



# **UK INR WORKFORCE SURVEY**

**June 2026**

## Introduction

Despite substantial progress with mechanical thrombectomy (MT) provision in the UK, access remains uneven. In October 2023 the Getting it Right First Time (GIRFT) mechanical thrombectomy review reported that only around 3.4% of stroke patients were being referred for thrombectomy, against the NHS Long Term Plan ambition of 10%, and identified workforce as one of the core domains required for improvement. Despite recent progress (16 of 28 UK centres now 24/7), national reporting indicates that as of April 2026, universal 24/7 thrombectomy access in England had still not been achieved. Parliamentary answers in March 2026 confirmed additional targeted national investment to support 24/7 provision, including funding directed to regions where round-the-clock access, had not yet been secured.

Against this backdrop, the UK neurointerventional workforce has grown markedly. The March 2025 UKNG workforce dataset shows an increase in the total UK neurointerventionalist workforce from 52 in 2014 to 154 in 2025, with growth particularly evident since 2022. In 2025, the workforce comprised 135 Interventional Neuroradiologists (INRs), 14 interventional radiologists, 4 neurosurgeons and 2 diagnostic neuroradiologists. England accounted for 135 of the 154 UK operators, with Scotland, Wales and Northern Ireland accounting for 8, 4 and 7 respectively. Importantly, the 2025 data also shows that in England, no centre was left with only one, two or three operators, whereas in 2022 several centres remained in those vulnerable categories.

This growth is encouraging and reflects major efforts by UK neurointerventional units, the UK Interventional Group (UKNG - the UK INR specialist interest group), commissioners, integrated delivery networks and national programmes to expand capacity. However, headcount alone does not equate to sustainable access. A resilient INR service must cover emergency thrombectomy, subarachnoid haemorrhage, elective aneurysm and arteriovenous malformation work, spinal and paediatric neurointervention in selected centres, diagnostic angiography, multiple disciplinary team (MDT) support, training, governance, research and quality assurance. It must also provide safe out-of-hours rotas, maintain operator experience, support professional wellbeing and create reliable pathways for new trainees and credentialed colleagues.

This report therefore sets out to describe the current UK INR workforce, quantify recent change, identify remaining gaps in regional and centre-level resilience, and frame the workforce requirements needed to deliver equitable, safe and sustainable neurointerventional care. The key question is no longer whether the UK workforce is growing; it is whether that growth is sufficient, appropriately distributed and supported by the infrastructure needed to deliver 24/7 neurovascular care for every eligible patient.

## Selection of sites and survey responses

The UK INR workforce survey was designed as a centre-level service survey, rather than an individual operator survey. Sites were selected on the basis that they provide, or contribute to neurointerventional services within the UK neurovascular network. The sampling frame was aligned to the UKNG workforce mapping exercise, which identifies 29 UK regional/tertiary neuroscience centres (inclusive of GOSH).

Survey inclusion therefore focused on NHS trusts, health boards or hospital sites delivering INR activity, including comprehensive stroke centres, neurosurgical centres, regional neuroscience centres and specialist services such as paediatric neurointervention. Each return was treated as a single centre-level response, even where the service covered more than one hospital site or where a trust-level response represented activity delivered across a networked service.

At the time of analysis, 29 completed returns had been entered into the workforce matrix. These included responses from centres in London, the South East, South West, Midlands, North West, North East and Yorkshire, East of England, Scotland, Wales and Northern Ireland. The dataset therefore provides complete UK-wide coverage across the major INR-providing regions, while recognising that the survey is based on submitted returns and should not be interpreted as a complete census of every potential thrombectomy or neurointerventional site unless explicitly reconciled against the full UKNG site list.

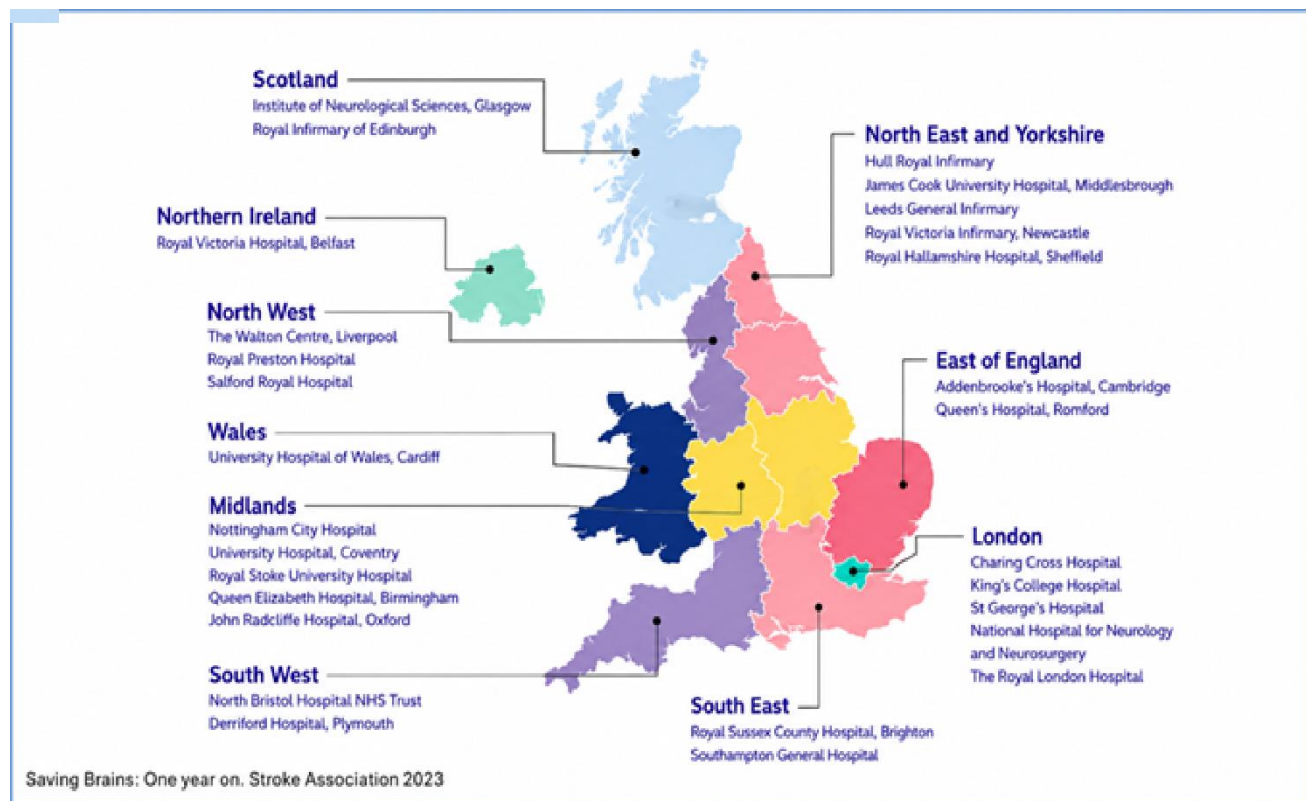
The responding sites included the following trusts or services: Barts Health NHS Trust, Great Ormond Street Hospital, King's College Hospital London, National Hospital for Neurology and Neurosurgery, Barking Havering and Redbridge University Hospitals NHS Trust, St George's Hospital, Imperial/Charing Cross Hospitals, University

Hospitals Sussex, North Bristol NHS Trust, University Hospitals Plymouth, Oxford University Hospitals, University Hospital Southampton, Nottingham University Hospitals, University Hospitals Birmingham, University Hospitals Coventry & Warwickshire, University Hospitals of North Midlands / Royal Stoke University Hospital, Lancashire Teaching Hospitals, The Walton Centre, Northern Care Alliance/Salford, Newcastle upon Tyne Hospitals, Leeds Teaching Hospitals, Sheffield, Hull University Teaching Hospitals, Cambridge University Hospitals, NHS Greater Glasgow and Clyde, NHS Lothian, Cardiff and Vale UHB, Belfast HSC Trust and South Tees NHS Foundation Trust. The sites' geographical location by region can be seen in Appendix A.

Responses were accepted from appropriate local clinical leads or consultant representatives with knowledge of the INR workforce, rota arrangements, thrombectomy provision, training capacity and recruitment position at their centre. The role of respondent was coded where supplied, most commonly as either clinical lead or consultant INR. Where a response contained narrative clarification, ranges, future-dated appointments or mixed numeric/text entries, these were retained rather than forced into a single numeric value, to preserve the meaning of the original submission.

Overall, the responding cohort represents a 100% response rate and a geographically complete sample of UK INR service provision. It is sufficient to describe national workforce themes, regional variation, rota resilience, training capacity and recruitment pressures. However, any centre-level denominators in the report should state whether they refer to the 29 responding centres or to the wider UKNG mapping denominator of UK neuroscience and thrombectomy-capable centres.

Modified Map -Saving Brains Stroke association 2023



## Current INR workforce

The survey demonstrates a substantial consultant INR workforce across the responding UK centres. Across 29 analysable centre returns, the current reported INR consultant headcount is 152 operators. This figure uses each centre's submitted total headcount where available; where the headcount field was blank, the submitted substantive

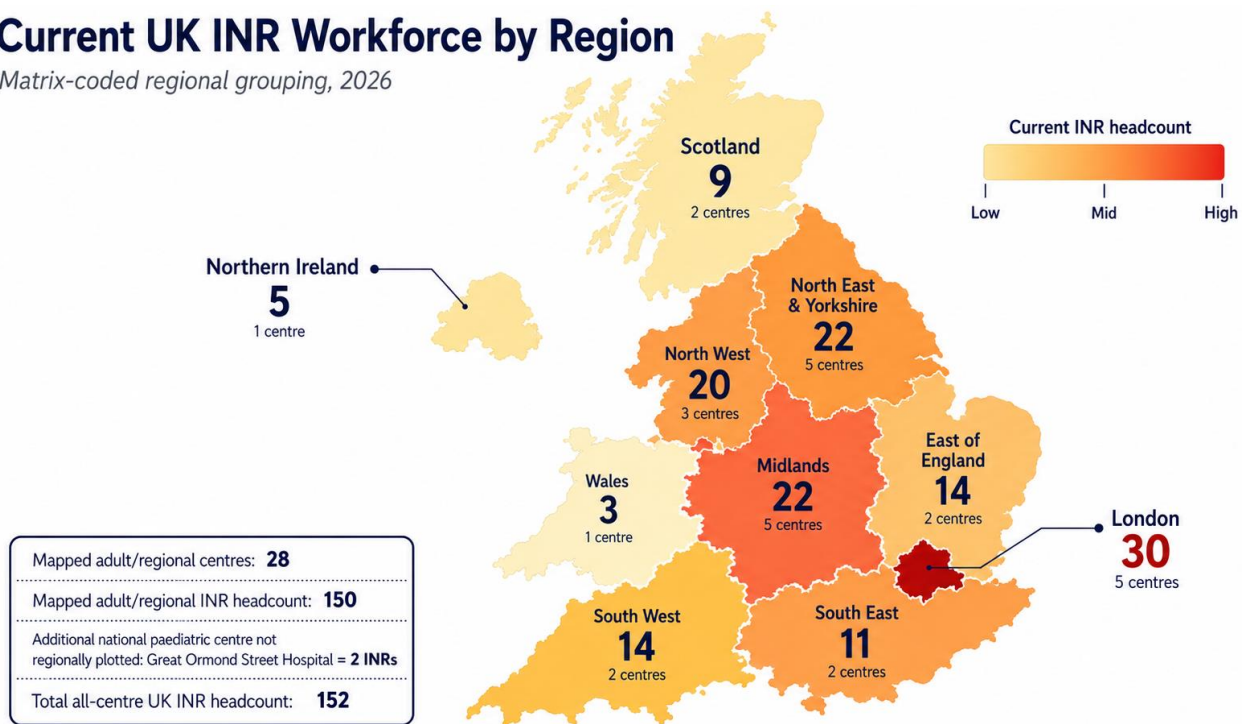
consultant establishment was used as the best available centre-level proxy to provide the fully established INR head count.

This survey finding is consistent with the broader UKNG March 2025 workforce position, which recorded 154 neurointerventionalists across the UK, rising from 128 in 2024 and 110 in 2022. The same UKNG dataset recorded 135 INRs, 14 interventional radiologists, 4 neurosurgeons and 2 diagnostic neuroradiologists contributing to the UK neurointerventional workforce in 2025.

Region	Responding centres	Current INR headcount*
London	6	32
South East	2	11
South West	2	14
Midlands	5	22
North West	3	20
North East & Yorkshire	5	22
East of England	2	14
Scotland	2	9
Wales	1	3
Northern Ireland	1	5
Total	29	152

## Current UK INR Workforce by Region

Matrix-coded regional grouping, 2026



## Non-INR operators contributing to MT rotas

A small but important component of the reported MT rota workforce is made up of non-INR operators. Across the 29 responding centres, 19 non-INR operators were reported as contributing to MT rotas, distributed across 12 centres. These contributors were most commonly from interventional radiology or vascular interventional radiology backgrounds, with additional representation from neurosurgery and, in one case, neurology. Reported examples

included IR operators in the East of England (BHRUT and Cambridge) and the Midlands (Coventry and North Midlands), vascular IR operators in Hull and Belfast, neurosurgical contributors in Southampton, Leeds and Manchester, and a neurology-background operator in Plymouth. Oxford also described a dual-trained operator with overseas INR training who undertakes general diagnostic radiology, ablation work and neurointervention.

By region, non-INR MT rota contributors were reported in the South East, South West, Midlands, North West, North East & Yorkshire, East of England, and Northern Ireland. No non-INR MT operators were reported in the submitted returns from London, Scotland or Wales. These figures should be interpreted cautiously because the survey captured self-reported rota composition, and local definitions may vary. In particular, some respondents may have counted any non-radiology or non-substantive thrombectomy contributor, while others may have restricted the field to clinicians without formal INR consultant posts. Nonetheless, the data show that non-INR operators make a measurable contribution to current MT rota capacity in several regions, particularly where services are seeking to maintain or expand 24/7 cover.

### Total interventional workforce

Operator group	Headcount	Share of total
INR operators	152	88.9%
Non-INR operators	19	11.1%
Total	171	100%

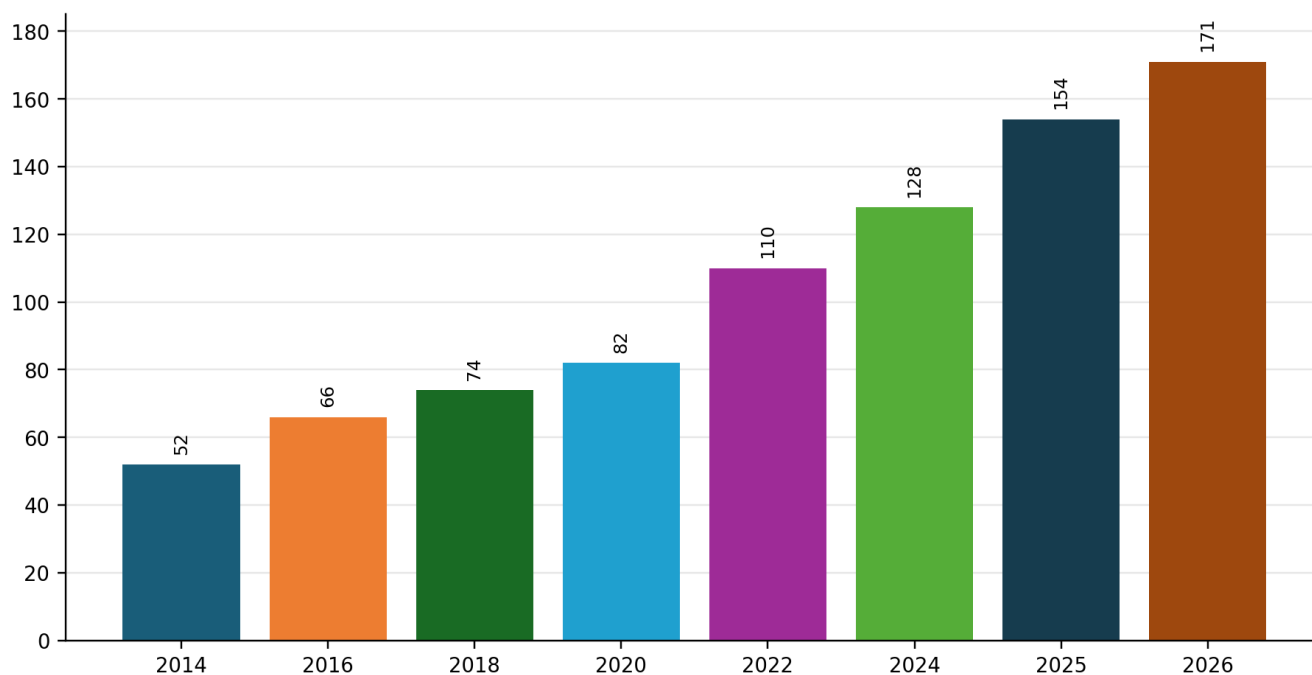
This suggests that UK neurointerventional service delivery is still principally dependent on consultant INRs, with non-INR operators providing a small but strategically important supplementary workforce. The non-INR group does not appear large enough to fundamentally alter the national workforce model, but it may make a meaningful difference locally, particularly in centres trying to maintain sustainable emergency rotas, expand thrombectomy provision, or bridge gaps while INR recruitment and training pipelines mature. This total interventional workforce denominator includes non-INR MT operators and should not be treated as interchangeable with the consultant INR headcount or the minimum INR workforce requirement.

The data should therefore be interpreted as showing limited workforce diversification rather than workforce substitution. Non-INR operators represent around one in ten of the reported operator pool. Their contribution may improve rota resilience in selected centres, but the scale of the numbers means that the UK workforce remains highly vulnerable to pressures affecting the INR consultant pipeline, including training capacity, recruitment, retirement, less-than-full-time working and competing elective/emergency workload.

A cautious interpretation is that non-INR participation is currently an adjunct to INR capacity, not a replacement for it. It may be most valuable where operators have relevant endovascular expertise and are integrated into established neurointerventional governance, training, audit and complication-management structures. However, because the survey records headcount rather than detailed case volume, competence level, independent practice status or out-of-hours commitment, these 19 operators should not automatically be assumed to provide equivalent capacity to 19 full-time consultant INRs.

Table showing trending increase in the number of operators between 2014 and 2026.

### TOTAL REPORTED NEUROINTERVENTIONAL OPERATORS - UK



## Aneurysm work volume

Annual aneurysm coiling volume was reported by 24 of 29 centres. Using mid-points for submitted ranges and conservative lower-bound estimates for non entries, the reported annual aneurysm treatment workload was approximately 3,605 cases across responding centres. Excluding Great Ormond Street, this equates to approximately 3,600 adult aneurysm cases across 23 adult centres, with a median centre volume of 150 cases per year and a range from 60 to 275 cases per year. Reported volumes were highest in London at approximately 645 adult cases, followed by the Midlands at 625, Scotland at 525, the North West at 460, and North East & Yorkshire at 430. These data show that aneurysm work remains a substantial component of UK neurointerventional practice and reinforces that workforce planning cannot be based on thrombectomy activity alone. A sustainable INR workforce must preserve capacity and training exposure for aneurysm treatment, subarachnoid haemorrhage care and wider complex neurovascular work, alongside expansion of emergency MT provision.

## Current training pipeline

The confirmed current trainees are distributed across a broad range of UK centres, but the pipeline is uneven. Four centres report three current trainees each: Manchester/Preston, Oxford, Birmingham and Hull. Six centres report two current trainees each: Belfast, Southampton, Queen Square, Cambridge, Plymouth and Sheffield. A further thirteen centres report one current trainee each: Newcastle, Liverpool, Romford, Glasgow, St George's, King's, the Royal London, Edinburgh, Stoke, Nottingham, Brighton, Cardiff and Coventry.

Two centres are listed with no confirmed current trainee on this tab: Leeds and Bristol. Bristol has recently confirmed their trainees have completed or are applying for consultancy. Leeds have recently completed training a consultant neurosurgeon through the credential process and are training a stroke physician in mechanical thrombectomy. Both centres are training 2 new fellows from September 2026.

Overall, the current UK INR trainee pipeline appears stable. The confirmed figure of 40 current trainees should not be interpreted as 40 imminent consultant INRs.

Trainees will be at different stages of training, and future consultant output will depend on completion of training, fellowship progression, consultant post availability, retention within UK INR and individual career choices. We are estimating approximately 13 trainees completing training every year.

## Visiting / international trainees

Six responding centres reported current international or visiting trainee activity. These were concentrated mainly in London, with additional entries from Bristol and Edinburgh. Edinburgh specifically reported an RCR MTI fellow from Malaysia. Leeds also reported a visiting fellow from Hull, but this appears to represent UK inter-centre visiting training rather than international recruitment and has therefore not been included in the international trainee count.

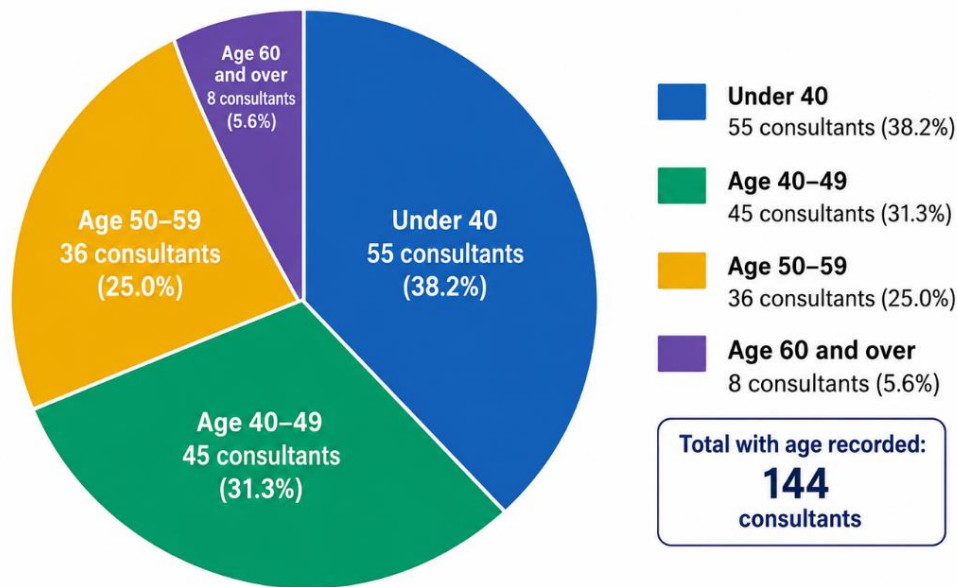
Centre	Current 2025-6
Charing Cross	3
Newcastle	1
Manchester/Preston	3
Belfast	2
Liverpool	1
Oxford	3
Southampton	2
Romford	1
Glasgow	1
Birmingham	3
St Georges	1
Hull	3
Kings	1
Queens Square	2
Royal London	1
Edinburgh	1
Leeds	0
Stoke	1 (hybrid IR/INR)
Nottingham	1
Cambridge	2
Plymouth	2
Brighton	1
Sheffield	2
Bristol	0
Cardiff	1
Coventry	1
<b>Total</b>	<b>40</b>

## Potential UK INR retirement forecast

The current UK INR consultant workforce has a relatively young age profile, with just under 70% of consultants aged under 50. This provides a reassuring degree of medium-term workforce stability, although almost one-third are aged 50 or over and a smaller group is already approaching retirement. The age distribution shown below therefore provides important context for the subsequent analysis of anticipated retirements and future replacement requirements.

### Age Distribution of UK INR Workforce

29-centre workforce matrix, 2026



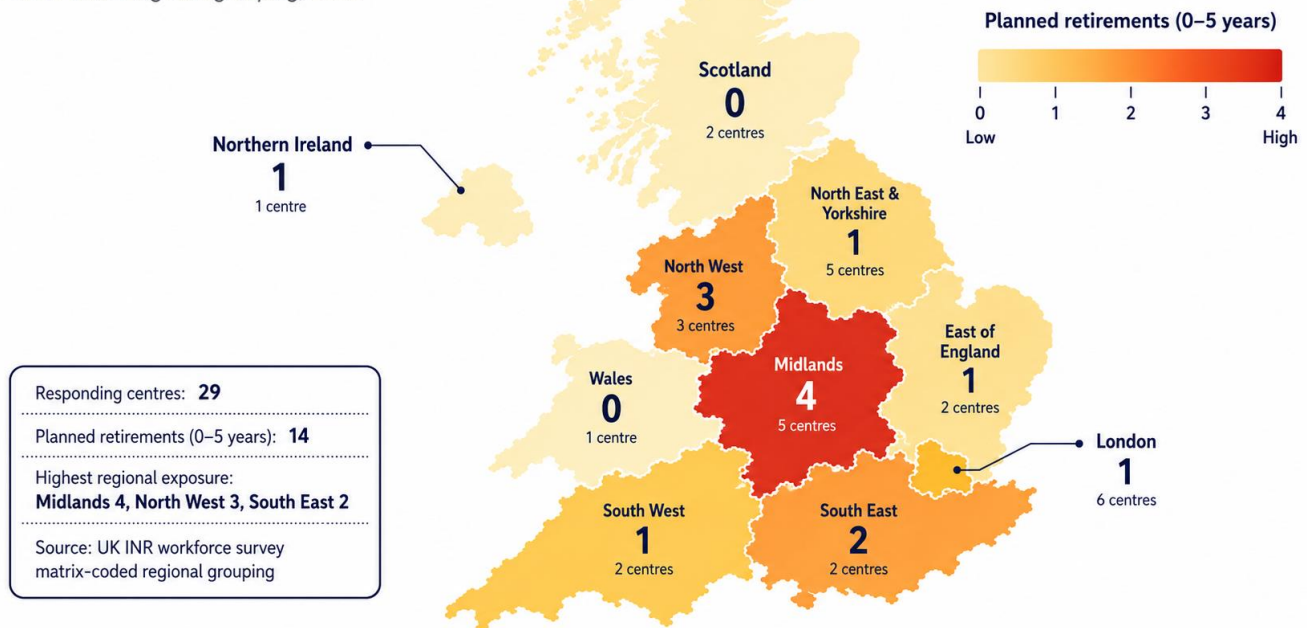
- Age recorded for 144 consultants; total workforce headcount 152.
- 8 net headcount records were not completely age classified.

Region	Retirements 0-5 years	Retirements 6-10 years	Total expected retirements within 10 years
London	1	3	4
South East	2	2	4
South West	1	1	2
Midlands	4	2	6
North West	3	3	6
North East & Yorkshire	1	4	5
East of England	1	0	1
Scotland	0	1	1
Wales	0	0	0
Northern Ireland	1	1	2
<b>Total</b>	<b>14</b>	<b>17</b>	<b>31</b>

Despite age not being completed for 8 consultants, the replies identify 14 expected INR retirements within the next five years and a further 17 within six to ten years, representing approximately 20% of the current reported INR headcount of 152. This could correlate with the age data and creates a replacement requirement. The risk is regionally uneven, with the Midlands and North West reporting the highest near-term retirement exposure, followed by the South East. The current trainee pipeline is active and would be sufficient to expand services and also replace predictable consultant attrition over the next decade.

# Planned UK INR Retirements in the Next 5 Years

Matrix-coded regional grouping, 2026



## Mechanical thrombectomy expansion and current provision

Mechanical thrombectomy provision has expanded substantially across the UK, but the pace and maturity of expansion remain uneven between nations. In England, MT expansion is the most advanced, with 16 out of 24 regional centres now providing 24/7 access, although universal round-the-clock provision has still not been achieved. In Scotland, thrombectomy is delivered through a national hub-and-spoke model centred on Glasgow, Edinburgh and Dundee, but expansion has been slower and more variable; Scottish planning documents describe continuing inequity of access and retain 24/7 national provision as a long-term ambition rather than a fully delivered service. (Dundee is not a INR neuroscience centre and has not formally been included in this survey). In Wales, provision has historically depended heavily on cross-border access to English services, particularly for patients outside Cardiff, although South Wales access expanded in July 2025 from a limited Cardiff-only weekday service to a broader weekday service at University Hospital Wales. The 2026 Welsh stroke quality statement sets an explicit ambition to expand toward a national round-the-clock thrombectomy service, but current planning expectations indicate that this remains developmental rather than fully established. Overall, MT expansion across the UK has moved from isolated provision toward a more systematic national model, but England remains closest to full 24/7 delivery, Scotland is progressing through a nationally planned regional hub model, and Wales remains at an earlier stage of developing comprehensive domestic access.

## Current consultant vacancies in the UK

The survey identifies 15 current consultant INR vacancies across nine responding centres. Vacancies are distributed across several regions, suggesting that recruitment pressure is national rather than confined to isolated centres. Some posts are already in progress or awaiting start dates, but others have been vacant for 12 months or longer. In addition to these current vacancies, future workforce demand will need to be balanced between trainee output and planned retirement rather than rapid service expansion. List of vacancies can be seen in Appendix B.

## Workforce sustainability

Survey responses on workforce sustainability suggest optimism. Among centres providing a response, 16 reported that the UK INR workforce is currently sufficient to meet demand, 2 felt it was not sufficient, and 6 were unsure. Looking ahead, 18 centres anticipated an adequate workforce position in 10 years without intervention, while 6 anticipated a shortage; no centre selected “severe shortage” in the coded responses. Excluding Great Ormond Street, the equivalent adult-service figures are 15 centres reporting current sufficiency, 2 reporting insufficiency and 6 unsure. The strongest national priorities identified were improving job planning and work-life balance, selected as a top-three priority by 22 centres and ranked first by 13, followed by improving retention, selected by 20 centres. Alternative workforce models and expansion of thrombectomy hubs were less frequently selected, while increasing training numbers and international recruitment were comparatively low-priority responses. This suggests that respondents do not see sustainability as simply a problem of producing more trainees, but as one of retaining existing consultants, making emergency rotas tolerable, recognising out-of-hours work appropriately, and ensuring that service expansion is supported by adequate wider MDT staffing. Some centre response themes highlight funding constraints, chronic staffing shortages, burnout, high turnover in supporting staff groups and the need for ring-fenced funding and staffing to protect INR service growth. Infrastructure constraints such as a single biplane angio suite shared with other care teams and a lack of access to two dedicated neuro biplane suites is seen as a restriction to sustainable interventional neuroradiology services and growth.

## National consultant feedback

Free-text responses indicate that the major workforce risks are not limited to consultant headcount. Respondents repeatedly highlighted the intensity of 24/7 thrombectomy rotas, inadequate recognition of out-of-hours work in job planning and remuneration, burnout, and the potential loss of experienced consultants. Concerns were also raised about dilution of complex non-thrombectomy case exposure as the workforce expands to meet MT demand. Several centres emphasised that INR workforce planning must not focus solely on thrombectomy, but should also preserve training and expertise in complex neurovascular practice. The comments also identify wider MDT constraints, including anaesthetic, nursing, radiographer, theatre and stroke physician capacity, which limit service expansion even where INR numbers are adequate. Overall, the responses support a national approach to workforce planning, trainee-number coordination, vacancy visibility, retention, remuneration and regionally appropriate service models.

## Conclusion

The UK INR workforce has expanded substantially and has exceeded the minimum consultant INR workforce requirement for mechanical thrombectomy delivery. The current survey identifies 152 INR operators across responding centres, with a further 19 non-INR operators contributing to thrombectomy rotas. This gives a total reported interventional operator pool of 171, but the non-INR contribution should be treated as supplementary and should not be used to meet the minimum INR workforce target.

This distinction is important because the minimum target now exceeds 150 INR operators. On an INR-only basis, the current reported headcount of 152 is above the lower threshold and does not imply surplus national capacity. It also does not account for regional maldistribution, rota fragility, vacancies, impending retirements, or the need to maintain elective and complex neurovascular services alongside MT.

The expansion of mechanical thrombectomy also demonstrates that national workforce adequacy cannot be judged by total operator numbers alone. England is closest to comprehensive 24/7 access, but universal round-the-clock provision has still not been achieved. This does not appear to be due to a shortage of Interventional Neuroradiologists. A strong trainee pipeline is in place to provide future workforce. Scotland continues to develop provision through a national hub-and-spoke model, while Wales remains at an earlier stage of building comprehensive domestic access and has historically relied partly on cross-border pathways. This variation reinforces the need for workforce planning to be aligned with actual service delivery, not just national headcount. Centres without current 24/7 MT access, centres with rota fragility, and regions with limited domestic provision may require targeted workforce support even if the UK-wide total appears adequate.

Even the INR-only minimum should be interpreted cautiously. A target set around MT delivery does not fully reflect the breadth of work required for a sustainable INR service, including emergency thrombectomy, aneurysm treatment, subarachnoid haemorrhage care, AVM and dural fistula management, spinal and paediatric neurointervention in specialist centres, diagnostic angiography, MDT work, complication management, training, governance and research. A workforce planned solely around MT rota numbers risks misinterpreting the staffing required to maintain high-quality comprehensive neurointerventional services.

The survey identifies 40 current INR trainees, with an estimated output of around 13 trainees completing training per year. Incoming trainees and credential learners have not been included in this analysis. At the same time, the survey identifies 15 current consultant INR vacancies and 31 expected retirements over the next decade, with 14 expected in the next five years. This means that the existing trainee pipeline will be required to meet a combination of current vacancies and retirements. Care should be made in future to tailor training numbers for predictable retirements and selective service growth taking account the minimum INR workforce requirement now exceeds 150.

A key implication is that trainees may increasingly need to be geographically mobile. If consultant vacancies and retirements do not align with the centres where trainees are currently based, some trainees may need to travel or relocate to secure substantive consultant posts. In regions where consultant opportunities are not immediately available, post-CCT fellowships may become more common as a bridge between completion of training and substantive appointment. These fellowships may be valuable if they provide high-quality complex neurovascular experience, but they should not become a marker of poor workforce planning or a substitute for timely consultant appointment where service need exists.

The data also shows that non-INR operators provide a useful supplementary contribution, making up approximately 11% of the reported operator workforce. Their role may support local MT rota resilience, particularly where services are moving towards 24/7 provision. However, the current scale of non-INR contribution does not fundamentally change the workforce model. UK neurointerventional care remains predominantly INR-led, and non-INR operators should be viewed as an adjunct to, not a replacement for, a substantive consultant INR workforce.

The main risk over the next five years is not insufficient national headcount. Instead maldistribution and mismatch of workforce should be considered. Some centres may continue to struggle with vacancies and rota sustainability, while others may have trainees approaching CCT without obvious local consultant posts. Workforce planning should therefore move beyond national totals and focus on regional demand, consultant vacancies, retirement timing, trainee location, case volume, rota burden and the ability of centres to provide broad neurovascular training.

In summary, the UK INR workforce has grown to a point where it has exceeded minimum INR workforce requirement to provide mechanical thrombectomy 24/7. The current INR current headcount is 152. Sustainable neurointerventional service delivery requires more than reaching a numerical target. The priority should now be to consolidate the current workforce, retain experienced consultants, fill existing vacancies, replace predictable retirements, and guide current trainees into areas of genuine service need. Workforce planning should also address the factors identified by centres as central to sustainability: manageable emergency rotas, appropriate job planning and recognition of out-of-hours work, retention, wider MDT capacity, and regionally targeted support for centres that have not yet achieved resilient 24/7 MT provision. A period of measured, regionally targeted expansion appears more appropriate than rapid national growth, with ongoing annual workforce review to ensure that trainee output, consultant vacancies, retirement risk and service requirements remain aligned.

## Author and acknowledgments

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### Acknowledgments:

The members of the UKNG executive committee: Dr Hannah Stockley (Salford), Dr Rob Lenthall (Nottingham), Dr Alex Mortmer (Bristol), Dr Amarit Gill (UKNG Trainee representative - Sheffield) and Dr Tim Edwards (TERC trainee representative - Hull)

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## Appendix A

Region	Sites / trusts included
London	Barts Health / Royal London; Great Ormond Street Hospital; King's College Hospital London / Denmark Hill; UCLH / Queen Square; St George's University Hospitals; Imperial College NHS Trust / Charing Cross
South East	University Hospitals Sussex / Royal Sussex County Hospital; University Hospital Southampton / Southampton General Hospital
South West	Bristol NHS Group; University Hospital Plymouth / Derriford Hospital
Midlands	Oxford University Hospitals / John Radcliffe Hospital; Nottingham University Hospitals / QMC; University Hospitals Birmingham / Queen Elizabeth Hospital; University Hospitals Coventry & Warwickshire / Walsgrave; University Hospitals of North Midlands / Royal Stoke University Hospital
North West	Preston / Lancashire Teaching Hospitals; The Walton Centre; Northern Care Alliance / Salford Royal Hospital
North East & Yorkshire	Newcastle upon Tyne Hospitals / Royal Victoria Infirmary; Leeds Teaching Hospitals / Leeds General Infirmary; Sheffield / Royal Hallamshire; Hull University Teaching Hospitals / Hull Royal Infirmary; South Tees NHS Foundation Trust / James Cook University Hospital
East of England	BHRUT / Queen's Hospital, Romford; Cambridge University Hospitals / Addenbrooke's
Scotland	NHS Greater Glasgow and Clyde / Institute of Neurological Sciences; NHS Lothian / Royal Infirmary of Edinburgh
Wales	Cardiff and Vale UHB / University Hospital of Wales
Northern Ireland	Belfast HSC Trust / Royal Victoria Hospital

## Appendix B

Centre / trust	Region	Vacancies
Barts Health / Royal London	London	2
University Hospitals Sussex / Royal Sussex County Hospital	South East	2
Nottingham University Hospitals / QMC	Midlands	2
Preston / Lancashire Teaching Hospitals	North West	2
Leeds Teaching Hospitals / LGI	North East & Yorkshire	1
Hull University Teaching Hospitals / Hull Royal Infirmary	North East & Yorkshire	2
NHS Greater Glasgow and Clyde	Scotland	1
NHS Lothian / Royal Infirmary of Edinburgh	Scotland	1
University Hospitals Coventry & Warwickshire / Walsgrave	Midlands	2