Section 4: Quality Management of Training posts/ Programmes

Quality Management of Training posts/ programmes

We wanted to get a better understanding of any ongoing issues and successes in relation to training posts and programmes across the CSACs. When asked if there were any ongoing issues with training posts or programmes PEM, CCH, Clinical Pharmacology and Oncology had no issues to report. The committees below are aware of the following issues and where applicable have requested additional support or advocacy from the College to help address them.

CSAC	Any ongoing issues with training posts or programmes?	Action taken by the CSAC to address it	Further support the CSAC would like from the College
Diab & Endo	Concerns were raised regarding training at University Hospitals Leicester regarding access to appropriate tertiary endocrine training. While the hospital team has provided a structured rota and assured dedicated training time and opportunities for rotating trainees, the latest CSAC review still highlights ongoing organisational issues.	The Chair has previously written formally to the training centre and to the TPDs for both East and West Midlands, outlining the recommended changes. However, no specific remedial response has been received to date.	We would appreciate guidance from the College on how best to proceed with addressing these outstanding concerns.
TQB Response: A formal email will need to be submitted to the College is there are significant concerns outlining the concerns and the actions taken by the CSAC to date. Although, this is a Trust issue, with more information the College may be able to provide further guidance with support from the GMC.			
Neph.	Currently there is an unequal number of training posts between successive years meaning that in the year when the competition is higher a trainee may not be successful but would be in a less competitive year.	Discussions with trainee leads at each centre are taking place to determine if a solution can be found	No further support requested
Neurodis.	Consistency of neurology placement and access to tertiary vs secondary care	Chair is reviewing regional programmes and mapping them to regional models of care for neurodisabled	No further support needed

	for ND.	children, as these vary across the country.	
Neuro.	One trainee had to move deanery due to concerns about working environment and the support available to them from their department. Another centre had previous struggles and RCPCH made aware previously but would be good to have further discussion between RCPCH Quality Team and Neurology CSAC regarding this.	The CSAC are continuing to monitor the situation. The HoS and TPD are aware and have been providing support.	The CSAC would like a meeting with the RCPCH quality team to discuss concerns about training centres and how the college can support local deaneries.
TQB Response: A formal email will need to be submitted to the College is there are significant concerns outlining the concerns and the actions taken by the CSAC to date. Although, this is a Deanery issue, with more information the College may be able to provide further guidance with support from the GMC.			
PAIID	Some issues with trainees request[ing] prospective and retrospective approval of posts to enable eligibility for subspecialty applications.	CSAC to continue to monitor	No further support requested
PICM	Ongoing monitoring of rotational programmes to ensure residents don't progress until they've acquired all competencies in a certain area - e.g. completion of all cardiac ICU competencies prior to rotation away from CICU rather than extension of training later when the resident has already rotated away.	ISAC goal is to review programmes every 3 years to ensure that they are still meeting resident needs.	No further support requested
PGHAN	The Royal Free is merging with GOSH and so there will be 2 subspecialty trainees at GOSH.	CSAC to continue to monitor	No further support requested

Resp.	Minor supervision at a single site.	This has been highlighted to the site and is under review.	In a separate request - We would like a subspeciality in sleep to be re-considered
TQB Response: The GMC are not currently recognising any new subspecialties.			
Rheum.	Trainees have voiced concerns about their rotas and time away from their specialty posts for night shifts/days in lieu etc. This can become a significant issues in hospitals with rota gaps...Rheumatology is a predominantly outpatient based specialty with very little inpatient commitment so time away from specialty really does impact [trainees]. Departments also have different levels of staffing: e.g. some have St1/2s, some have fellow posts, and in some the subspecialty trainee is the only training grade.	We have encouraged our subspecialty trainees to be open to differences in departments and to make the most of their training opportunities.	No further support requested

CSAC successes in relation to training posts and programmes

The CSACs are continuing to advocate for high quality training in their respective subspecialties and have been successful in creating new training programmes, supporting flexible working pattens and restructuring existing programmes to optimise training opportunities and minimise the disruption caused by trainees moving between centres. Other CSAC successes include;

Creating new training programmes

- **PAIID** – A PID trainee will start in Wales in Sep 2025.
- **PGHAN** - Norfolk and Norridge are trying to become a training centre.
- **PICM** - East Midlands training programme has been established - this allows residents to remain in East Midlands rather than rotate to West Midlands or London.
- **PIMM** - For the first time Scotland have appointed to a training post starting in September 2025. The CSAC will monitor trainer staffing to ensure adequate support for the trainee placed in this post.

Trainee Progression

- **Neurodisability** - Ongoing oversight of all trainee progression and the role the CSAC have played in supporting local teams and trainees requiring additional support to facilitate the continuation of training.
- **Neurology** - majority of trainees who achieved CCT in past year had no major issues achieving competencies pre-CCT.
- **PEM** - High number of trainees continuing to excel and advance to consultant posts.
- **Respiratory** - Residents have been successful at achieving substantive consultant interview.

Flexible Working Patterns

- **Diab & Endo**
    - Several trainees are successfully combining clinical lectureships with their ongoing subspecialty training.
    - 83% of the trainees were working LTFT and the majority can access training opportunities appropriately within this time (2024 Trainee Survey Results).

Improving existing training programme structures

- **Diab & Endo** - Subspecialty trainees at the Royal London Hospital will have protected time in their subspecialty during the week working day hours from Sept 2025. This has been achieved by the Trust hiring additional General Paediatric Fellows in response to formal feedback to the TPD and Centre Clinical Lead.
- **Nephrology** - All UK sites are involved in subspecialty training either as a single or shared site.
- **PICM** - Agreement for rationalisation of St Marys/GOSH/Brompton rotations and addition of King's liver unit to training programme.
- **Respiratory** - Dual centre training has allowed a well-rounded experience for trainees.
- **Rheumatology** - Trainees are committed to 2 centre training, with the 2 centres fixed in the job description at the time of advert. ‘We’ve worked hard over the last few years to make this work for individuals with a degree of flexibility in timing and length of placement in the 2nd centre. We’ve had a few trainees apply for IDT (inter deanery transfer) to stay in the 2nd centre for the rest of their training often for personal reasons - whilst this is not ideal for the trainee it seems to have worked well for those who have had success’.

Section 5: SPIN

The SPIN Review continues to progress and as part of the SPIN Review all CSACs have been set an 8-week deadline for reviewing portfolio submissions for sign-off. With this deadline in mind, CSACs were asked if they needed to co-opt DGH colleagues to support portfolio sign-off and what other resources they may have enlisted to meet the new deadline. CSACs were also asked to confirm if they would be able to have reviewed and

standardised their SPIN curricular by 31 Jan 2026 and were asked to comment on the current quality of SPIN training and supervision. The responses are collated below along with a breakdown of the number of people participating in SPIN across Trainees, Post-CTT and Doctors in Paediatrics (DiP). The number of SPINs signed-off between 1 Mar – 31 Aug 2025 have been included alongside the completion rates for the first half of the training year (1 Sep 2024 – 28 Feb 2025).

SPIN	SPIN curricula reviewed by 31 Jan 2026.	Quality of SPIN training and supervision	Sign-off support	Total No. of Spinners	No. of SPINs signed off	
					1 Sep 2024 – 28 Feb 2025	1 Mar – 31 Aug 2025
Adolescent Health	No data collected			12 Trainees 9 Post-CCT **Total: 21**	**0**	**0**
AVM SPIN (CCH)	Yes	There are experienced AVM trainers and informal feedback from both trainee and trainers has been positive. 1 trainee is progressing well and is due to be signed off soon. A SPIN trainee who previously enrolled had dropout due to issues with arranging time away from acute Paediatric training.	As the AVM SPIN workload is low, this has not been an issue.	1 Trainee 1 Post-CCT 1 DiP **Total: 3**	**0**	**0**
Cardiology	No data collected			37 Trainees 12 Post-CCT **Total: 49**	**1**	**1**
CMH	Yes	Good	If we have bigger numbers, we might need more support for sign off.	4 Trainees 1 Post-CCT **Total: 5**	**0**	**1**

Diabetes (D&E)	This should be feasible, provided we are given the necessary template with advanced notice.	Trainees access a comprehensive range of opportunities covering the full scope of the Diab. SPIN module, as demonstrated in their portfolio submissions. The SPIN training approval process enables early identification of any gaps in training, particularly relevant for centres without tertiary services, and helps direct trainees to appropriate sites where these opportunities can be accessed. It may be beneficial to conduct a formal survey of SPIN training to gather structured feedback on the process.	This has not fully filtered to impact us at the current stage, we may see this as a work pressure building on us next year. Co-opt option may not be in the best interests as this may dilute the rigour of the assessment process.	91 Trainees 44 Post-CCT **Total: 135**	**2**	**1**
Epilepsy (Neuro.)	Yes	Good	No, managing with CSAC at present	66 Trainees 26 Post-CCT 2 DiP **Total 94**	**2**	**2**
HDU (PICM)	Yes	This is not within the remit of the ISAC - this TPD appointed and ISAC's only role is assessment at completion of the module.	No. In 2026 succession planning for lead of HDU SPIN portfolio assessment will need to occur - this may require co-opting another individual to support this.	95 Trainees 26 Post-CCT 0 DiP **Total: 121**	**2**	**1**
Neonatal Med.	No information submitted by CSAC			209 Trainees 40 Post-CCT **Total: 249**	**4**	**4**
Neph.	Yes	Excellent- informal feedback from trainees, consultant	These have all been signed off by the SPIN lead Dr Cottis	27 Trainees 7 Post-CCT **Total: 34**	**2**	**2**

			colleagues and SPIN supervisors				
Neuro-disability		Closed to new applicants			3 Trainees 2 Post-CCT **Total: 5**	**0**	**0**
Oncology		Yes – we're awaiting a response to our position statement prior to doing this.	Adequate	This is currently not underway, but we do have a pool of shared care consultants affiliated to the CSAC who are willing to facilitate this process.	38 Trainees 7 Post-CCT **Total: 45**	**0**	**0**
PA IID	**Allergy**	Yes	No concerns	No need to co-opt others.	24 Trainees 9 Post-CCT **Total: 33**	**2**	**3**
	Derm.				5 Trainees 6 Post-CCT **Total: 11**	**1**	**0**
	ID				26 Trainees 6 Post-CCT **Total: 32**	**0**	**0**
Palliative		No information submitted by CSAC			8 Trainees 5 Post-CCT 1 DiP ***Total: 14***	**1**	**1**
PGHAN		Yes	Excellent	Local networks and active involvement of paediatricians with a special interest on CSAC and active within BSPGHAN	23 Trainees 6 Post CCT **Total: 29**	**0**	**2**
Resp.	**Resp.**	Yes, we would like to recruit some gen. paediatric cons to our CSAC to enable us to do that.	Variable and unquantifiable We support the colleges stance for mid-SPIN review but needs extra capacity on CSAC to be able to deliver.	We have requested a permanent member - general paediatrician - to support portfolio sign-off. We have not yet heard back from the college regarding this.	54 Trainees 9 Post-CCT **Total: 63**	**2**	**2**
	Sleep				1 Trainees 3 Post-CCT **Total: 4**	**0**	**0**
TQB Response: It is acceptable for CSACs to co-opt General Paediatricians to SPIN Co-opted roles as set out in the paper circulated to CSACs in August 2025. We ask that CSACs wait until their ToR are updated at TQB in November 2025 so that the necessary governance can take shape before colleagues are appointed to such roles as the ToR need to allow for this new role.							
Rheum.		Yes	We have a gap in SPIN due to updating our curriculum, but trainees can participate in SPIN now. We have not	This hasn't been a problem up until now with the numbers we have but will keep an open mind.	9 Trainees 6 Post-CCT **Total: 54**	**0**	**2**

		had any concerns raised.				
Safe-guarding	Closed to new applicants			2 Trainees 4 Post-CCT **Total: 6**	**0**	**0**
Totals (All SPIN including trainees, Post-CCT & DiP):				**1007**	**19**	**22**

Figures have been provided using ePortfolio reporting. There may be some discrepancy with these figures if individuals are no longer completing SPIN but still have a SPIN role assigned on their ePortfolio.

Section 6: Portfolio Pathway

The number of Portfolio Pathway applications has reduced significantly during the second half of the training year. Between 1 Sep 2024 – 28 Feb 2025 6 CSACs (Nephrology, Oncology, Palliative, PGHAN, Respiratory & Rheumatology) received and reviewed 8 Portfolio Pathway applications. This reduced to just PICM who received 2 new applications for the period 1 Mar 2025 – 31 Aug 2025. Both applications were subsequently rejected due to insufficient evidence.

Although they have not been involved directly in the PP application and sign-off process between Mar – Aug 2025, the following CSACs highlighted their concerns regarding the current process and the barriers that they believe would prevent them from assessing applicants within the given timeframe. The number of non-CCT applications received from the GMC can be highly variable and do not necessarily indicate a trend. The Training Services Team has been working on collating specialty specific guidance (SSG) to establish the standard that applications should be assessed against and asked for the CSACs to confirm if the specialist learning outcomes (LO) and key capabilities (KC) in their subspecialties adequately address the requirements for a successful application.

CSAC	Are there any issues with the current PP application and sign off process?	Barriers preventing the CSAC from assessing applicants within the given timeframe	Do the Specialist LO and KC in your subspecialty syllabus adequately address the requirements for a successful PP application?
CCH	Yes. This work is not funded …the timeframes are often short. It is not clear why the college are asking members to do this work for free when there is a fee for drs to apply through this pathway. The college shouldn't be supporting the expectation that this	Time is a big issue and is not renumerated either through the college or through departments giving time for College activities that do not directly relate to revalidation/ training needs in a department. It is a challenge when the college team want regular meetings during their	Unsure. It is very difficult to tell from the limited evidence (though accept there is still an enormous amount) whether a doctor will make a safe community paediatrician as a lot of the work is about building relationships and working in teams which is very difficult to

	work is unrecognised and unpaid. It is not fair or right to expect trusts to be giving time for their employees to be contributing to a process which is paid for by the GMC / candidate. If the fee is not sufficient then the college should be advocating for a higher fee to be paid so the work can be done appropriately and renumerated as such.	working week (which is a completely reasonable ask by them but challenging to manage with a full time job).	assess thorough a selection of written documents which the applicant has chosen to share.
TQB Response: The College, of which the CSACs are a part, are hugely thankful for what the CSACs do to support training within their various subspecialties. The funding RCPCH receive per application is minimal and only just covers the admin costs of processing the application. We have discussed raising this amount with the GMC on many occasions (with our fellow Colleges) to cover our members time however they have always refused. However, we are continuing to feed into the College's wider 'Member In College Role' workplan regarding areas like PP applications which are intense activities.			
Diab & Endo	Concerns regarding the equivalency of the PP to the subspecialty training pathway, specifically in relation to meeting competencies in general paediatrics/ neonates/ community paediatrics pertinent to Paediatric Endocrinology has been flagged to the GMC as a patient safety issue.	Each PP application involves careful review of substantial evidence submitted. A typical PP application is several hundred pages long with multiple evidence/reflections over the years. This is simply not possible in the time allocated given all members of the CSAC are working in voluntary capacity on top of full time NHS posts. GMC has moved on with acknowledgement of concerns with the previous PP application and we highly recommend that the applicants should also demonstrate gen paediatrics competencies as otherwise this may not match the competencies of a Day 1 tertiary endocrinologist in the UK.	We recommend that the proposed parallel core skills be achieved to support applications through the portfolio pathway, particularly in relation to general paediatrics. There is significant overlap between general paediatrics and our sub-specialty, and it is essential that trainees demonstrate general paediatric competencies to a reasonable standard, in addition to sub-specialty competencies, to ensure safe and effective clinical practice. We have shared these recommendations with the GMC, who have acknowledged and begun to address the

			concerns raised by the CSAC. We strongly advise that applicants also demonstrate competencies in general paediatrics, as failure to do so may result in a mismatch with the expected competencies of a Day 1 tertiary paediatric endocrinologist in the UK.
TQB Response: The draft PDE proposed standards were annotated with comments from the Officer for Training & Quality and VP for Training & Assessment and email communications sent by the College to the CSAC. The College did not receive a response to the latest draft of concerns raised. A new sub-specialty guidance document has therefore been drafted by the College based on the existing expected standard and will be circulated to the CSAC by 30 September 2025 for review and comment.			
Neurology	Yes, a trainee was signed off without evidence being reviewed by the Neurology CSAC. Evidence for paediatric neurology was reviewed by the GMC assessors despite the CSAC having concerns and this has been highlighted to RCPCH. We would like to set up a meeting between RCPCH and the Neurology CSAC to formally discuss how a trainee has had a portfolio pathway review signed off without the curriculum aspects being reviewed by the CSAC and how to avoid this in future.	Yes - not being given the application to review in the first place.	Yes
TQB Response: The Training Services team can set up a meeting with you to discuss this further and ensure we work to capture all Paediatric Neurology Portfolio Pathway applications notified to us by the GMC. The GMC can choose to appoint a GMC associate however a recent meeting with them established that they will only do so where a CSAC panel cannot be convened within the legal deadline.			
Oncology	The Portfolio Pathway process is incredibly	As above	Yes

	time consuming. As a CSAC we will need to ensure financial renumeration for those involved if this is to remain sustainable.		
PGHAN	It is time consuming and difficult not to feel there is an inherent conflict of interest as the PP sign off candidates will be in direct competition with subspecialty trainees applying for consultant jobs. The process is inherently unfair to UK trainees who have equivalent training but have not undertaken subspecialty training.	v small CSAC and no time in job plans for this work	Yes
PICM	Yes - there have been issues with RCPCH awareness of the PP requiring ISAC assessment which has resulted in two applicants being solely assessed by the GMC alone with no ISAC input. Concerns who the GMC assessors are for sub-specialty PP applications. Adherence to timelines and ensuring that ISAC member is part of panel assessing applications for quality.	There is good engagement from all ISAC in this process as long as adequate notice given of upcoming applications.	Not currently but the new curriculum and new non-CCT sub-speciality guidance document will improve this and will support higher quality and improved standardisation of sign-off.
TQB Response: The Training Services team has discussed this with PICM CSAC and fully appreciated their concerns. We have taken this to the GMC for action. The GMC can choose to appoint a GMC associate however a joint meeting has established that they will only do so where a CSAC panel cannot be convened within the legal deadline.			
Resp.	No	No	Yes. We've submitted revisions to the document that was

			sent by Ben Harper (we've not heard back yet).
Rheum.	A long, time-consuming process but compared to some other specialties we likely have less applications.	No	Yes

Section 7: Careers, Recruitment & Workforce

Careers Promotion

This year all CSACs were asked to support and contribute to the *Choose Paediatrics initiative*. MY-AFF and A-AFF feedback indicated that all CSACS have achieved this and contributed to the initiative in some way. In addition to this, CSACs have supported the promotion of their subspecialties by developing website resources, attending roadshows, contributing to webinars and virtual career fairs, supporting taster day initiatives for medical students (PGHAN) and inviting interested trainees to join the POTG to access training opportunities and network (Oncology). CSAC members have also made themselves available to answer questions from prospective trainees.

Subspecialty Recruitment Process

Subspecialty recruitment continues to be a competitive process, to see a full break down of the application figures including fill rates, please refer to the 2024-2025 Mid-Year Quality Report where this was reported in full.

Changes to the subspecialty recruitment process were introduced this year as part of longer-term development plans to align all medical recruitment to sit under MDRS governance and the National Recruitment Team. The changes that were made to the application, shortlisting and interview process were shared with all CSACs as part of the November CSAC Assembly. Many of the CSACs noted improvements in the recruitment process compared to previous rounds. Neurodisability and PIMM were successful in appointing to all available posts. PEM noted that the '*shortlisting was quicker than previous years. The team interviewed most candidates to discriminate*' and Rheumatology found the process '*relatively straightforward…albeit we only had 3 posts advertised*'. No major changes are planned for the upcoming recruitment round (2026-2027 intake), so as part of the ongoing work to share best practice across the committees, we asked CSACs to identify what has worked well for them that they think other CSACs may benefit from knowing.

Sharing best practice

- **CCH** - Having members from all 4 nations of the UK enabled us to ensure that interview questions did not unintentionally disadvantage candidates who did not work in England (e.g. child death procedures and education vary across the regions).
- **Diab & Endo** – Introduced 2 sets of panels to reduce the pressure on the CSAC.

- **Neonatal Medicine** – The Chair met with all new interviewers in advance of the interview process. Discussed the process of online interviews, questions, the need to familiarise oneself with questions in advance, how to plan for breaks during a long day (prepare your lunch in advance). This really helped prepare the interviewers for their day.
- **Neurology** – Facilitate annual recruitment webinars including one for application form support by trainees and further webinar for interview support.
- **Oncology** - Have filled vacancies in the committee and introduced role-shares to ensure there is enough people to conduct CSAC reviews, sign-off at CCT, and offer support to trainees and educational supervisors. They have introduced an annual ES Masterclass and written clear guidance to improve communication and clarity about educational and training requirements and expectations.

Areas of improvement

Neurodisability, PEM, PICM and PIMM noted areas of the recruitment process which could be improved and requested additional support from the college to address them.

- **Neurodisability**
    - The shortlisting process was more "time efficient" [but] it was less discriminating
    - With maximal score allocated for first author peer review journal, there were candidates who had OOPE or overseas training in a completely unrelated specialty who gained maximal points, compared to a junior ST5 trainee who has passion for the specialty, presented multiple posters at local and national conferences, or completed relevant governance projects and scores lower.
- **PEM** - Some areas (publications and presentations) could be scored by college staff
- **PICM -** Improvement in overall recruitment process (shortlisting and interview) process to ensure process allows selection of individuals who are truly appropriate for the specialty.
- **PIMM -** The interview questions were mostly generic [and] not very discriminating. Shortlisting process - 2 candidates were far shorter of the standard than the top 5, ideally, we would not have shortlisted them. However, the nature of the application form and the shortlisting marking process meant that almost all candidates were interviewed (we held 8 interviews for 3 posts). Those 2 candidates were not appointable at interview and 1 further candidate was barely appointable. We would have preferred being able to interview fewer candidates.

Medical Recruitment Response:

1. Shortlisting – notable changes were made to the process for 2025 but it should be highlighted that the scoring criteria varied only very minimally from previous years, with the emphasis on improving the way that candidates' could share their evidence with the scorers, as clearly as possible. While there has been a higher set of average scores across the majority of specialties, we don't have any clear evidence of an adverse effect on the ability to discriminate between applicants. It would be useful to have some more specific examples of where items are felt to be less discriminatory, however, saying that, the aim of shortlisting is to get PGDiTs to interview (or not), so the main aim should be to identify those that are definitely not at that level. The shortlisting score has no significance beyond this point.

2. Publications/Posters/Presentations section – one of the things that we must aim to do, is reduce the emphasis on expecting all PGDiTs applying to sub-specialty to have gone "over and above" and pursued considerable extra-curricular activities, to be deemed suitable for an interview. As such, the shortlisting criteria, in it's current state, should aim to provide a bassline level of what is needed. The interview is the arena in which the assessors then have the opportunity to delve deeper into a candidate's experience and additional activities, experiences etc. In that sense, those that do find the opportunity to pursue more additional activities, can still be rewarded for them, by evidencing them at interview and gaining higher scores, based on things that are really relevant and necessary for someone who will be working in a particular sub-specialty.

3. Interview questions – following on from the above, we are very keen to ensure that questions are not too generic and would encourage writers to create questions that are suitably tough and discriminatory, according the sub-specialty. As such, where we do provide the career motivation and, from 2025, a selection of potential academic questions, for panels to use at interview, it is very important that assessors have a clear steer from the writers as to what specific qualities, experiences etc are particularly important for each sub-specialty. We will keep working with CSACs to help make each set of questions as suited to their sub-specialty as possible, with specialty-specific scoring criteria as a very important component.

4. Number of trainees interviewed – as touched upon above, we have been moving to a position whereby the shortlisting is intended to weed out only those who are clearly not suitably prepared for an application to their chosen sub-specialty. All those applying to sub-specialty recruitment are PGDiTs already successfully progressing through training, so most, who have properly prepared themselves for an application, should be eligible for an interview at least. As was started in 2025, we are now working nationally to expand the number of consultants who sit on panels as assessors, taking pressure off of the small numbers CSAC members to be trying to cover everything. PGDiTs do not get the opportunity to interview for many years, so this should be seen as a chance for them – even if they are not successful, it gives them valuable experience, which will help them when it comes to interviewing for a consultant job.

The Recruitment Team also wanted to understand what were the most important and least important of the current assessment areas covered in shortlisting and interview for each subspecialty.

CSAC	Most Important	Least Important
CCH	Clinical questions	The academic questions didn't always enable candidates to 'sell themselves' especially if describing in detail what they did, rather than the impact of it.
Clin Pharm.	The pre-existing knowledge and enthusiasm for the specialty	The value of the clinical scenarios helps in understanding how the candidates think but are less relevant.
Diab & Endo	Commitment to the sub-specialty, e.g. clinical experience, academic commitment and out of programme experience demonstrating dedication to specialty. D&E is very competitive (3-4 posts/per yr) - it is very important to ensure that the candidates that have put an extensive effort in demonstrating the above qualities are given a fair chance. It will be helpful to create sub-categories for scoring system to acknowledge this.	
Neonatal Med.	Shortlisting : Clinical, Audit/QI, – clinical – is a hands-on specialty, audit QI - lots of implementations of practice change and need to benchmark. Interview: Clinical (as above) and teamworking – we are very much MDT based and leading and working effectively as a team is key to safe effective Neonatal care.	Shortlisting: Research / academic
Neph.	All equally important	
Neurodis.	Professional behaviour, passion for the specialty, communication skills and understanding complexity and ED+I. Knowledge in neurodisabling conditions can be taught. It is crucial we have trainees who are committed to the specialty and have excellent communication skills.	It is extremely challenging to assess this on current shortlisting proforma and virtual interview.
Neuro.	All equally important in interview. Perhaps motivating factors would be the most important aspect.	
Onc.	Academic achievements have been the most helpful way of differentiating between candidates.	Commitment to speciality was the least helpful as all applicants had strong reasons for applying to our subspecialty.

PAIID	Evidence of experience in the subspecialty	Vignette about case. Everyone had full marks or near full marks. Not a good discriminator
Pall.	No response provided by the CSAC	
PGHAN	What experience the trainee has had in the specialty, evidence of their aptitude and understanding of the specialty. Demonstrating enthusiasm and excellent communication skills.	
PICM	Evidence of quality projects with meaningful learning/reflection rather than projects for projects' sake. Evidence of breadth of experience.	Current shortlisting and interview process does not allow for any true/in-depth assessment of the candidate.
PIMM	Aptitude for and preparation for the speciality.	Research should be an important aspect but the way it is included in shortlisting means good quality research struggles to stand out against poorer quality work.
Resp.	Evidence of clinical experience, and enthusiasm for the specialty	Extra points for specific courses such as 'teach the teacher'
Rheum.	Interest/ motivation in the specialty - ability to work in a team and good communication.	Not sure what is least important in the areas that are covered currently as we use it to build a picture.
MRB Response: It is always helpful to receive feedback around any part of the process and when it comes to the interview questions, this gives us a really useful basis for how approach the question writing sessions, so we can ensure that the questions reflect the areas, skills, experiences etc that are most important each sub-specialty. As noted above, it will be of particular importance to make sure that the sub-specialty specific requirements of the two questions that we provide templates for (i.e. career motivation and academic) are clearly covered in the scoring criteria.		

Evidencing Prior Experience

The Recruitment team continue their ongoing conversations with CSACs regarding trainees evidencing prior experience when applying at ST5 onwards. Standardising this process is challenging, and it is acknowledged that time does not equate to competence. The Recruitment team wanted to get the CSAC's perspective on how this process can be better administered and linked to capabilities, as opposed to time.

PEM felt their 'current system works. Candidates need to apply for training to be reviewed and counted in advance of starting subspecialty training'. In contrast to this, Diab & Endo noted that 'retrospective experience is not usually recognised...as quite often they may not have a structured or syllabus matched training'.

Neonatal Medicine, Neurology, Oncology and PICM all proposed giving trainees access or 'temporary access' to the subspecialty curriculum so they can evidence prior

experience against the same learning outcomes that they would map their subsequent evidence to. Neonatal Medicine suggested *'this could then be changed to "permanent" …when successfully recruited to subspecialty training. The Neonatal Curriculum is very broad, and not all trainees are good at developing their evidence from their "pre-approved posts which means there is significant "catch-up" needed when they are formally appointed to Subspecialty training.'* It was noted by Neurology that '*if they are not successful in the interview, then the portfolio may look messy if the subspecialty curriculum is still there!'. In addition to granting early access to the curriculum,* CSACs provided the following suggestions;

- **Additional verification from Educational Supervisors**
    - **PICM -** *A requirement for an ES report that details all capabilities achieved and suitability for subspecialty – an eportfolio document to formalise this would be needed.*
- **Developing components of the application form**
    - **Nephrology** - *encourage to evidence knowledge from an experience that has demonstrated an aptitude for the specialty*
    - **PIMM** - *Application form can have sections linked to the PIMM key capabilities and candidates can be encouraged to give examples of how these have been covered before - but this should not detract from a keen candidate's ability to apply for training without having worked in a PIMM centre before.*
- **Logbooks**
    - **CCH** - *Reflections of skills learnt/ experience. Logbook if performed specific procedures e.g. number of safeguarding medicals and reports written.*
    - **Respiratory** - *Completion of a logbook. Identifying breadth of experience that they are proposing to count with simple reflections.*

CSAC Requests for additional support in relation to subspecialty recruitment

- **Webpage updates**: *The information on the webpage needs to be updated to clarify that we cannot prospectively approve more than 6 months of sub-specialty training at a time. The total duration of sub-specialty training is 2 years, as previously highlighted, this time is limited. Therefore, we are unable to prospectively approve a full year of training.* (Diab & Endo)
- **Communication:** *Improved communication around the plans for sub-speciality recruitment* (Resp.)

- **Application Process:** *We were not happy with the subspecialty application process in 2025. Shortlisting was difficult with the generic and short answers available on the application form and it was very challenging to differentiate between excellent candidates with the limited information available, both on the application form and at interview. We need more information about academic achievements, publications etc which is very challenging to get from brief shortlisting text and closed questions at interview.* (Onc.)

Medical Recruitment Response:

Webpage update re: prior experience – we are currently looking to make the guidance around prior experience clearer to all involved. As such, we want to make a conscious move away from using the words 'counted' or 'counting', as it is not as clearly transferable as that. Prior experience only needs to be assessed by CSACs, as part of an application, if the PGDiT in question has less than the required indicative time left in training, for the sub-specialty they are applying for. With training being capability-based, what is needed is a judgement about whether the PGDiT has sufficient prior experience that they won't potentially need significant extension of their training time. As such, we would like to look at expressing this less in terms of specific time and more in terms of capabilities gained. Hopefully this will make it easier for CSACs to focus on the things that are most relevant to their own sub-specialties.

Communications – we certainly appreciate that there was a lot of information to be shared last year, and that some aspects were shared rather later than we had wanted. It is always our aim to provide clear and timely guidance around all our processes and we have made efforts to share the plans for this year's recruitment much earlier, and with a wider audience; most notably the educational supervisors group. If at any point, things need additional clarification, we are more than happy to speak to any stakeholders, so do contact the sub-specialty team inbox, if this is ever the case.

Application process – please refer back to comments provided above in the 'Areas of improvement' section (page 44), regarding the intended approach to shortlisting and also regarding the question writing process. As we look to put greater emphasis on the confirmation of eligibility, the importance of clearly discriminating and sub-specialty specific questions at interview becomes ever more important and we will be addressing this with sub-specialty teams in the writing sessions. For this year, we have now added QI/Audit to the confirmation of eligibility form, so that evidence can be pre-verified by educational supervisors and we will also be asking PGDiTs to upload evidence for their publications/ presentations/posters with their application form, which shortlisters be able to refer to, when scoring.

Workforce planning

CSACs were asked to identify what plans they had in relation to workforce planning as well as their future priorities regarding workforce development or sustainability. Several CSACs noted the current scarcity of Consultant Posts available for trainees who are CCT-ing and exiting training.

Workforce Expansion

- **CCH** – '*Consideration of Community SPIN to allow other paediatricians to transfer to CCH even after the end of their training.*'

- **Oncology – '***There is a shortage of paediatric neurooncologists. In view of this we are developing specific neurooncology training programmes and opportunities, both integrated into subspecialty training and as fellowships which can be taken as additional training opportunities. We have appointed a neurooncology subcommittee to the CSAC to facilitate this and have plans to pilot our first neurooncology programme in GOSH in 2026.'*
- **Respiratory** – '*we have an additional post in London and Leicester-Birmingham post, and we would be keen for those to remain.'*

Concerns re. Lack of Consultant Job Opportunities

- **Nephrology** - *it appears that there will be more trainees completing training than there are Consultant posts. This has previously been documented but unusual for trainees not to get a Consultant Paediatric Nephrology post*
- **PEM** – increasingly high competition ratios for consultant posts
- **PICM** - ISAC is concerned that '*PICM consultant jobs are no longer filed solely by sub-specialty trained doctors; Doctors who have completed alternative training pathways and those who have achieved sub-specialty recognition via PP are being appointed to these roles which makes workforce planning impossible as the numbers of non-subspecialty trained doctors are unknown'.*
- **Rheum** - *We currently have very few consultant vacancies and trainees are understandably concerned about what this will mean to them.*
    - *We have met with trainees individually as needed to go through opportunities including locum posts, working as a general paediatrician with interest, or time away from specialty e.g. in research - we have examples of trainees doing all of these and being happy in their outcomes.*
    - *We have also met with departments to discuss job plans, timings of adverts, and signposting to trainees who may be interested in working with them.*
    - *Finally, we have encouraged trainees to consider periods of acting up at the end of their training as this can really help the transition to the consultant role.*

WPB Response: Bottlenecks at several career stages (entry to national paediatrics training at both ST1 and ST3, and at the post-specialty registration level) have been a consistent concern raised by the College to central decision-makers and in our public workforce advocacy activity for several years. In 2019, the College recommended an additional 800+FTE consultants posts were needed in the immediate-short term, and the W&C team are regularly tracking this data at Paediatric workforce information and evidence library | RCPCH.

Recent policy and advocacy activity also include a parliamentary roundtable on the child health workforce with attendance from DHSC and NHSE LTWP teams, Spotlight on the child health workforce in England 2025 - policy briefing | RCPCH , Flexible working in paediatrics: Insights and data, legislation and guidance | RCPCH and upcoming outputs from the post-CCT survey and Facing the Future refresh. Recruitment for a new dedicated Policy & Insights Manager role within the Workforce & Careers department is also in progress.

Monitoring & Information gathering

- **D&E** - Plan to conduct a workforce survey via BSPED (referred to in section 1) across 19 centres in the UK to understand demand and capacity.
- **Neurodisability** – Plans to complete a gap analysis by surveying current trainees, cons with CCT and looking at current vacant posts to '*ensure that training programmes and numbers of trainees appointed match consultant vacancies*.'
- **Neurology** is undertaking ongoing work by BPNA and RCPCH including *'mapping consultant post requirements and recruiting adequately for this.'*
- **PICM** - Workforce survey completed 2022 - this will be repeated in 2025/2026.
- **PGHAN** - We would like to avoid the situation where excellent trainees have to move overseas because there is a freeze in consultant recruitment. Work force development is very fluid and unpredictable. A future where there was a national number of consultants per head of population covered might improve this.
- **PIMM** - Working with BIMDG to plan Consultant workforce

Workforce development and sustainability

Alternative recruitment processes to support LTFT Training

- **Respiratory** –'*moving to an acknowledgment that most residents now work LTFT so 2 posts could be advertised and recruited for 3 people to take this into account.'*

MRB Response: As we have discussed with several sub-specialties, in order to manage issues around the effects of LTFT on rotas, serious consideration should be given to how many posts are advertised during each recruitment round, to ensure a full rota for service and how this plays out in the long-term, from a workforce point of view. In an ideal world, the service aspects would not be so reliant on PGDiT roles filling rotas and other types of paediatric role could be utilised. However, in reality we appreciate this is not always a viable option; certainly not without sufficient planning. We need to be cognisant of not over-recruiting PGDiTs, ultimately resulting in there being too many qualified doctors for not enough consultant roles, so alternative methods of staffing must be considered as well, if there is a risk of this.

From a recruitment process point of view, it is unfortunately, not as simple as looking to "shoe-horn" appointed applicants into roles, during the latter part of the offers process, based on WTE, as there is not a lot of scope for managing this in a way that is fair to all concerned. There are pilots taking place nationally, to see if it is possible to work it so that some posts are advertised at LTFT but there is currently no acceptable method of doing this and it also doesn't necessarily help with the issue of producing more CCTs than there are jobs at consultant level. We are monitoring these pilots though and is anything can be taken from them, we will obviously share it with the sub-specialties, when appropriate.

Increasing training numbers

- **CCH** – '*the numbers of CCH workforce will decrease in view of a significant proportion of Consultants, Associate Specialists and Staff Grade doctors approaching retirement age. Recruiting more CCH clinicians is a priority.*'
- **Clin Pharm** hope to establish further training centres offering clin pharm training
- **Diab & Endo** – '*More training posts from training centres can be helpful to meet the work force demand.*'
- **Neonatal Medicine** – '*We struggle to get robust information regarding workforce needs across the UK*'
- **PAIID** – '*Both Allergy and PID would like increased number of consultants and trainees - but unlikely in current financial climate!*'
- **PEM** - Ensuring ongoing sub speciality growth is matched to training sites and numbers
- **PIMM** – *'getting a match between training posts and expected consultant posts. Training posts have increased from 4 to 7 so this should help.'*
- **Rheum** – *'will continue to work with departments and trainees. At a national level it is recognised that consultant expansion is needed (E.g. GIRFT) but at hospital level there is very little investment.'*

Sustainability and trainee development

- **Neurodis** – *'Ensuring we are encouraging trainees with passion for the specialty, and who are competent clinicians committed to lifelong careers. Ensuring that training programmes support trainees to develop appropriate competencies for their consultant role'.*
- **Neph** - There is a slight concern about the decline of academic Paediatric Nephrologists. *'academic paediatric nephrology shows an increased percentage of older consultants and that the process of selection of subspecialty trainees does not encourage those who would like to pursue an academic career. This in turn will result in fewer academic paediatric nephrologists.*

Requests of the College

Neurodisability wanted additional advocacy from the college on behalf of their subspecialty to draw attention and awareness of the importance of trainees receiving adequate exposure to clinics and activities relevant to their subspecialty.

- **Neurodisability** – *'Support to recognise that management of neurodisabled children and families are a high priority for health, social and educational support. If they are well managed in their home and local environment that has a huge impact on reducing need in acute settings. There is false economy to withdraw training and support for professionals managing chronic conditions, in favour of training staff in more acute settings, as this population then presents more frequently to ED and have longer in-patient admissions in secondary and tertiary care than is needed. Thus,* ***ND subspecialty trainees need adequate time in clinic and OP activities vs acute training. Ensuring that adequate recognition for management of chronic vs acute issues is recognised by TPD[s], to support time in clinics vs acute services/ on call rota.*** *Needing support from college to understand what SPINs are available in similar specialties so we don't overlap and how to support this.'*

TQB Response – Balancing out of hours/ acute and clinic work: The Board are looking at this as part of a wider piece of work in relation to outpatient experience. The aim is to establish a clearer stance on balancing emergency/ out of hours/ clinic work for both subspecialty and general paediatric trainees. This will build on previous recommendation with the view of making it fit for all trainees and applicable to a capability-based approach. More data from residents will be needed to support future recommendations and guidelines. The Board are also looking at potential revisions to strengthen the key capabilities across both the Core Level and Specialty Level curriculums relating to clinics and outpatient work. TQB is aware that any recommendations will need to be achievable across a range of services and training centres. Conversations regarding this are ongoing and CSACs will be updates as this initiative develops. A post-CCT assessment of exposure to training in emergency/ out of hours/ clinic work is also planned.

TQB Response - SPINs: All available SPINs are listed on our website: https://www.rcpch.ac.uk/education-careers/training-assessment/SPIN-modules.

SPINs are designed to enhance DGH practice and are pursued by general paediatricians as an optional supplement to their general paediatric curriculum. This perspective might be helpful to consider when developing any new SPIN materials. Whilst the SPIN Review has been ongoing, no new SPINS have been permitted. The Training and Quality Team will continue to liaise with the SPIN Working Group and will update CSACs including when and if new SPINs might be accepted.

- **Neonatal Medicine** - It would be helpful to get updated information annually from RCPCH AAC team on the number of Consultant Neonatal posts recruited to and the number of Neonatal "Special interest" posts put forward for subspecialty recruitment.

- **PICM** - *We would like workforce planning and AAC teams to input data to this survey. ISAC need RCPCH to share with them the number of AAC panels that are happening without a request for an RCPCH assessor.*

AAC Team Response: Over 75% of subspecialties have an AAC Lead role in place who look after matters relating to consultant appointments and we would ask CSACs to encourage colleagues to apply for these vacancies. At present Neonates and PICM are without a AAC Lead – and a lead would be ideally placed to liaise when it comes to producing reports from the AAC team's data (this is happening with other subspecialties currently.) These vacancies are live on our website; Education and training - get involved | RCPCH

Neonates – Yes, the AAC team can provide an annual update. Please email aac@rcpch.ac.uk with your request.

PICM – With reference to AAC panels happening without an Assessor, these are by definition done without the knowledge of the College team and so it is impossible to say how many are occurring. An appointment panel without an RCPCH Assessor is inquorate and therefore not an AAC. The data that the AAC have access to it limited to the AAC tickets that go through the College process. The AAC Team would be very happy to discuss further with the ISAC.

Section 8: General Feedback

How could the RCPCH support the CSAC better/ differently?

Recognition of time

- Voluntary roles [which] take a significant amount of time. Consider renumeration (discount of college fees, conference, given fellow status, or reduced membership fees whilst volunteering at this level or similar) (CCH & PAIID)
- The budget allocated to ISAC is significantly lower than the expenses incurred by panel members - this is currently under review within RCPCH. (PICM)

TQB Response: Following a budget scoping exercise with all CSACs, the amount of funds made available through individual CSAC Funding Pots has been revised. Individual budgets will now reflect reasonable spending and cost requirements of each CSAC rather than the previously arrange fixed amount. The single Terms of Reference will be revised to reflect this update with updated amounts made available from 1 Jan 2026.

- *For the forms we submit (such as this form) can we have a receipt email, and a PDF to be circulated to the CSAC so we know we have submitted, and all members can review content* (Resp).

TQB Response: The A-AFF was created on MS Forms with the option for respondents to save responses and download a copy of their submission for future reference. However, we can happily arrange for groups to receive a copy of their response data for future reference. Please contact the Quality and Training Projects Team if you would like to receive a copy; qualityandtrainingprojects@rcpch.ac.uk

CSAC Communications & streamlining requests

- Providing advanced notices and adequate timelines for proposed meetings, actions and tasks, being mindful of the time required to complete these requests.
- Reduce the amount of requests made for forms to be completed.
- *Could there be a monthly summary email (newsletter style?) with CSAC actions for specific roles, rather than multiple emails from several members of the college…emails can be repetitive and confusing and [may] be overlooked* (Respiratory)

TQB Response: The College appreciate the volume of emails CSAC members balance alongside their clinical commitments and do not want to add unnecessarily to this workload. Last year we introduced an end of year CSAC email which recapped any changes made during the year and reset our focus for the new year ahead. Alongside this the Education and Training Division has launched *Insights* – a quarterly divisional newsletter to keep you up to date on paediatric training, workforce and professional development. *Insights* has recently been instated and circulation will extend to all members (including CSACs) in 2026 once our new CRM is in place.

We are working to centralise information where possible to avoid things being missed or duplicated, for example the CSAC Calendar of events 2026 has been published on our CSACs - guides and resources for committee members | RCPCH, this provides CSACs with an overview of the year including meeting dates, quality review reporting deadlines and recruitment timelines. Similarly, all CSAC actions should be logged and tracked on the centralised action-log available via your Teams Channels. The action log is updated following each CSAC Chairs Forum and Assembly and reviewing and updating the action log should be a standing item on your CSAC Meeting Agendas. The actions logged as part of the Quality Review Reports are reviewed and cleared annually as they are ratified by TQB.

- *CSAC forums have reduced the ability to discuss processes with college staff as now the information is 'given' in these meetings. There is little opportunity for debate in this setting, with tight time frames and short time periods on the agenda to discuss. This can make the forums feel like something set up by the college to demonstrate consultation, whilst actually stifling this discussion from happening.* (CCH)

TQB Response: When CSAC Assemblies were introduced they were a new meeting. Prior to this there were only individual CSAC meetings which college staff and clinical leads (from TQB, MRB, EXB etc.) could not attend due to the volume of meetings that would mean (3 x 17 CSACs). It also meant that updates to CSACs were variable.

CSAC Chairs, through their forum, help control the agenda and suggest items and workshops for the Assemblies. We are also trying to introduce workshops where we can break the meeting down into smaller sections to promote conversations.

As always, we are open to any constructive suggestions about how this could be improved.

- *The CSAC do this work in their own time, so facilitating admin support to ensure there is notice is required. RCPCH pressure to trusts to encourage them, that if clinicians have formal roles, then additional SPA time may be granted* (Neurodisability)

TQB Response: As noted above we aim to give all CSACs as much notice as possible when setting meeting dates. We aim to keep ad-hoc requests to a minimum and where possible set reasonable deadlines for tasks requiring input from CSACs.

On a broader front, we have contributed to multiple national projects (i.e. Medical Training Review) to push for more support for trainers and those undertaking 'trainer adjacent' roles like examiners, START assessors and CSAC members.

We are also happy to write to your CEO/MDs if helpful to be clear on the importance of your work if you are discussing job plans.