Workforce information and planning

Rota gaps survey findings 2024

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RCPCH
Royal College of Paediatrics and Child Health
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RCPCH 2024
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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 'Less than full time (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 locally employed doctors (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 regarding expected resources.

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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 in some UK jurisdictions 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'.

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.

Introduction

There are enduring, critical issues in the UK paediatric workforce with understaffed rotas, burnout and unfilled vacancies; all set against a backdrop of accelerating demand on acute paediatric services, a post-pandemic referral backlog and increased waiting times.

Workforce planning is a key issue for the paediatric service. Currently, there are no plans to increase the number of paediatric training places, but there is an NHSE strategy in place for the redistribution of training posts with paediatrics falling into the second phase of this process.

It is critical, therefore, that we understand collectively why rota gaps occur and how best to address them to ensure high quality service, staff wellbeing and a sustainable future workforce.

In September 2019, the workforce team conducted a snapshot workforce survey of general paediatrics and neonatology in collaboration with Getting it Right First Time that looked at services during one weekday and one weekend day. Findings showed that there was an average of 10% of staff missing on weekday training rotas with a quarter of units using at least one locum, while 10% of neonatal units were also experiencing rota gaps.

The Workforce Information and Planning team have conducted a study to address questions around rota gaps in paediatrics within the post-pandemic landscape. Our rota gaps survey explores the frequency of Tier 1 and Tier 2 rota gaps in General Paediatrics, Neonatology (level 3 units at Tertiary/ Teaching Hospitals) and other paediatric sub-specialties across the UK. We have also examined combined General Paediatric and Neonatal rotas found primarily in a district general hospital (DGH) settings and combined General Paediatric and Sub-specialty rotas found primarily in Tertiary/ Teaching Hospital settings.

For the survey, we targeted rota planning staff at the Trust/Health Board level across all four nations investigating information concerning existing gaps, rota type, extent, duration and cause. The survey was open for just over two months from April and June 2024 and while we were not able to determine an absolute response rate given that the definitive number of UK paediatric rotas is unknown, there was a good level of engagement with even regional distribution across NHSE trust regions and the Devolved Nations (see appendix).

Rota gaps across the UK

For responses received, rota gaps were relatively consistent across England, Scotland, and Northern Ireland ranging from 20% to 23.5% across all types of rotas; Wales experiencing considerably lower rota gaps at 11.3%. When looking at Tiers 1 and 2 independently, the percentage of gaps was higher for Tier 2 compared to Tier 1 with the exception of Northern Ireland, where Tier 1 gaps exceeded Tier 2 gaps. Please note, the number of rotas for which information was received was relatively low so these results should be treated with caution; see appendix.

	No. of Trusts/ Health Boards	No. of units	No. of rotas	% gaps Tier 1	% gaps Tier 2	% gaps Total
England	75	86	123	19.1%	20.9%	20.0%
Northern Ireland	5	6	6	27.8%	19.1%	23.5%
Scotland	6	7	8	16.2%	26.3%	21.7%
Wales	3	3	3	7.4%	20.0%	11.3%
Total	**89**	**102**	**140**	**18.9%**	**21.3%**	**20.0%**

Table 1: Rota gaps across the UK; some trusts submitted information from multiple units and in some cases multiple rotas were submitted for individual units. Percentage relates to the proportion of rotas experiencing gaps

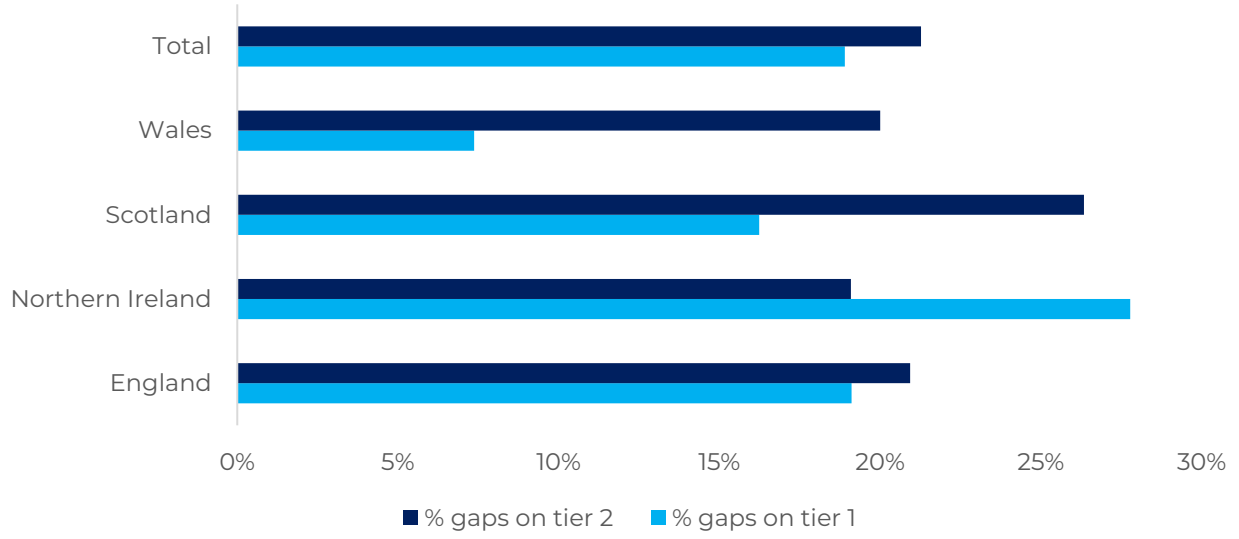

Figure 1: Rota gaps across the UK by tier; some trusts submitted information from multiple units and in some cases multiple rotas were submitted for individual units. Percentage relates to the proportion of rotas experiencing gaps.

We asked all respondents to describe what a fully staffed rota would look like in terms of Full Time Equivalent (FTE) and explored gaps as a proportion of a fully staffed FTE rota for each rota type (where applicable).

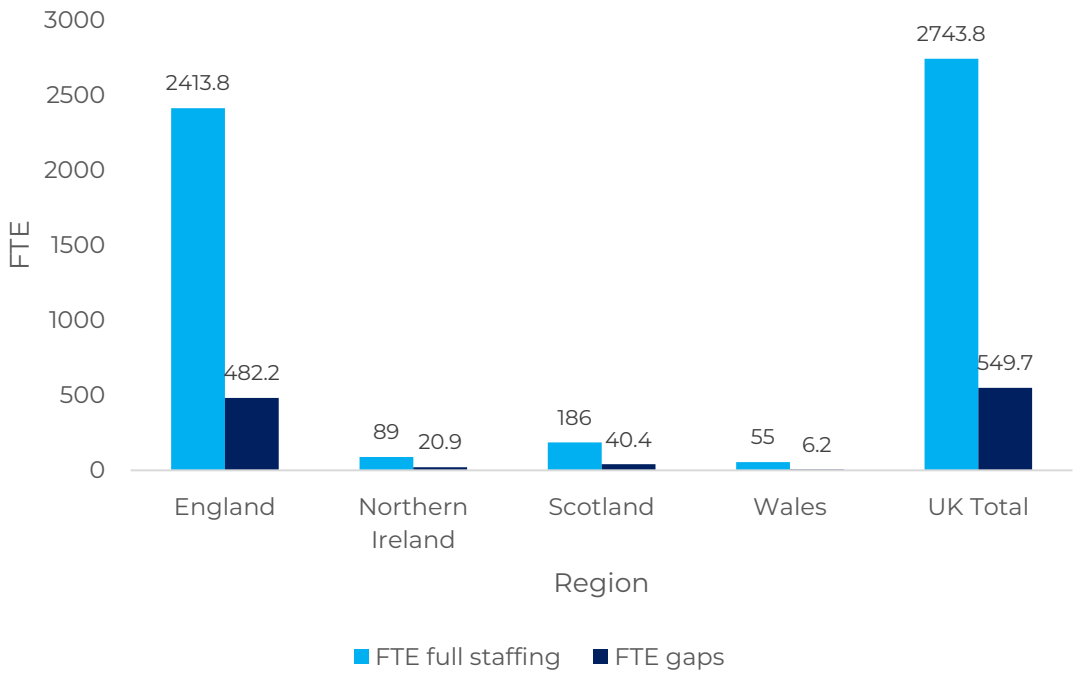

Figure 2: Proportion of rota gaps as a percentage of recommended fully staffed FTE rota across the UK.

Rota gaps by region

When looking at regional breakdown for surveys completed, the spread of responses across NHS England Trust regions shows that rota gaps are highest in the Midlands and South East, closely followed by the North East and Yorkshire, but lowest in London and East of England. Both Scotland and Northern Ireland have rota gaps equivalent to that of the highest in England, compared to Wales which has the lowest total. For Tiers 1 and 2, NHSE Trust regions South East, North West, North East and Yorkshire, East of England plus both Wales and Scotland recorded higher gaps on Tier 2 compared to Tier 1, whereas the opposite was reported for South West, Midlands, London and Northern Ireland.

Region	No. of Trusts/ Health Boards	No. of units	No. of rotas	% gaps Tier 1	% gaps Tier 2	% gaps Total
East of England	11	13	21	14.4%	17.4%	16.0%
London	14	17	25	16.4%	12.1%	14.6%
Midlands	13	15	17	30.5%	22.7%	26.8%
North East and Yorkshire	13	15	21	22.0%	25.4%	23.7%
North West	9	9	13	12.5%	19.4%	16.2%
South East	7	8	12	13.6%	35.2%	24.0%
South West	8	9	14	19.5%	16.4%	18.1%
Northern Ireland	5	6	6	27.8%	19.1%	23.5%
Scotland	6	7	8	16.2%	26.3%	21.7%
Wales	3	3	3	7.4%	20.0%	11.3%
Total	**89**	**102**	**140**	**18.9%**	**21.3%**	**20.0%**

Table 2: Rota gaps by region and tier; some trusts submitted information from multiple units and in some cases multiple rotas were submitted for individual units. Percentage relates to the proportion of rotas experiencing gaps

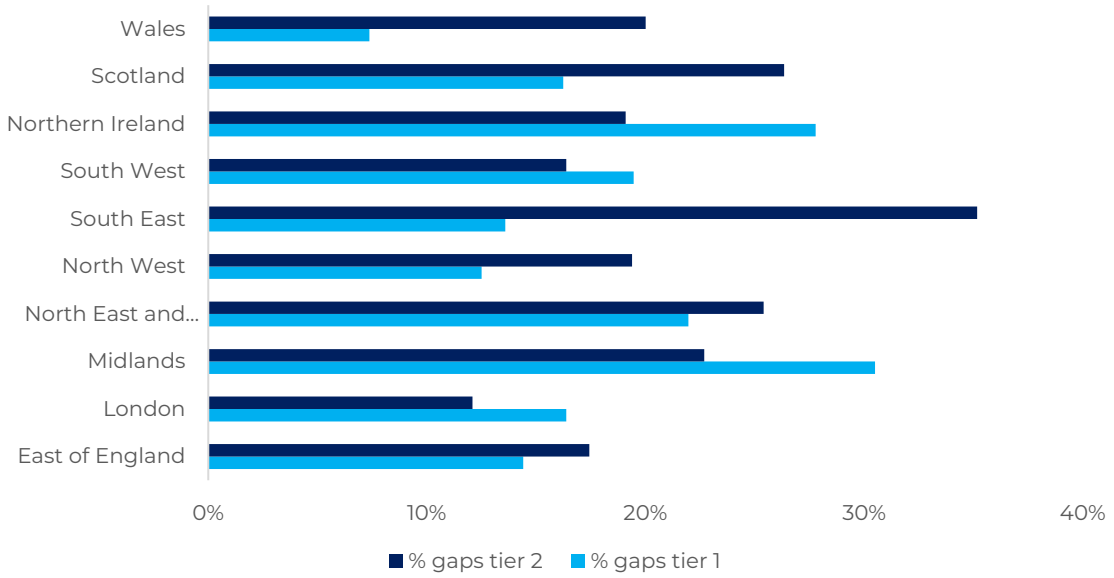

Figure 3: Rota gaps by region and by rota tier some trusts submitted information from multiple units and in some cases multiple rotas were submitted for individual units. Percentage relates to the proportion of rotas experiencing gaps.

We also explored the extent of gaps measured as a proportion of FTE when fully staffed for each NHSE region and nation.

Region	No. of Trusts/ Health Boards	No. of units	No. of rotas	FTE full staffing	FTE gaps
East of England	11	13	21	379	60.7
London	14	17	25	476	69.7
Midlands	13	15	17	383	102.8
North East and Yorkshire	13	15	21	453	107.3
North West	9	9	13	213	34.4
South East	7	8	12	258	61.8
South West	8	9	14	251.8	45.5
Northern Ireland	5	6	6	89	20.9
Scotland	6	7	8	186	40.4
Wales	3	3	3	55	6.2
Total	**89**	**102**	**140**	**2743.8**	**549.7**

Table 3: Rota gaps as a proportion of FTE for full staffing; some trusts submitted information from multiple units and in some cases multiple rotas were submitted for individual units.

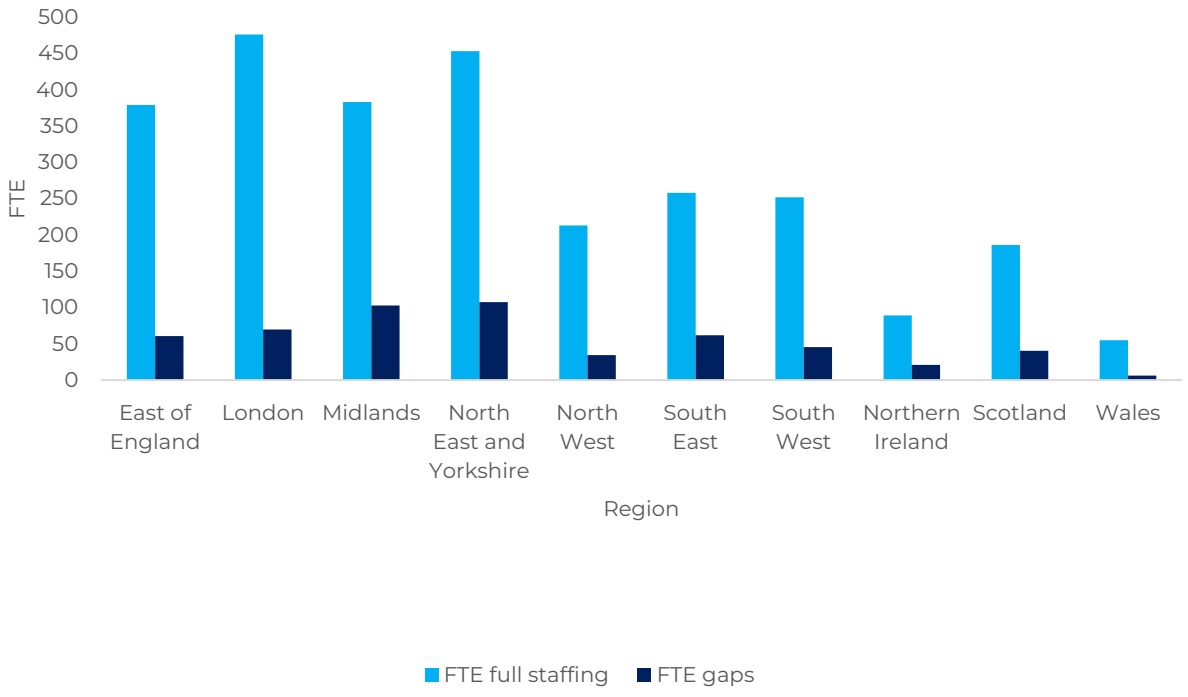

Figure 4: Rota gaps represented as a proportion of recommended fully staffed FTE rotas by NHSE region and nation

Rota gaps by rota type

The majority of responses received were in relation to General Paediatric, Neonatal, and Combined General Paediatrics/Neonatal rotas. The survey originally included Sub-specialty and Paediatric Intensive Care as distinct rotas but due to small numbers these rotas have been combined into a single sub-specialty category. Combined General Paediatrics/Neonatal rotas experienced the highest proportion of gaps (23.4%) with a higher percentage for the Tier 1 relative to Tier 2 rota. This was followed by Combined General Paediatrics/Sub-specialty (19.2%) similarly with a higher proportion of gaps on Tier 1 rotas. Conversely, Neonatal and General Paediatrics saw a higher proportion of gaps on Tier 2 rotas.

Region	N. rotas	FTE Full Staffing Tier 1	FTE gaps Tier 1	% gaps Tier 1	FTE Full Staffing Tier 2	FTE gaps Tier 2	% gaps Tier 2	FTE Full Staffing Total	FTE gaps Total	% gaps Total
Combined General/ Sub-specialty and Sub-specialty	16	128	18.9	14.8%	150	34.4	22.9%	278	53.3	19.2%
Neonatal	36	366	58.9	16.1%	290	61.4	21.2%	656	120.3	18.3%
General Paediatrics	41	467.8	76.5	16.4%	352	67.5	19.2%	819.8	144	17.6%
Combined General/ Neonatal	47	469	117.1	25.0%	521	115	22.1%	990	232.1	23.4%
Total	**140**	**1431**	**292.5**	**20.4%**	**1313**	**279.3**	**21.3%**	**2744**	**549.7**	**20.0%**

Table 4: Rota gaps by rota type; some trusts submitted information from multiple units and in some cases multiple rotas were submitted for individual units. Rota gaps are presented as a percentage of responses received and as a proportion of recommended fully staffed FTE rotas

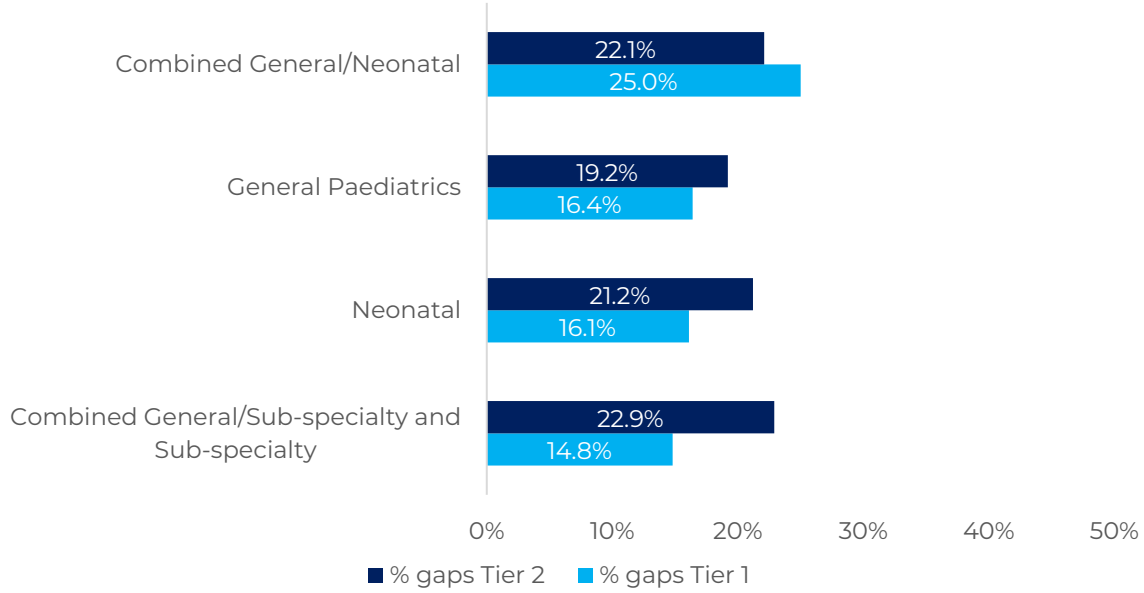

Figure 5: Rota gaps by rota type; some trusts submitted information from multiple units and in some cases multiple rotas were submitted for individual units. Rota gaps are presented as a percentage of responses received and as a proportion of recommended fully staffed FTE rotas.

We also explored the extent of gaps measured as a proportion of FTE when fully staffed for each rota gap type.

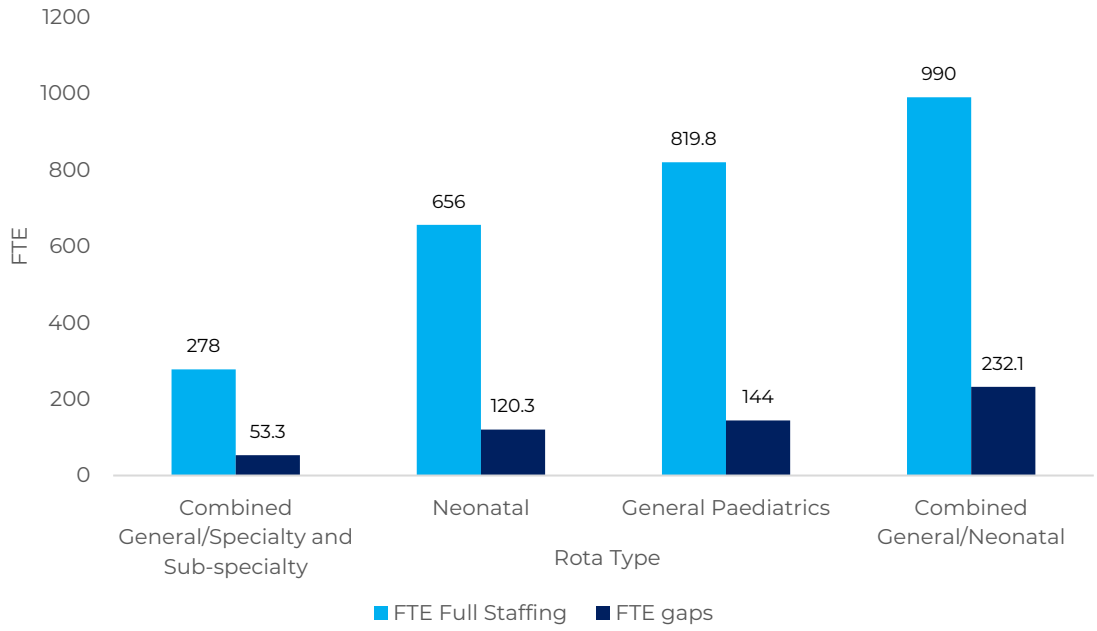

Figure 6: Rota gaps represented as a proportion of recommended fully staffed FTE rotas by rota type.

Rota gap duration

Rota Gap duration by tier

Respondents stated how long rota gaps had been ongoing for each role experiencing gaps within rotas. Durations of less than a week and 1 to 2 weeks received no responses and were therefore, excluded from the table and figure below. The most common rota gap length for both total (38.8%) and Tier 1 (45.3%) and 2 (31.7%) individually was 3-6 months followed by 6 months to a year.

	Tier 1 - all rota types	% rota gaps Tier 1	Tier 2 - all rota types	% rota gaps Tier 2	Total - all rota types	% rota gaps Total
2-4 weeks	6	3.3%	1	0.6%	7	2.0%
1-3 months	34	18.8%	25	15.0%	59	17.0%
Up to 6 months	82	45.3%	53	31.7%	135	38.8%
6 months to 1 year	36	19.9%	51	30.5%	87	25.0%
Over 1 year	23	12.7%	37	22.2%	60	17.2%
Total	**181**	**100.0%**	**167**	**100.0%**	**348**	**100.0%**

Table 5: Rota gap lengths by tier; presented as both number of roles and percentage of roles surveyed.

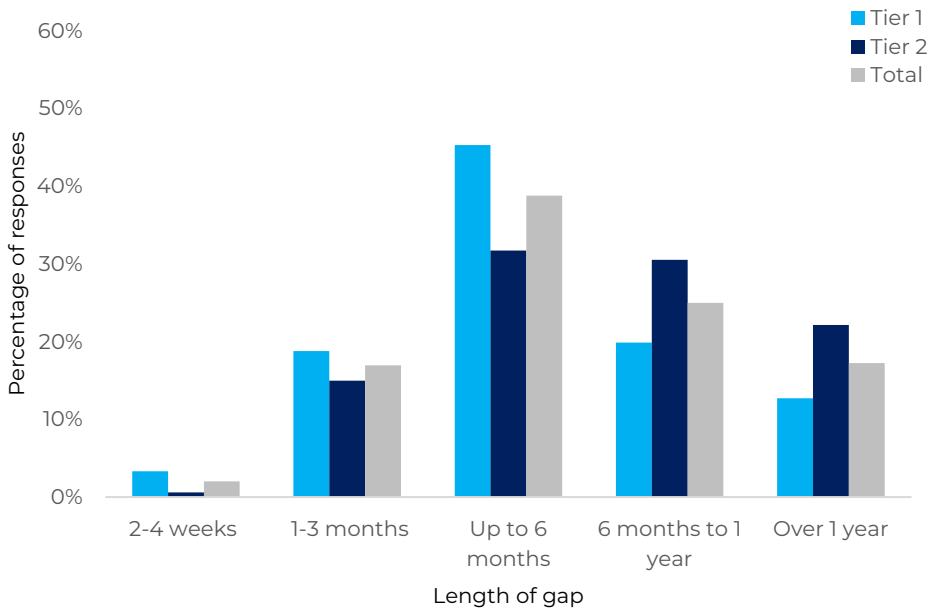

Figure 7: Rota gap lengths by tier and total; presented as both number of roles and percentage of roles within rotas surveyed.

Rota gap duration by region

When viewed regionally, the pattern in terms of length of rota gap mirrors that of the total trend with up to six months being the most common length of rota gap across all regions in England (with the exception of the South West) and Northern Ireland. This is followed in most case by gaps of six months to a year except for the North West where rota gaps over a year are more common and in Scotland and the South West where gaps of up six months to a year are most common.

	2 -4 weeks	1-3 months	Up to 6 months	6 months to 1 year	Over 1 year
East of England	0	9	15	14	13
London	1	11	22	11	5
Midlands	2	9	21	9	9
North East and Yorkshire	1	7	29	14	3
North West	1	8	15	6	10
South East	1	0	12	12	9
South West	1	6	9	11	1
Northern Ireland	0	3	7	0	3
Scotland	0	3	3	10	7
Wales	0	3	2	0	0
Total	**7**	**59**	**135**	**87**	**60**

Table 6: Rota gap lengths by region; presented as number of roles experiencing gaps within rotas surveyed.

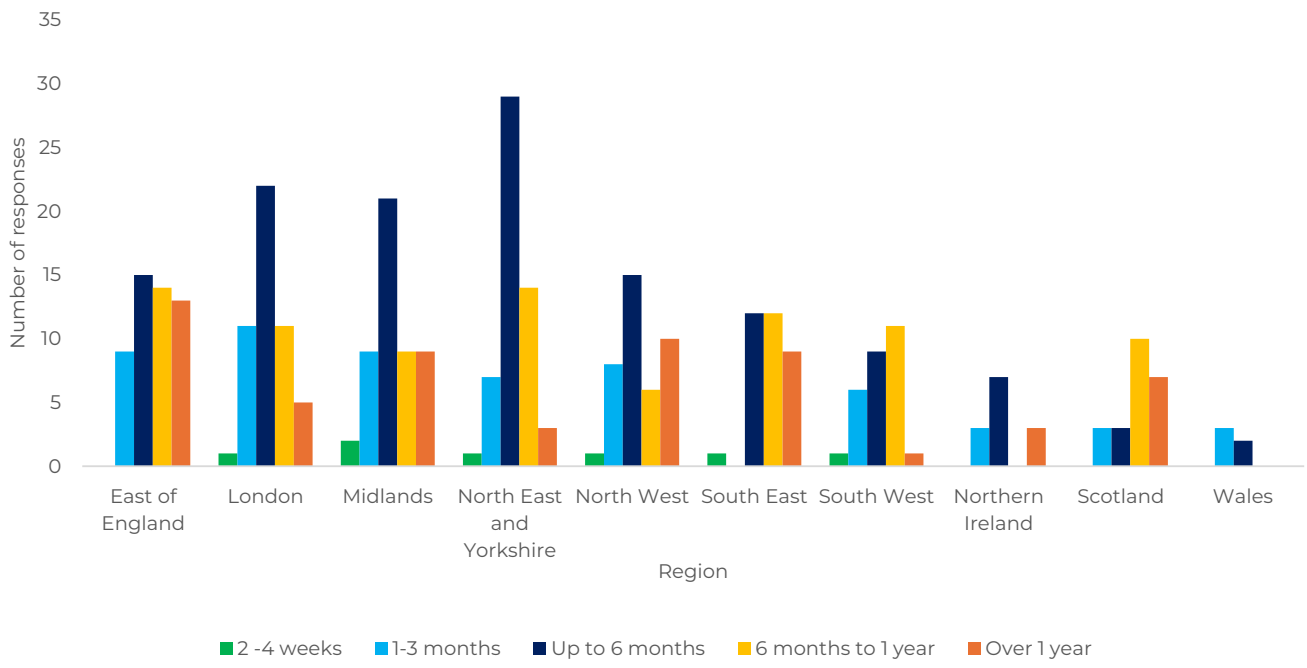

Figure 8: Rota gap lengths by region; presented as number of roles experiencing gaps within rotas surveyed.

Reasons for rota gaps

For this section, some reasons have been combined for ease of visualisation: short- and long-term sick leave plus occupational health have been combined as duty of care, maternity and parental leave. When taking into consideration both tiers, the most common reason for rota gaps was less than full time (LTFT/flexible) working (32.4%) and lack of deanery trainee allocation (26%); health reasons accounted for a relatively small proportion of rota gaps. Lack of deanery allocation was much more significant at the Tier 1 level while failure to recruit impacted Tier 2 more; LTFT/flexible working was equally impactful for both tiers.

Reasons for gaps	Tier 1 - all rota types	% rota gaps Tier 1	Tier 2 - all rota types	% rota gaps Tier 2	Total - all rota types	% rota gaps Total
LTFT/flexible working	52	31.3%	50	33.6%	102	32.4%
Lack of deanery trainee allocation	55	33.1%	27	18.1%	82	26.0%
Failure to recruit	20	12.0%	32	21.5%	52	16.5%
Duty of care, maternity and parental leave	15	9.0%	21	14.1%	46	14.6%
Health Reasons (short and long term sickness; OH)	22	13.3%	17	11.4%	29	9.2%
Retirement	2	1.2%	2	1.3%	4	1.3%
Total	**166**		**149**		**315**	**100.0%**

Table 7: Reasons for rota gaps; OH – occupational health.

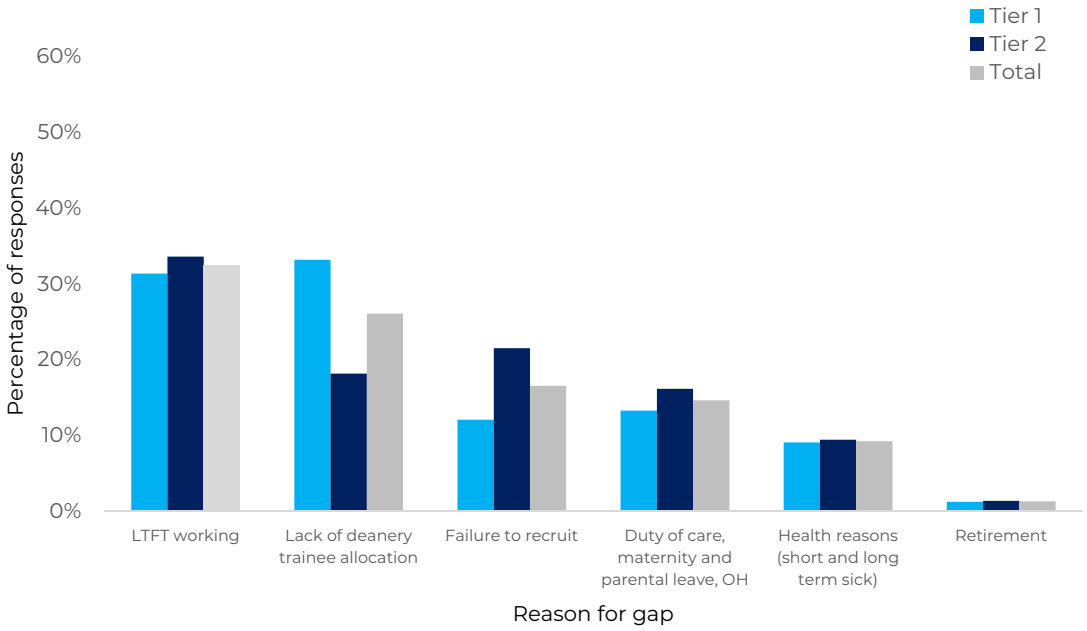

Figure 9: Reasons for rota gaps; OH – occupational health.

Reason by region

When looking at reasons for gaps by NHSE region and nation, the pattern emulates that seen overall with LTFT working, and lack of deanery trainee allocation appearing to be the most dominant. Failure to recruit is also a significant contributory factor in East of England and the Midlands. Health reasons only appear to be considerable in London relative to all other regions.

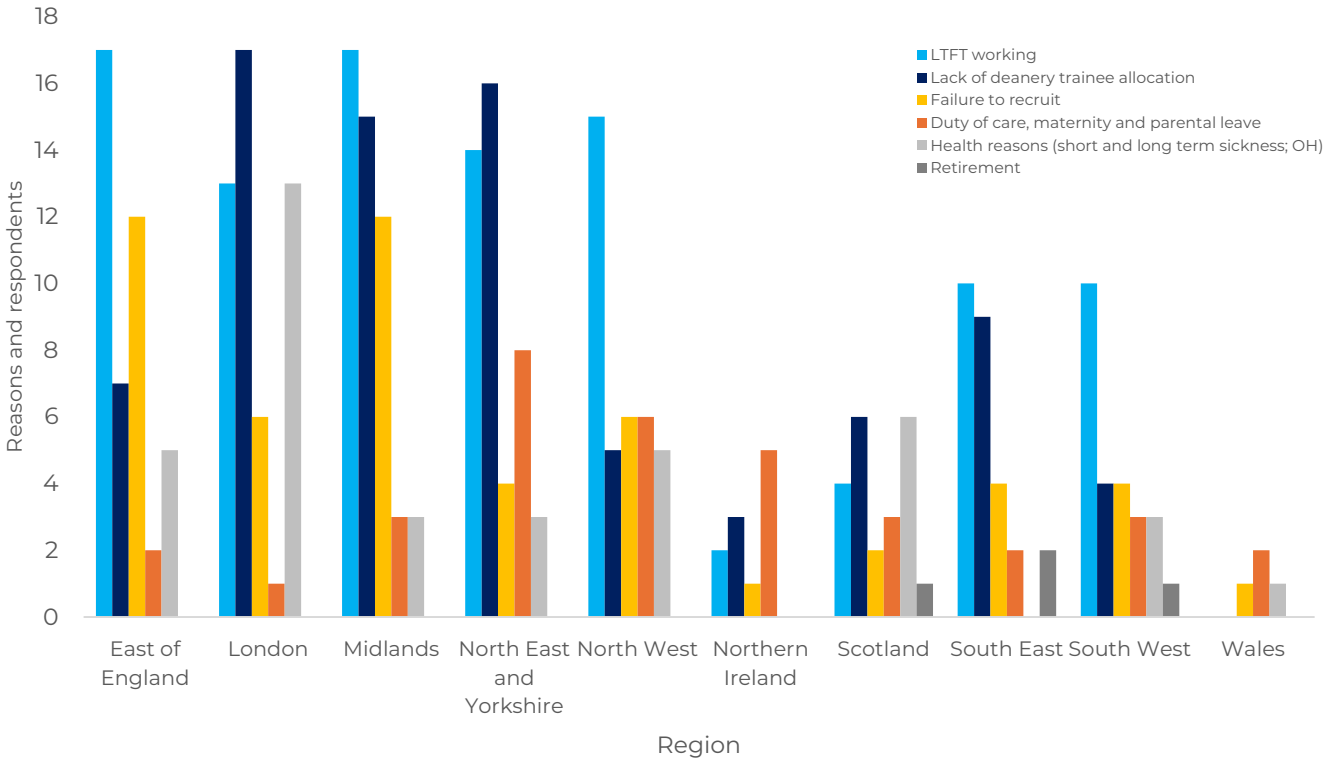

Figure 10: Reasons for rota gaps by region; OH (occupational health).

Locums as a rota gap solution

409 roles experiencing gaps answered this question as follows: Yes (34.7%) and No (38.4%) and not applicable (26.9%). The table below shows only Yes/No responses with a relatively even split between those units that did and did not use locums for a particular rota; the same pattern is evident when examined by individual tier.

Locum cover	Tier 1 Rotas	% of locum cover on Tier 1 rota	Tier 2 Rotas	% of locum cover on Tier 2 rota	Locum cover total	% locum cover total
No	81	50.9%	76	54.3%	157	52.5%
Yes	78	49.1%	64	45.7%	142	47.5%
Total	**159**		**140**		**299**	

Table 8: Locum cover for rota gaps; taken as number and percentage of number of roles surveyed.

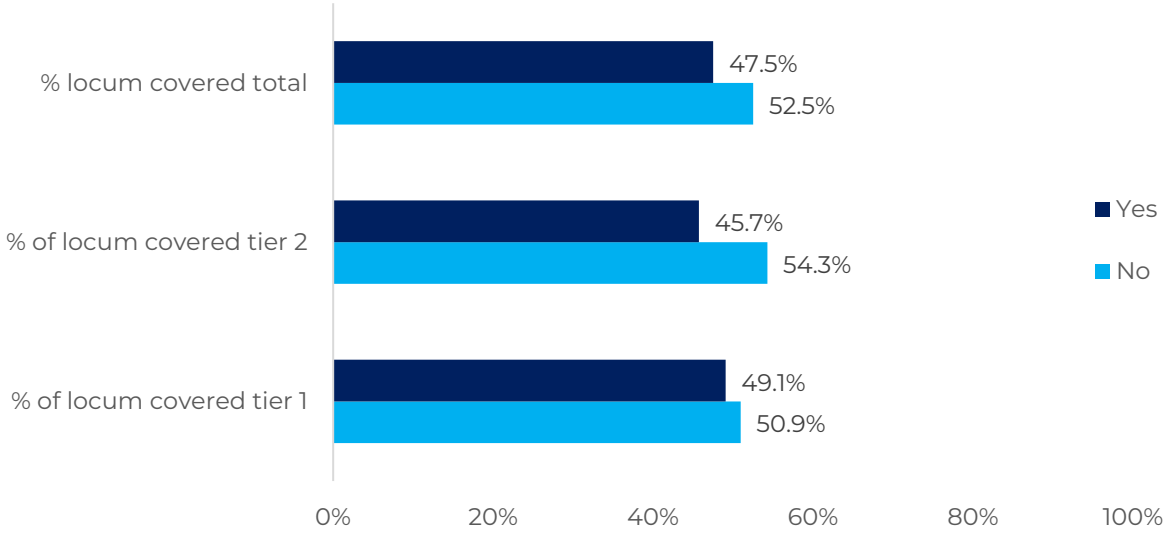

Figure 11: Locum cover for rota gaps; taken as a percentage of number of roles experiencing gaps with or without a locum cover.

Changes in rota gaps

Respondents were asked to describe the nature of rota gap improvements where applicable. Likewise, respondents were also asked to provide more detail as to why rota gaps had not improved over the last six months.

Reasons for lack of improvement in rota gaps

The major reasons given for there being no improvements in rota gaps over the last six months included LTFT working, an insufficient number of postgraduate doctors in training (PGDiT) allocated by the Deanery combined with recruitment in terms of both numbers and quality of trainees/ recruits.

LTFT working was the most acknowledged reason for rota gaps; frequently tied in with occupational health restrictions. Several respondents referred to the fact that many trainees are working at 50-80% and lower WTE has created gaps which have been compounded by recruitment difficulties and limited compensation in terms of PGDiT numbers. Furthermore, it can be challenging to fill gaps left by LTFT working, but this can impact delivery of training and service. Likewise, in situations of occupational health issues or long-term sickness including mental health, it is harder to recruit into partially vacant positions.

A large number of respondents also spoke of either a lack of deanery allocation to deal with gaps or a lack of adequately trained PGDiT to perform duties required. Deanery allocation was considered to be unpredictable and often late giving limited time to compensate for ensuing gaps with e.g. non-training doctors; there were also expected funding issues that impacted on recruitment and in turn, rota gaps.

Occupational health restrictions, long-term sick leave and maternity leave also contributed to gaps especially where unable to recruit maternity leave replacements.

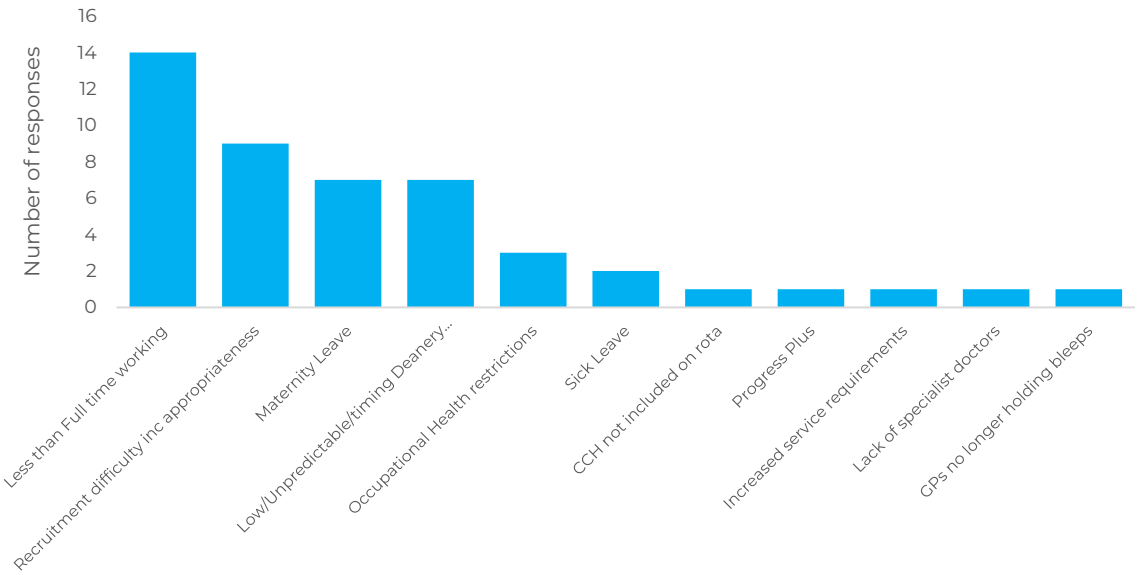

Figure 12: Reasons for lack of improvement in rota gap status

Reasons for improvement in rota gaps

The main reason given for improvement in rota gaps was the use of short-term staffing solutions largely in the form of clinical fellows, with a pool of doctors readily available, many of whom had come through the international trainee route. A number of respondents stated that their trust is approved for MTI, while many doctors who have been accepted via the overseas route have been recruited as locally employed doctors at a trust grade level. A number of trusts have also used locums at all levels of seniority and for varying durations in addition to agency doctors and alternative clinical staff including Physicians Associates and Advanced Nurse Practitioners (ANPs).

The Deanery allocation has also contributed to improvement in rota gaps with more PGDiT being allocated to fulfil required quotas plus an increase in slot shares, especially useful in cases where there are an increasing number of PGDiT working LTFT. Some respondents have also seen an increase in funding to facilitate short-term staffing solutions or long-term recruitment plans. This has been eased by improved communication between TPD, Postgraduate Medical Education (PGME) and College Specialty Advisory Committee (CSAC) to understand better allocation and anticipate the impact of less than full time working impact.

Finally, the shift to self-rostering in some cases has had a positive impact providing more autonomy for PGDiT in terms of shift allocation.

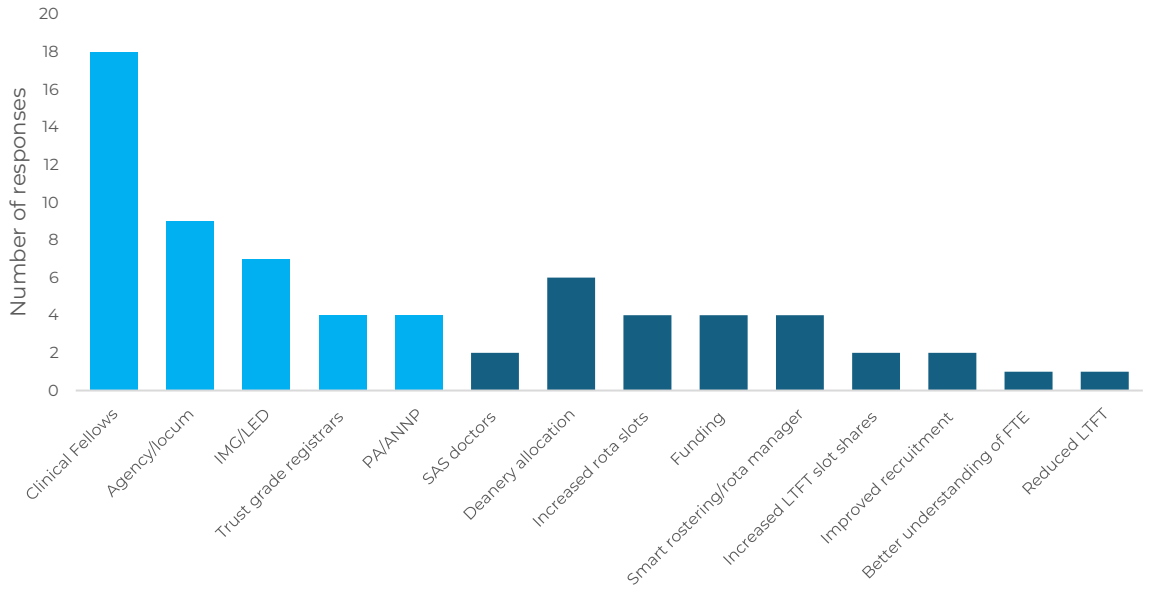

Figure 13: Reasons for improvement in rota gap status

Appendix

Response rate

College Tutors across the UK were asked either to complete or pass the Rota Gaps survey for completion to those staff responsible for rota management. College Tutors were identified as best placed to act as the initial point of contact for rota managers and rota coordinators.

The survey questionnaire was designed in conjunction with the Workforce Planning Board and College and subsequently developed using Survey Monkey. Data collection opened on April 10 2024 and closed June 20 2024 following two deadline extensions.

The submissions received initially covered 110 Trust or Health Boards (THB); 13 of these were blank and were removed. The remaining 97 THBs had data for at least one paediatric rota. These 97 THBs covered 110 units/hospitals, within these 153 paediatric rotas had data.

Of the 232 THBs present in the UK, 204 were identified as providing some paediatric services. This was done based on expert opinion, internal knowledge, and internet search of organisation and services. As such, data were received from almost half of applicable THBs (47%, 96/204). Of these 96, 7.2% (7/96 THBs) had no gaps. In terms of number of hospitals, 6.4% had no gaps (7/109 units/hospitals). In terms of number of rotas, these were 12 of 152. Therefore the majority of gaps analysis is based on 89 THBs, 102 units/hospitals, 140 rotas.

While we are unable to quantify the exact response rate with respect to number of units as there is no clear indication of the exact number of units/hospitals with paediatric services in the UK nor the number of rotas that would be applicable, we instead calculated engagement/responsivity based on THBs having paediatric services/rotas. This provided a good indication of engagement and regional spread (see table below) rather than a definitive response rate.

Region	No. of Trust/Health Boards	No. of Units/ Hospitals	No. of rotas
East of England	10	12	22
London	15	18	28
Midlands	14	16	18
North East and Yorkshire	15	17	22
North West	10	10	14
South East	9	10	14
South West	9	10	17
Northern Ireland	5	6	6
Scotland	6	7	8
Wales	3	3	3
UK Total	96	109	152

Table 9: Engagement by THB, hospital, and number of rotas with data from at least one paediatric rota.

Limitations

This survey was intended as a snapshot of gaps on rotas occurring or that had occurred in the six months before and during data collection. It does not account for periods extending prior to six months and therefore, does not necessarily include longer term gaps. The survey also essentially targeted sites that were experiencing gaps, and therefore, those sites not experiencing gaps may have had less incentive to submit a response.

In some instances, FTE gaps were entered without also indicating the total amount of FTE required for full staffing, resulting in gaps appearing higher than FTE required for full staffing when probing at regional level. For length and reason for gaps, the numbers are the sum of all reasons and length for each of the roles on rota experiencing gaps, therefore the numbers could be multiple on a single rota.

Further analysis of rota gaps by rota type

General Paediatrics

For General Paediatrics, within England, London had the highest proportion of rota gaps with 21.1% driven by Tier 2 rota gaps, with East of England the lowest at 13.5% equally distributed between Tiers 1 and 2. Scotland conversely, experienced the highest gaps overall at 25.1% driven by Tier 2; this is similar to the pattern seen in the North East and Yorkshire and the South West. These findings should be treated with caution given the small number of responses.

Region	No. of rotas	FTE Full Staffing Tier 1	FTE gaps Tier 1	% gaps Tier 1	FTE Full Staffing Tier 2	FTE gaps Tier 2	% gaps Tier 2	FTE Full Staffing Total	FTE gaps Total	% gaps Total
East of England	7	79	10.7	13.5%	62	8.4	13.5%	141	19.1	13.5%
London	8	98	23.3	23.8%	40	5.8	14.5%	138	29.1	21.1%
Midlands	5	75	11.5	15.3%	56	8.4	15.0%	131	19.9	15.2%
North East and Yorkshire	6	62	8.9	14.4%	46	11	23.9%	108	19.9	18.4%
North West	3	17	2.4	14.1%	22	3.4	15.5%	39	5.8	14.9%
Scotland	3	30	1.2	4.0%	32	9.7	30.3%	71	17.8	25.1%
South East	3	58.8	12.7	21.6%	55	8.8	16.0%	62	10.9	17.6%
South West	5	32	5.8	18.1%	39	12	30.8%	113.8	21.5	18.9%
Wales	1	16	0					16	0	
Total	**41**	**467.8**	**76.5**	**16.4%**	**352**	**67.5**	**19.2%**	**819.8**	**144**	**17.6%**

Table 10: General Paediatric rota gaps by region and tier: partial responses for Wales

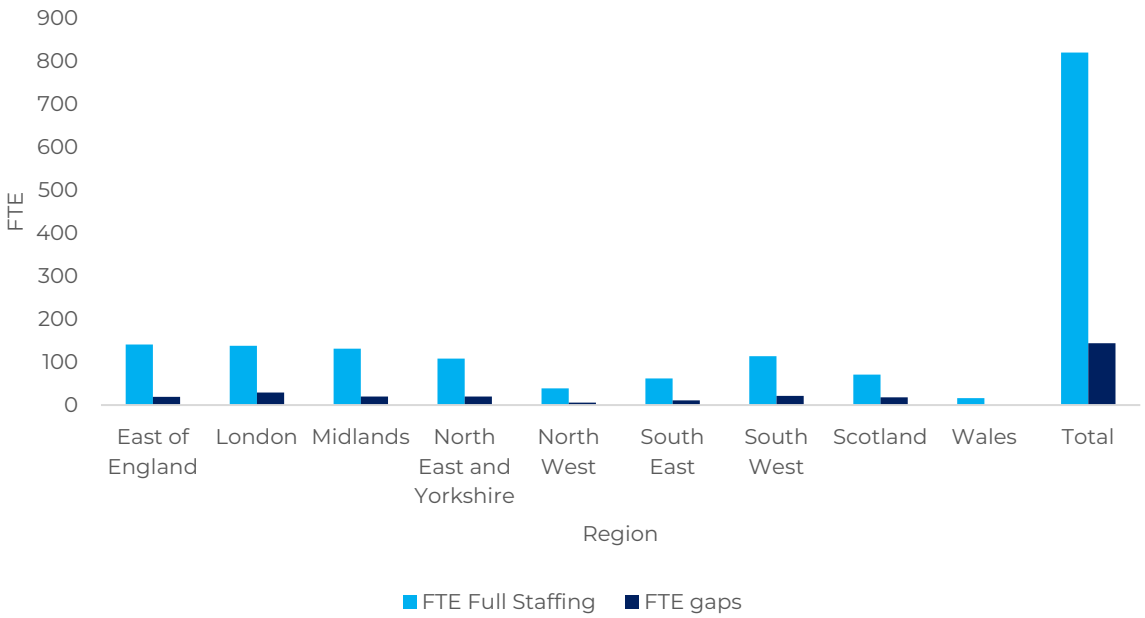

Figure 14: General Paediatric rota gaps by region and FTE

Neonatal

For Neonatal paediatrics, the highest proportion of gaps in England was in the South East, followed by the North East and Yorkshire (20.2%), while the region with the lowest proportion of gaps was London with 13.6%. When looking at individual tiers, gaps were higher for Tier 2 (21.2%) compared to Tier 1 (16.1%). Relatively high figures were reported for Wales on Tier 2 and Scotland and the South East for both Tiers, however these findings should be treated with caution given the small number of responses.

Region	No. of rotas	FTE Full Staffing Tier 1	FTE gaps Tier 1	% gaps Tier 1	FTE Full Staffing Tier 2	FTE gaps Tier 2	% gaps Tier 2	FTE Full Staffing Total	FTE gaps Total	% gaps Total
East of England	5	50	7.3	14.6%	38	6.9	18.2%	88	14.2	16.1%
London	8	96	11.5	12.0%	66	10.5	15.9%	162	22	13.6%
Midlands	4	31	4.2	13.5%	22	3.7	16.8%	53	7.9	14.9%
North East and Yorkshire	5	55	7.6	13.8%	48	13.2	27.5%	103	20.8	20.2%
North West	4	41	4.9	12.0%	32	7.4	23.1%	73	12.3	16.8%
South East	2	19	10.4	54.7%	21	7.4	35.2%	40	17.8	44.5%
South West	4	33	7	21.2%	27	2.1	7.8%	60	9.1	15.2%
Northern Ireland	1	10	1	10.0%	10	1	10.0%	20	2	10.0%
Scotland	2	19	4	21.1%	18	6.2	34.4%	37	10.2	27.6%
Wales	1	12	1	8.3%	8	3	37.5%	20	4	20.0%
Total	36	366	58.9	16.1%	290	61.4	21.2%	656	120.3	18.3%

Table 11: Neonatal Paediatric rota gaps by region and tier

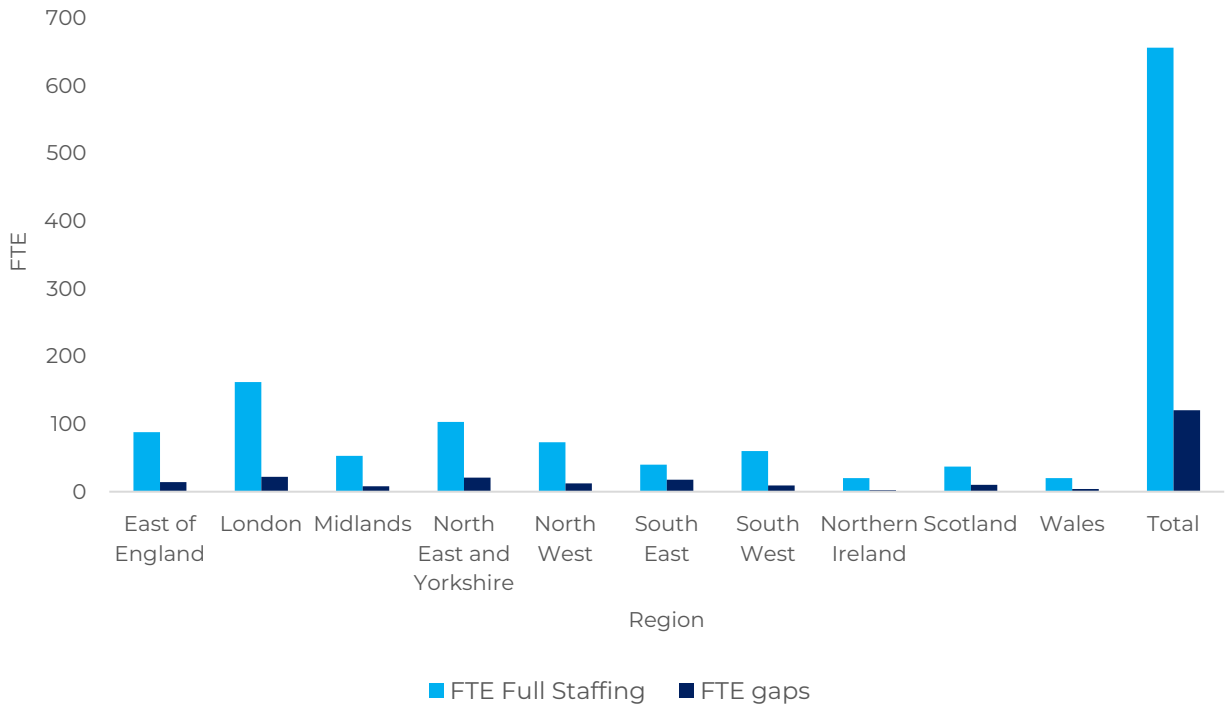

Figure 15: Neonatal Paediatric rota gaps by region and tier.

Combined General Paediatrics/Neonatal

Combined General Paediatrics/Neonatal rotas are most commonly found in District General Hospital (DGH) settings. The highest proportion of gaps was in the Midlands (34.5%) followed by the North East and Yorkshire (33.7%). The lowest was in London (11.5%). When looking at Tier 1 and Tier 2 individually, gaps were higher for Tier 1 overall; the opposite was true for Scotland, the South East, South West, and North West, and East of England. These findings should be treated with caution given the small number of responses.

Region	No. of rotas	FTE Full Staffing Tier 1	FTE gaps Tier 1	% gaps Tier 1	FTE Full Staffing Tier 2	FTE gaps Tier 2	% gaps Tier 2	FTE Full Staffing Total	FTE gaps Total	% gaps Total
East of England	7	41	3.5	8.5%	80	19.7	24.6%	121	23.2	19.2%
London	4	73	10.2	14.0%	61	5.2	8.5%	134	15.4	11.5%
Midlands	7	98	46.1	47.0%	93	19.7	21.2%	191	65.8	34.5%
North East and Yorkshire	8	70	26.6	38.0%	92	28	30.4%	162	54.6	33.7%
North West	5	42	5.2	12.4%	54	8.3	15.4%	96	13.5	14.1%
South East	4	53	5.4	10.2%	47	12.8	27.2%	100	18.2	18.2%
South West	4	23	4.8	20.9%	31	7.6	24.5%	54	12.4	23.0%
Northern Ireland	5	35	11.5	32.9%	34	7.4	21.8%	69	18.9	27.4%
Scotland	2	24	2	8.3%	20	5.9	29.5%	44	7.9	18.0%
Wales	1	10	1.8	18.0%	9	0.4	4.4%	19	2.2	11.6%
Grand Total	47	469	117.1	25.0%	521	115	22.1%	990	232.1	23.4%

Table 12: Combined General Paediatric and Neonatal rota gaps by region and tier

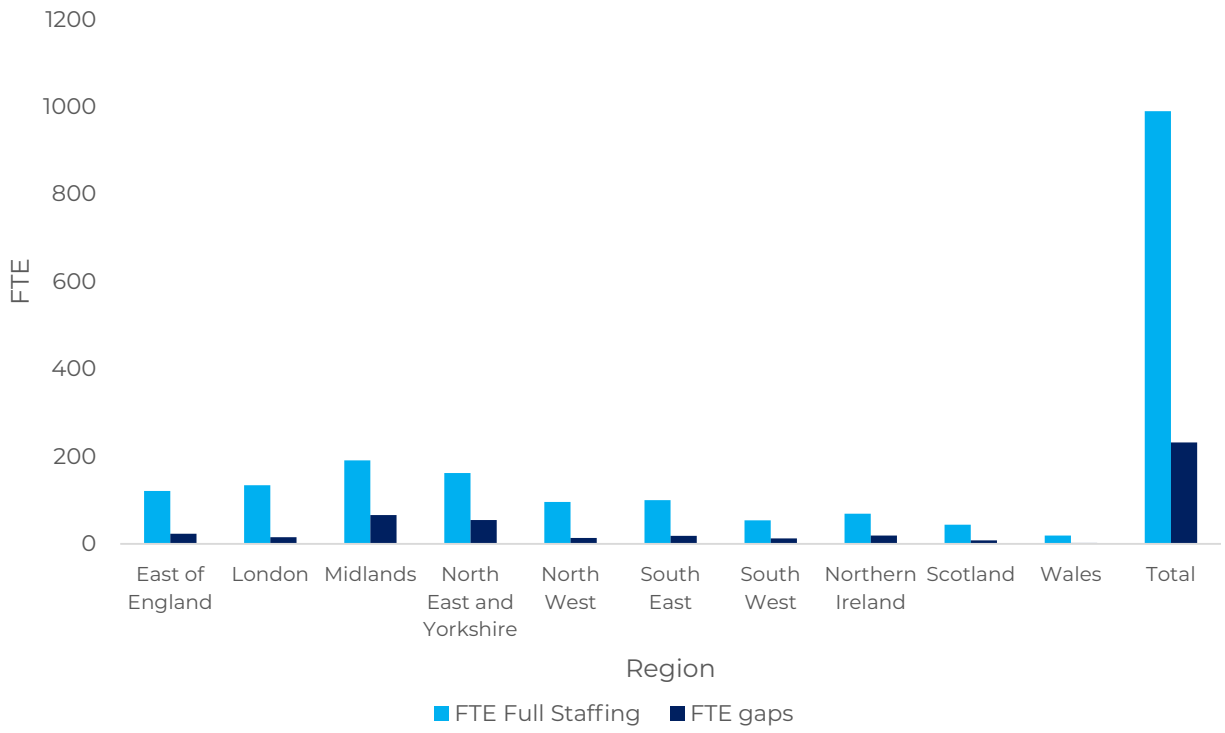

Figure 16: Combined General Paediatric and Neonatal rota gaps by region and tier.

Combined General Paediatrics/Sub-specialty and Sub-specialty rotas

For combined General Paediatrics/Sub-specialty and Sub-specialty rotas the data have been amalgamated given the small numbers. These rotas are most commonly found in Tertiary Hospital/ Teaching Hospital settings. The table below shows number of rotas, FTE for full staffing, FTE gaps, and percentage of gaps broken down by region. Nation for Sub-specialty and Combined General Paediatrics/Sub-specialty. In total, the 16 rotas taken into consideration recorded 19.2% of gaps.

Region	No. of rotas	FTE Full Staffing	FTE gaps	% gaps
East of England	2	29	4.2	14.5%
London	5	42	3.2	7.6%
Midlands	1	8	9.2	115.0%
North West	1	5	2.8	56.0%
South East	3	56	14.9	26.6%
North East and Yorkshire	2	80	12	15.0%
South West	1	24	2.5	10.4%
Scotland	1	34	4.5	13.2%
Total	16	278	53.3	19.2%

Table 13: Combined General Paediatrics/Sub-specialty and Sub-specialty rotas: partial responses for Midlands.

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Workforce information and planning:
Rota gaps survey findings 2024

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