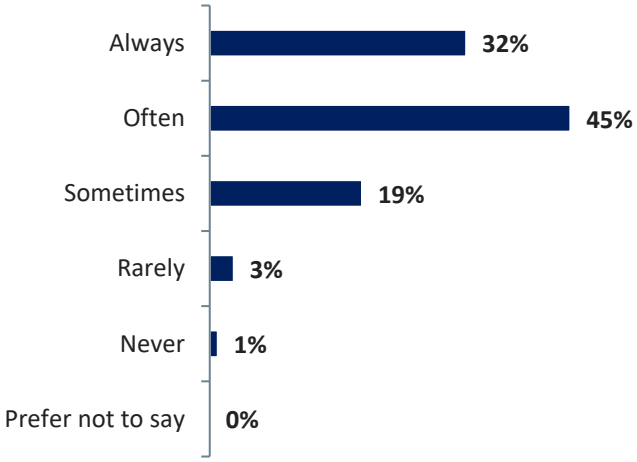
Figure 28 – Are the Programmed Activities allocated sufficient for your educational role(s)?



Enjoyment of educational roles

Despite the issues around PA allocation, many respondents expressed positive sentiments about their experience in educator roles (Figure 29).

Figure 29 – Do you enjoy your educator role(s)?



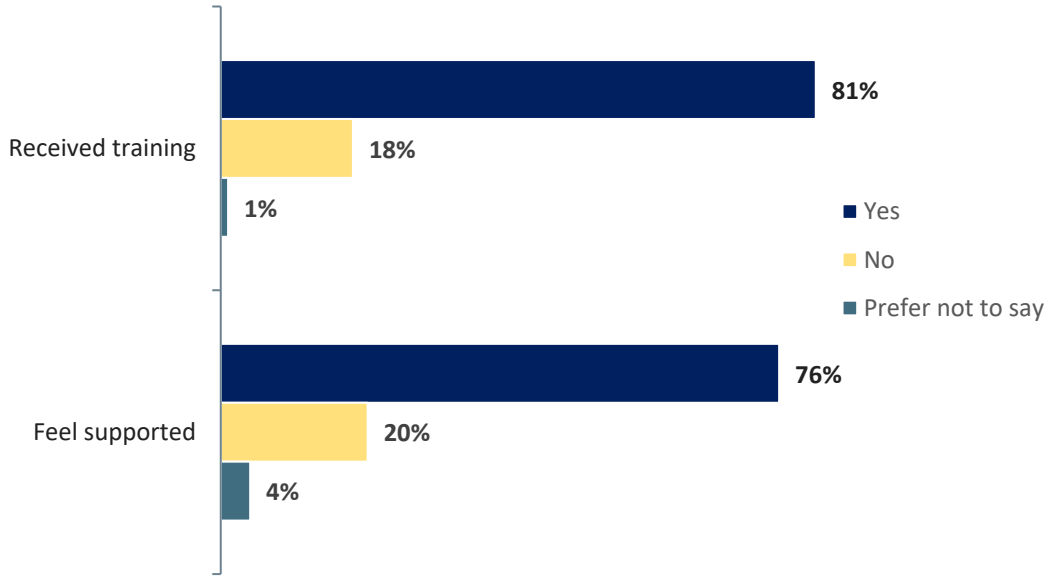
Training and support in educational roles

Encouragingly, most respondents (81%) reported receiving training for their educator roles, and 76% said they feel supported in carrying out their roles. This is in stark contrast with clinical leadership roles, where only 36% reported they had received training and 60% said they felt supported.

Figure 30 displays findings on training and support for educator roles. These findings suggest that once in post, the majority of those in educator roles have access to support structures

and resources. However, the census also found that one in five did not feel supported and did not receive training, indicating some room for improvement.

Figure 30 – Did you receive any training for your educator role(s)?/Do you feel supported in your educator role(s)?



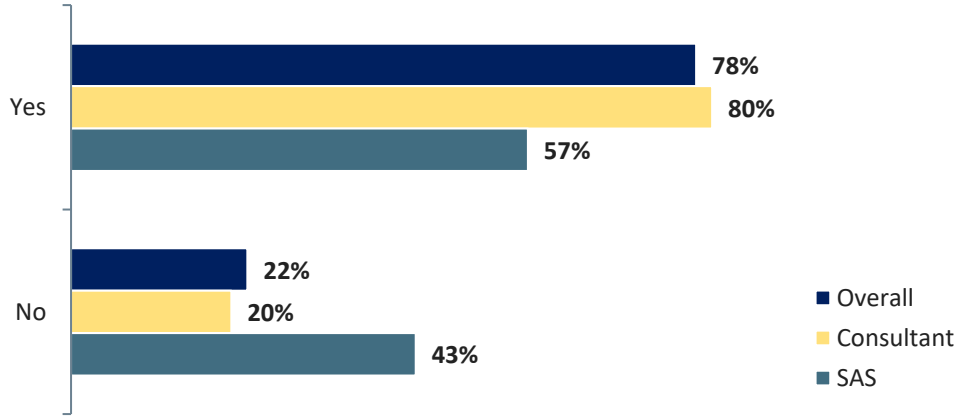
Out-of-hours work

Out-of-hours PAs

The census explored the extent and nature of out-of-hours work among respondents, recognising its impact on workload, wellbeing and work–life balance.

Around three-quarters (78%) of those on PA job plans reported having at least one PA allocated to out of hours work (Figure 31). This figure was higher among consultants (80%) than SAS doctors (57%), but SAS doctors are more likely to be doing resident out-of-hours work (95%) than consultants (11%).

Figure 31 – Are any of your Programmed Activities out of hours (evening, weekend, emergency, on-call etc.) (by career role)?

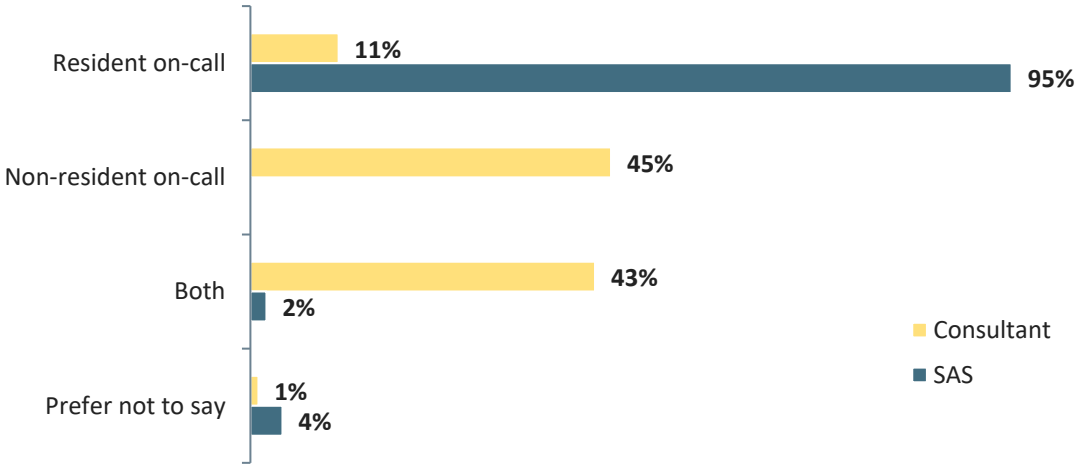


The vast majority (88%) of those aged 55 and under on PA job plans reported that at least one of their PAs was allocated to out-of-hours work. A smaller proportion (52%) of those aged 56 and above said at least some of their PAs were out of hours.

Resident and non-resident on-call work

Among those with out-of-hours PAs, 18% said their work was delivered on a resident on-call basis (Figure 32). This was more likely to be SAS doctors (95%) than consultants (11%).

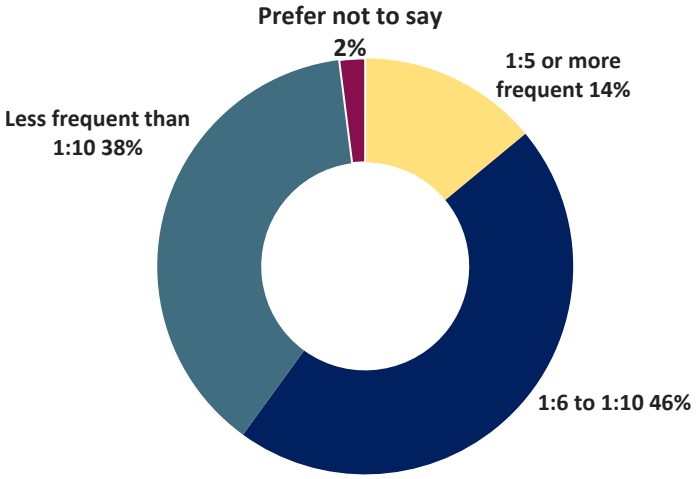
Figure 32 – If you answered yes, is this resident or non-resident work (by career role)?



Frequency of on-call work

In terms of frequency working out of hours, being on-call between one in six and one in ten shifts was most common (46%) (Figure 33). A further 38% reported this was less frequent than one in ten shifts, whilst 14% worked out of hours on one in five shifts or more frequently.

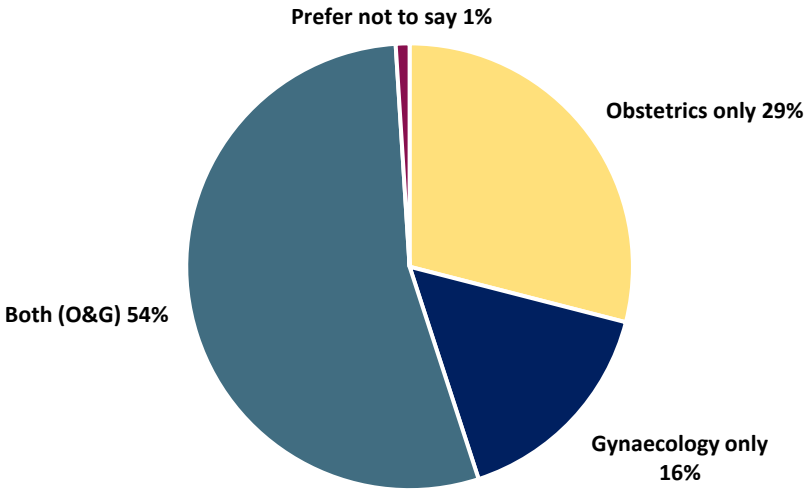
Figure 33 – On average, how often are you on-call?



Clinical area

When asked about the clinical area of their out-of-hours responsibilities, over half (54%) said it was in both obstetrics and gynaecology, 29% in obstetrics only and 16% in gynaecology only roles (Figure 34).

Figure 34 – Is your out-of-hours work in obstetrics, gynaecology or in both O&G?

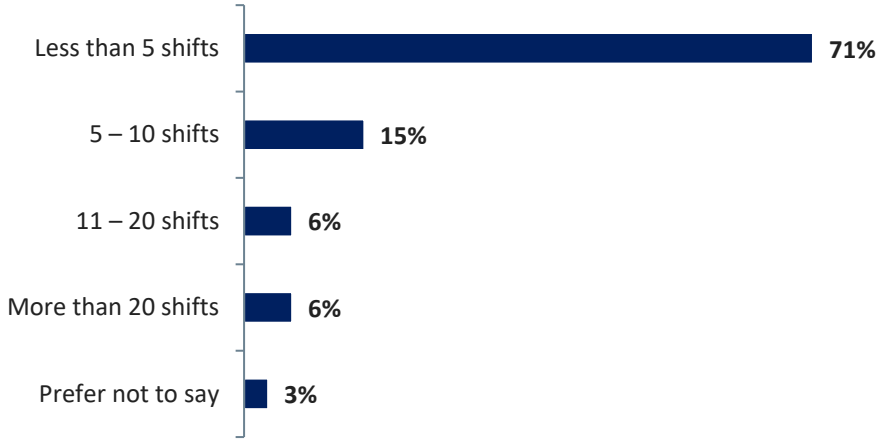


Non-resident on-call cover

The census also asked respondents working non-resident on-call how many times in the last year they had been asked to cover resident shifts. Among this group, the most common response was fewer than five shifts (71%), but small minorities reported it was five to ten shifts (15%), 11 to 20 shifts (6%) and more than 20 shifts (6%) (Figure 35). These figures

suggest that some doctors working non-resident on-call are frequently stepping in to cover resident duties.

Figure 35 – If you normally work non-resident on-call, how many shifts in the last year have you been asked to cover resident on-call?



Compensatory rest after out-of-hours working

The RCOG have produced updated guidance on appropriate standards for compensatory rest for consultants and senior SAS doctors following non-resident on-call activity.[14] The census asked respondents whether they were able to take compensatory rest after non-resident night on-calls, if necessary.

Overall, half of those who work out of hours said they were able to take compensatory rest after non-resident on-call activity, leaving just under half (46%) who do not have the opportunity to do so. This is potentially concerning, given the physical and emotional demands of working unsociable hours, and the potential risks to wellbeing and clinical decision-making when adequate rest is not provided.

The unpredictability of activity out-of-hours poses challenges when organising compensatory rest, but astute approaches to job planning can facilitate this.

Recommendations

Providing O&G doctors with structured, supportive job plans is essential in maintaining high standards of patient care, clinical continuity and work–life balance.

- Job plans should be reviewed regularly to reflect the ever-evolving needs of current service provision. This will enable teams to work together to identify issues and address gaps, both for the individual and the wider team.
- All job plans should have adequate, protected SPA time. This is fundamental to supporting doctors' personal career progression and learning, as well as long-term service development. SPA time covers essential non-clinical activities that contribute to the overall quality of health services. Examples of SPA responsibilities include

teaching, training, continuing professional development, clinical governance, audit and appraisal.

- Given the increasing number of medical students, as well as supporting the educational needs of early career trainees, SAS doctors and LEDs, there is a need for all consultants and suitably qualified/experienced senior SAS doctors to have allocated time in their job plan for the role of Educational Supervisor.[4]
- Compensatory rest is fundamental to patient safety and clinician wellbeing. Fatigue affects both performance and decision-making. Job planning should factor in the recommendations for compensatory rest set out in the RCOG safe staffing guidance.[14]

Future plans and retirement

Intentions to leave the specialty

Most respondents intended to remain in O&G (63%), but a substantial proportion are considering leaving. Overall, 19% said they intend to leave the specialty in the next five years and a further 18% were unsure (Table 13).

At a career role level, consultants and SAS doctors were much more likely to intend to leave the specialty in the next five years (26% and 22%) than trainees (5%) and LEDs (4%).

Although only a small proportion (5%) of trainees said they plan to leave the specialty in the next five years, around a quarter (24%) said they were unsure. This may suggest that although they have not yet taken any hard steps toward leaving, there is a substantial proportion of trainees who are potentially considering this as an option.

Table 13 – Do you intend to leave the O&G specialty within the next five years (by career role)?

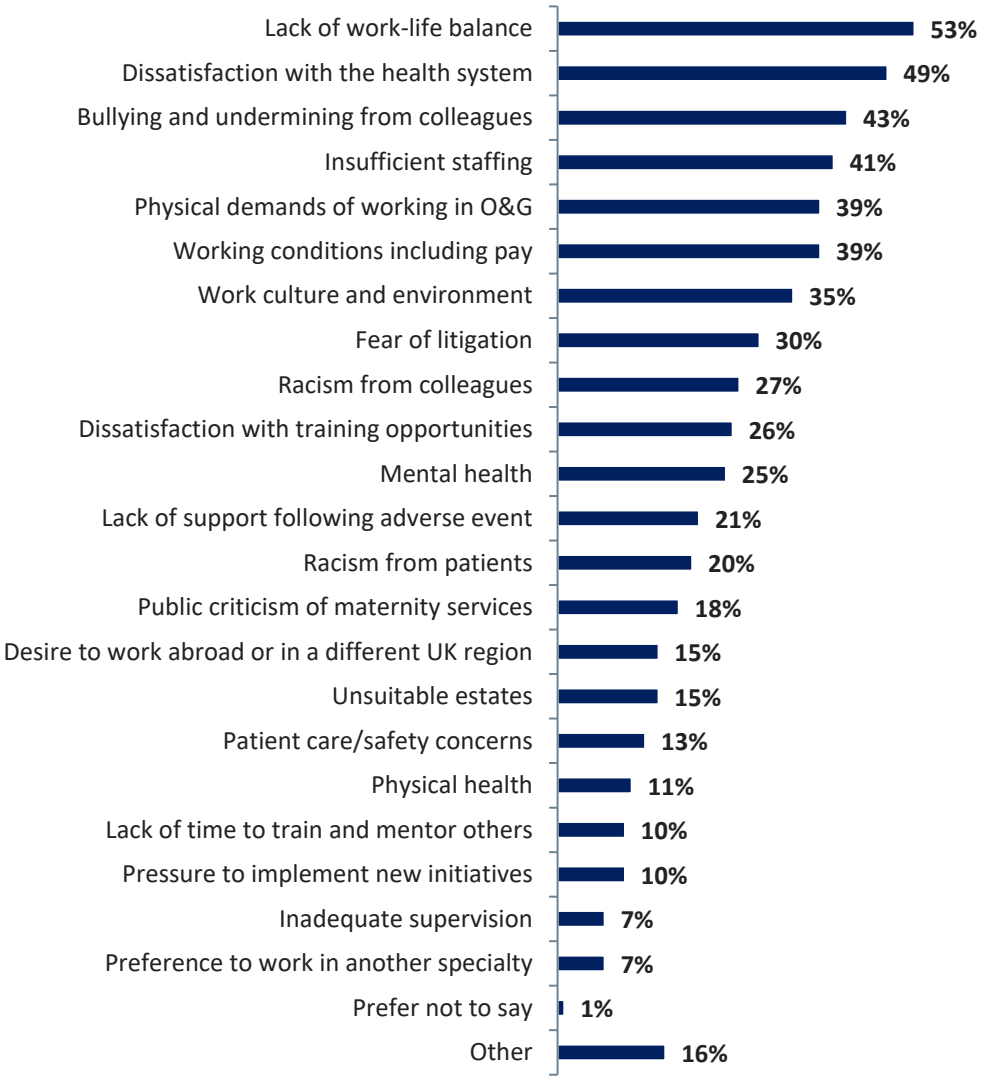
Response	Overall %	% of consultants	% of SAS doctors	% of trainees	% of LEDs
Yes	19%	26%	22%	5%	4%
No	63%	58%	61%	71%	76%
I don't know	18%	16%	17%	24%	20%

Reasons for intending to leave

Figure 36 outlines the reasons cited for potentially leaving the specialty. Among those intending to leave, excluding for retirement (see next section), a lack of work–life balance was the leading reason, followed by dissatisfaction with the health system. Bullying and undermining from colleagues, insufficient staffing, the physical demands of working in O&G

and working conditions (including pay) were all also commonly cited. However, when interpreting the results for this question, note the smaller base than for other questions.

Figure 36 – What reasons would you give for intending to leave the O&G specialty within the next five years?



Retirement

Retirement was the most common reason for planning to leave the specialty over the next five years.

Out of the overall total sample, 13% plan to retire in the next five years. This includes:

- 20% of consultants
- 18% of those in a clinical leadership role
- 18% of those in an educator role.

The census findings also suggest that some doctors are considering early retirement: 48% of those aged 56–60 and 10% of those aged 51–55 intend to retire in the next five years. These figures underline the need for succession planning to retain valuable skills and expertise in the workforce, and particularly the challenges doctors earlier in their careers have expressed with regards to a lack of training in scanning and operating skills. Alongside clinical skills, doctors taking on new leadership responsibilities or moving into a new role as a consultant or specialist would benefit from being mentored by senior colleagues.

In addition, the educator workforce consistently raises time and capacity as key barriers that prevent them from delivering training for others. These pressures are likely to increase with the planned expansion of medical school places, increasing the cohort of doctors that will require supervision.

It is critical that the valuable skills of senior staff approaching retirement can be utilised as clinical educators, trainers and mentors. This also will have a positive impact on the wellbeing of senior clinicians who have dedicated their careers to the profession.

Intentions to reduce clinical sessions

Excluding those who intend to leave the specialty in the next five years, a third said they plan to reduce their clinical sessions within the next five years, and a further fifth (19%) said they were unsure. These results, taken together with the proportion that intend to leave the specialty, indicate there is a significant challenge ahead for future workforce stability, in a workforce that already feels that understaffing is a patient safety concern.

By career role, trainees and consultants (37% and 35%) were most likely to plan to reduce their clinical sessions.

Recommendations

Overall, 13% of respondents plan to retire in the next five years. This has implications in terms of the number of new posts needed and a concerning loss of experienced senior doctors, at a time when younger doctors are expressing concerns about lack of training in scanning and operating skills. This outlines a need to support those approaching retirement, by:

- Supporting senior clinicians to work flexibly if they choose to – this is fundamental to their wellbeing and the retention of valued skills and expertise.
- Providing opportunities for mentorship, especially of new consultants and specialist (senior SAS) doctors, and succession planning. This will retain a wealth of expertise and knowledge within the workforce, whilst also supporting the future workforce.

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Appendix 1: Methodology

Survey design

The RCOG 2025 Workforce Census was developed collaboratively by RCOG and Enventure Research. The questionnaire built upon the 2018 census and the 2022 workforce planning tool, with updated and expanded content to reflect current workforce issues and support detailed subgroup analysis.

The survey was structured into key thematic areas, including:

- Respondent demographics and employment details
- Career development and training
- Job planning and professional responsibilities
- Workplace challenges and wellbeing
- Provision of abortion care
- Retirement intentions and future workforce planning.

A mix of closed, multiple-response, Likert scale and open-ended questions were used to ensure comprehensive data collection while keeping the survey manageable in length. The survey was designed to have an average completion time of around 10–15 minutes.

Administration and promotion

The census was conducted online from **24 March to 2 May 2025**, using both personalised and open-access links. The survey was promoted to:

- RCOG Fellows, Members, Trainees and Associates
- Lapsed members
- Wider O&G workforce, including non-members.

A detailed marketing schedule was implemented, combining:

- Direct email campaigns (including targeted reminders to non-responders)
- Social media promotion via Facebook, LinkedIn and X (formerly Twitter)
- Paid LinkedIn advertising
- Communications via professional networks, including Clinical Directors, Council representatives and specialist societies.

Open-access links were distributed to help reach doctors outside of RCOG membership and ensure the census was inclusive of the wider UK O&G workforce.

Sample

A total of 1,715 responses were received. From these, 126 were screened out where respondents said they were not an obstetrician and/or gynaecologist working in the UK. This provided a total of **1,589 valid responses** for analysis. With the survey sent out by email to 8,128 potential respondents, this represents a **response rate of 19.5%**.

Responses were received from a mix of consultants, SAS doctors, trainees, LEDs and others working in O&G roles, covered all UK regions and represented a wide range of demographics.

While the sample does not represent a formal census of the entire workforce, it is sufficiently large and diverse to allow robust analysis and meaningful subgroup comparisons. Where appropriate, data has been tested for statistical significance between subgroups.

Data processing and analysis

Enventure Research carried out all data cleaning, processing and analysis in accordance with Market Research Society guidelines and the UK GDPR.

- Responses were cleaned for erroneous responses and to ensure that routing logic was applied as intended.
- Open-ended responses were thematically coded for analysis.
- Where relevant, cross-tabulations and z-tests were used to identify significant differences between groups (e.g. role, region, etc.).

Detailed results are presented, split into chapters in this report, with narrative interpretation supported by data tables and charts.

Appendix 2: Interpreting the findings

Percentages in figures

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

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

Response options

For the analysis of certain questions, response options have been grouped together to provide an overall level. For example, in some instances 'strongly agree' and 'agree' have been grouped and shown as 'total agree'. Where combined percentages do not equal the overall level reported (being 1% higher or lower), this is due to percentages being rounded to the nearest whole number.

Subgroup analysis

Subgroup analysis has been undertaken to explore the results provided by different groups, such as role, region, working status and key demographics, such as age group, gender and ethnic group. This analysis has only been carried out where the sample size is seen to be sufficient for comment, as smaller base sizes tend to produce less reliable results due to a wider margin of error. Where sample sizes were not large enough, subgroups have been combined to create larger groups if possible, such as MTI trainees being combined with LEDs.

It should be noted that the percentages shown in the subgroup analysis reflect the proportion of the subgroup who answered the question and gave a particular response.

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

Thematic coding of open-ended responses

The survey included a few questions that allowed respondents to provide comments through free-text responses. To quantitatively analyse these responses, all free-text responses were read in detail, and a coding frame was developed for each question based on the key themes emerging. This allowed for categorisation of the themes emerging in the comments. This analysis has been presented as tables in this report, showing the frequencies of each theme from the comments, along with example comments for the most common themes. It should be noted that a single comment from a respondent could have been assigned more than one theme. This can result in a higher number of comments than the base number of respondents to a question. It should also be noted that wording for themes reflects the language and terminology used by respondents, rather than that used by RCOG.

Confidence in the data

The RCOG 2025 Workforce Census received 1,589 valid responses from doctors working in obstetrics and gynaecology across the UK. While the survey was self-selecting and not a random probability sample, the total number of responses represents a substantial proportion of the UK O&G workforce. For context, if the responses were drawn from a random sample of a population of 7,500 (a rough estimate of the total O&G doctor population in the UK), this would yield a notional margin of error of approximately ±2.2% at the 95% confidence level. However, because this was a voluntary, self-selecting sample, this margin of error should be treated as a useful reference point only, not a precise statistical measure. Self-selection introduces the possibility of response bias – for example, those with strong views or certain experiences may have been more likely to take part.

While the survey response was not a probability sample, the size and diversity of responses offer a rich and meaningful dataset from which to draw insights. Several factors support confidence in the reliability of the data collected:

- Respondents represent a broad cross-section of the O&G workforce, including consultants, SAS doctors, trainees and LEDs, and responses were received from all UK regions and nations.
- The survey reached both RCOG members and non-members, helping to ensure inclusivity.
- A comprehensive promotion campaign helped encourage widespread engagement across different roles and demographics.
- All responses were reviewed and cleaned by Enventure Research and quality checks ensured that routing logic was applied as intended.

- While some underrepresentation may exist (e.g. among doctors on extended leave or non-members), the sample includes all major O&G roles and covers a broad range of demographic and professional backgrounds.
- Statistically significant differences between groups have been tested using the z-test at the 95% confidence level where appropriate, and findings are presented with attention to base sizes.
- All data processing and reporting have been carried out in accordance with the Market Research Society Code of Conduct and UK GDPR, and results have been reported transparently, with limitations and caveats clearly noted throughout.

While the voluntary nature of the survey introduces some limitations, the size and breadth of the response, combined with rigorous data handling and analysis, provide a strong level of confidence in the findings presented in this report.

Royal College of Obstetricians & Gynaecologists

A note on language

Within this document the terms ‘woman’ and ‘women’s health’ are used. However, it is important to acknowledge that it is not only people who identify as women for whom it is necessary to access women’s health and reproductive services in order to maintain their gynaecological health and reproductive wellbeing.

Gynaecological and obstetric services and delivery of care must therefore be appropriate, inclusive and sensitive to the needs of those individuals whose gender identity does not align with the sex they were assigned at birth.

Find out more

The Royal College of Obstetricians and Gynaecologists works to improve women’s healthcare across the world. We’re committed to developing the accessibility and quality of education, training and assessments for doctors wishing to specialise in O&G.

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