Quick read:
Workforce information and planning: Rota gaps survey findings 2024

Executive Summary

1. Services across England, Scotland, and Northern Ireland are facing rota gaps of over 20% with Wales services at 11.3%.

2. There is no regional pattern in terms of areas most affected with the Midlands, the South East, North East and Yorkshire, Scotland and Northern Ireland experiencing the highest gaps, and the least affected being London, East of England and Wales.

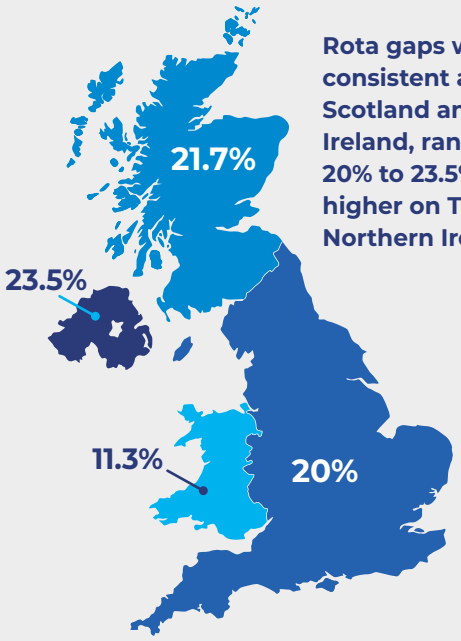
3. Tier 2 rotas are generally more impacted by rota gaps than Tier 1, with the exception of Northern Ireland and - while there was no clear pattern of regional bias - Tier 2 rota gaps were predominant across most of England, Wales, and Scotland.

4. Combined rotas (General Paediatrics/Neonatal and General Paediatrics/Specialty) were most heavily impacted by gaps especially at the Tier 1 level, while Neonatal and General Paediatrics saw a higher proportion of gaps on Tier 2 rotas.

5. Rota gap duration was largely over three months, lasting 3-6 months or six months to a year.

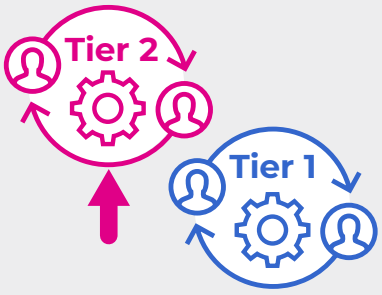
6. Both 'LTFT working' and 'lack of deanery trainee allocation' (either due to gaps in rotation or insufficient places for a fully compliant rota) were main causal factors behind rota gaps, with health reasons accounting for a relatively small proportion. Predictably, lack of deanery allocation was much more significant at the Tier 1 level with LTFT working equally impactful for both tiers.

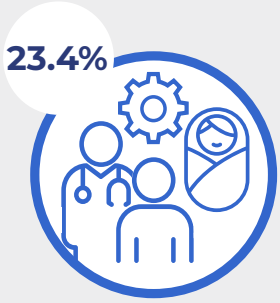
7. Where improvement had been seen, the solution was generally one of short-term staffing largely in the form of clinical fellows and trust-grade LEDs in addition to the use of locums and agency staff. Deanery allocation also contributed to improvement, especially where LTFT had increased e.g increased slot sharing in addition to better communication between those involved re expected resources.



Rota gaps were relatively consistent across England, Scotland and Northern Ireland, ranging from 20% to 23.5%. Gaps were higher on Tier 2 except for Northern Ireland.

Tier 2 rotas were generally more impacted by rota gaps than Tier 1.





When looking at rota types, Combined General/ Neonatal had the highest gaps with 23.4%.

Combined rotas (General Paediatrics/ Neonatal and General Paediatrics/ Specialty) were most heavily impacted by gaps, potentially suggesting District General Hospitals were more impacted.

Our recommendations

The survey results provide a snapshot analysis of the capacity of the workforce to staff acute rotas but a lack of a complete data set and the potential for reporting bias for those units experiencing a higher rate of rota gaps, means that the results may not be generalisable across the UK workforce and from one 6-month rotation to the next.

The reasons for rota gaps do not consider service infrastructure/design and cross-site working which may also impact the number of resident doctors available to staff a given rota. The underlying reason for a rota gap may also be more complex, a gap due to lack of deanery allocation may reflect a true gap or is a pseudo-gap due to parental or other statutory leave. For these reasons it is not possible to translate the survey results into recommendations that fit all rotas and sites. The recommendations are therefore deliberately broad in nature and designed to act as a starting point to increased awareness of good practice that can help teams be proactive in workforce discussions. Following merger with NHSE, Deaneries are now known as Healthcare Education Teams but for the purpose of this survey will still be referred to as Deaneries which should be taken to be synonymous with 'School of Paediatrics'.

	Recommendation
1	Deaneries to review their workforce plan 6-12 monthly in anticipation of potential gaps in the NHSE funded post graduate doctor in training (PGDiT) posts and request adequate PGDiT recruitment during the National Paediatric recruitment cycle.
2	To account for increased less than full time working, Deaneries should recruit to their Whole Time Equivalent (WTE) envelope and/or consider planning based on current 80% instead of 100% as being full time.
3	Local employers may also opt to release local funding to enable flexibility in the recruitment of short-term staff roles in paediatrics such as LEDs, Specialty, Associate Specialist and Specialist (SAS) doctors and Fellows.
4	Use of self-rostering (including Artificial intelligence (AI) tools) helps to improve full utilisation of staffing particularly given uptake of LTFT training and use of slot shares in run-through training.
5	All units should have a workforce plan that is reviewed on an annual basis alongside predicted service demands and NHS England, NHS Scotland, NHS Wales, and Northern Ireland Department of Health allocation of PGDiTs, so that recruitment can be planned both strategically at regional level and informed by operational need rather than being reactive.
6	Close liaison between Clinical Directors and Training Programme Directors (TPDs) is beneficial, allows early notification of likely gaps in rotas and enables strategic recruitment at a local level that reduces need for locums.
7	Relevant bodies should consider releasing data related to vacancies at specialty and regional levels, to characterise the service need landscape by combining with other information such as waiting times, bed occupancy, child population, and other relevant information that can inform commissioning and paediatric service configuration modelling across the UK.
8	To support workforce planning, local employers should be provided with information on the numbers of doctors that are required to be trained, alongside the number of doctors required to staff rotas legally and safely while providing adequate training opportunities.

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