Section 5: SPIN

The SPIN Review is nearing its conclusion. CSACs that currently offer SPIN were asked to provide an update on their modules and to identify any themes from current SPIN practitioners and supervisors. Additional feedback was also sought from the 3 SPIN Leads who oversee modules which sit outside of the existing CSAC structure; Adolescent Health, Cardiology and Dermatology.

Below are the number of people participating in SPIN across Trainees, Post-CTT and Doctors in Paediatrics (DiP). The number of sign-offs completed in the previous training year (1 Sep 2024 – 31 Aug 2025) have also been included alongside the number of SPINs signed-off during the first half of the current training year (1 Sep 2025 – 28 Feb 2026).

SPIN	Total No. of Spinners as listed on eP.	Total No. of SPINs signed off		% of SPINs anticipate being able to complete within 8 weeks of portfolio submission?
		1 Sep 2024 – 31 Aug 2025	1 Sep 2025 – 28 Feb 2026	
Adolescent Health	14 Trainee 9 Post-CCT **Total: 23**	0	**2**	100%
AVM SPIN (CCH)	2 Trainee 1 Post-CCT 1 DiP **Total: 4**	0	**0**	100%
Cardiology	36 Trainee 15 Post-CCT **Total: 51**	2	**3**	100%
CMH	6 Trainee **Total: 6**	1	**1**	80%
Dermatology	7 Trainee 7 Post-CCT **Total: 14**	1	**1**	100%
Diabetes (D&E)	87 Trainee 50 Post-CCT **Total: 137**	3	**4**	Aim to meet this deadline
Epilepsy (Neuro.)	59 Trainee 30 Post-CCT 2 DiP **Total: 91**	4	**4**	100%
HDU (PICM)	90 Trainee 32 Post-CCT 1 DiP **Total: 123**	3	**10**	100%
Neonatal Med.	222 Trainee 44 Post-CCT **Total: 266**	8	**10**	100%
Neph.	29 Trainee 7 Post-CCT **Total: 36**	4	**0**	No answer provided by CSAC
Neuro-disability	3 Trainee 2 Post-CCT **Total: 5**	0	**0**	Closed to new applicants

Oncology	39 Trainee 10 Post-CCT **Total: 49**	0	**2**	100%
Allergy (PAIID)	26 Trainee 9 Post-CCT **Total: 35**	5	**3**	100%
ID (PAIID)	31 Trainee 6 Post-CCT **Total: 37**	0	**1**	100%
Palliative	9 Trainee 4 Post-CCT **Total: 13**	2	**4**	Aim to meet this deadline
PGHAN	23 Trainee 6 Post-CCT **Total: 29**	2	**3**	*No response submitted by CSAC*
Respiratory (Resp.)	61 Trainee 11 Post-CCT **Total: 72**	4	**6**	100%
Sleep (Resp.)	2 Trainee 3 Post-CCT **Total: 5**	0	**0**	100%
Rheum.	9 Trainee 6 Post-CCT **Total: 15**	2	**3**	No answer provided by CSAC
Safeguarding	1 Trainee 2 Post-CCT **Total: 3**	0	**1**	Closed to new applicants
Totals (All SPIN):	**1014**	**41**	**58**	

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.

One of the aims of the SPIN Review was to understand the barriers preventing timely sign-off. Previously time and capacity were cited as limiting factor. As part of the SPIN Review an 8-week deadline was established for all SPIN sign-offs as well as the establishment of a SPIN Lead within the core CSAC structure. The majority of CSACs indicated that they anticipated 100% compliance with the new 8-week deadline. CSACs also highlighted the following actions that are contributing to timely SPIN sign-offs as reflected in the completion numbers in the above table:

- Clearer guidance e.g. **Cardiology** have established ground rules (around communication, scoping of SPIN, resource identification, etc) what have been distributed and are being followed
- Efficient SPIN leads & utilising SPIN Advisors **[PAIID, Palliative, Neonatal Med.]**
- Forming committees and panel to support timely sign & using pool of CSAC members with experience **[Derm, Epilepsy (Neuro.), Onc. & Pall.]**
- Manageable SPIN trainee numbers **[PAIID]**
- SPIN sign-off submissions are assessed by a panel every quarter as agreed with the RCPCH SPIN lead **[HDU (PICM)]**

Current Themes across SPIN

When asked what the consistent themes are coming back from practitioners and trainers in relation to SPIN, **Diab & Endo**, **PICM** and **Respiratory** reported that their modules are comprehensive and working well. **Adolescent Health** highlighted the breadth of their current curriculum but noted that 'adolescent health practitioners have a wide range of specialist interests'. Additional themes identified in relation to SPIN Modules and areas of challenge included:

Access (funding and/or time)

- **AVM (CCH)** - Primary training challenges are funding for post CCT doctors and facilitating paediatric trainee access to approve time for AVM SPIN training.
- **Cardiology -** Funding deficiency for providing supervision and training structure at the tertiary centres.

Adequate exposure

- **Oncology -** Trainees are struggling to get experience in primary treatment centre for SPIN training and are having to rely on OOPE opportunities creating inequality and unnecessary stress. RCPCH and CSAC have different views on the curriculum and knowledge requirement for SPIN in view of POSCU consultants.
- **Palliative** - There are ongoing discussions led by our SPIN advisor regarding the indicative time spent in specialist palliative care training posts. 6 months in a specialist PPM centre alone does not provide trainees with the amount of exposure and training they require to meet competencies- the SPIN curriculum review clarifies this.

Knowledge gaps & processes

- **CMH -** Trainers have found the system of support when signing off the SPIN quite challenging. They would like the process to be easy to follow and more accessible. Trainers would benefit from a network of support in the course of supervision.

Local Supervision

- **AVM (CCH)** - limited number and poor geographical distribution of trainers
- **CMH** - We have interest in SPIN training but do not have access to a supervisor locally to take on the post.
- **Neonatal Med.** - Ongoing work as to what forums exist or could be developed to support SPIN supervisors in their roles, current engagement is variable.

Training Capacity (DGH & Tertiary)

- **Cardiology -** Difficulty in ensuring training capacity in tertiary centres. This was a greater problem when SPIN candidates would appear on rota without

warning. This practice has now been eradicated. Funding deficiency for providing supervision and training structure at the tertiary centres.

- **Dermatology** - Lack of opportunities to complete the SPIN.
- **Epilepsy (Neuro)** - Need for tertiary neurology exposure as part of epilepsy SPIN, which has been agreed to be important aspect of SPIN training in epilepsy.
- **Oncology** - The limited availability of PTC training rotations for SPIN trainees meaning they have to take OOPE.
- **Palliative** - There are very limited SPIN training posts available nationally. Lack of DGHs that can support/provide this training resulting in some trainees being unable to achieve SPIN sign off.

SPIN Review Group Response: Tushar Vince as Clinical Lead for the SPIN Review and Cathryn Chadwick as VP for Training and Assessment as well as College staff from the T&Q team met with Oncology, PPM, HDU and Dermatology SPIN Leads. Sticking points to implementing recommendations from the SPIN WG were discussed and actions agreed with various items being brought to the upcoming TQB.

Oncology: The difference between what a tertiary centre needs and what the SPIN requires was discussed. It was agreed that the purpose of SPIN is to upskill the DGH general paediatrician. It was agreed that OOP should not be mandated as a method through which to attain a SPIN, and that training is capability based and the focus should be on the outcomes required from the curriculum. The CSAC are producing a briefing paper for TQB setting out what evidence, in particular what capability attainment is needed, that means training needs to be in a PTC. TQB will then determine whether this should form part of SPIN.

PPM: Amidst wider discussion, the different types of exposure a resident doctor would get in tertiary centres compared to a DGH was discussed. Agreement was not reached on whether a DGH would provide sufficient exposure to advanced complex care decision-marking. However, the group agreed that longitudinal supervision, allowing tertiary centre consultants to supervise SPIN doctors in DGHs would allow for the necessary level of expertise in supervision. This item will be discussed at TQB to also garner a general paediatrics voice. It was agreed that as a principle, SPIN should equip trainees with a secure enough knowledge base to then be more autonomous, and the focus is on capabilities rather than time.

HDU: It was agreed that the SPIN needs to develop safe practice in the learner and therefore there is a focus on capabilities rather than procedures. We suggested that "The CSAC experience is that the indicative time to achieve airway/anaesthesia capabilities is one month, but the priority is capability-based evidence that demonstrates the learner is able to support the care of the medically complex patient in a DGH." The SPIN Lead will discuss and agree this with the CSAC.

Dermatology: It was discussed that each School should have a network lead centre for Dermatology and this could be the tertiary or SPIN-specific lead centre which could provide 6 months of SPIN training. A plan was agreed whereby the SPIN Leads will explore how paediatric dermatology is delivered in their regions with the goal of producing a heat map of SPIN sites.

The SPIN Lead will approach Heads of School as a starting point and create a list of sites for SPIN. Once the proposal is received, this will go to TQB.

A hub and spoke network model is visualised and is an aspiration for SPINs which could go some way to supporting local supervision.

A lack of funding being a perennial issue is acknowledged although beyond the remit of RCPCH.

Resources to support the delivery of a high-quality SPIN Module

CSACs were asked what resources they would like to deliver a high-quality module, this included;

Training for Supervisors

- Training for SPIN Supervisors **[CMH & Derm.]**
- Ongoing support to engage with SPIN supervisors to ensure high quality training and supervision incl. awareness of mandatory assessments, and detail around curriculum engagement for SPIN trainees. **[Neonatal Med.]**
- Teams meeting for ESs to answer any questions about SPIN training and how to support trainees **[Sleep & Resp.]**

Curriculum (Access & Content)

- Access to curriculum prior to SPIN placements would be helpful as the curriculum is broad and this will aid appropriate planning **[Diab & Endo]**
- Need engagement from RCPCH to be allowed to develop bespoke SPIN curriculum for Oncology **[Onc.]**

Information sharing & Resources

- Annual SPIN webinars are delivered **[Epilepsy (Neuro.)]**
- Local training boards at which SPIN candidates are based should provide the funding for their 6-month (minimum) training allocation to a tertiary centre. Currently, in most cases the local training board retains the funding whilst the trainee is away, and the host tertiary centre is required to provide supervision, training structure and enhanced opportunities (for which SPIN trainees tend to be demanding) at its own cost. Some centres are now voicing an intention to stop taking SPIN trainees where funding has not been prospectively allocated from the local training board **[Cardiology]**
- Collating and centralising information about regional and teaching events aimed at SPIN trainees would be a very helpful resource which could be managed centrally (and advertised) by the college **[Neonatal Med]**

Trainee Reps for SPIN

- SPIN Trainee reps have been successful additions for Neonatal Med., Sleep and Resp.

Training Centres & OOPT opportunities

- Support for trainees to spend time within training at other larger centres around the UK for particular specialist training **[Adolescent Health]**
- OOPT opportunities for trainees - as they often have to come out of program to apply for fellow posts in order to gain competencies, however when completed at centres such as BCH the role very much also contributes to Paediatric training **[Derm.]**

SPIN Review Group Response: A SPIN Educational Supervisor Guide has been produced to support all SPINs which can be made bespoke to each SPIN. Further, a SPIN Handbook has been produced which will be circulated ahead of TQB in May 2026. This reflects the agreed changes to SPIN following the review. The above comments will be brought to TQB for further discussion and consideration of what supplemental support is feasible.

Section 6: Portfolio Pathway

Between 1 Sep 2025 – 28 Feb 2026 6 CSACs received and reviewed 9 Portfolio Pathway applications. The table below charts the number of PP applications received by each CSAC during each reporting stage and the outcomes.

	2023-2024 Annual Quality Review		2024 – 2025 Mid-Year Quality Review		2024-2025 Annual Quality Review		2025 – 2026 Mid-Year Quality Review	
CSAC	**No. of apps.**	**Comments**	**No. of apps**	**Outcomes**	**No. of apps**	**Outcomes**	**No. of apps**	**Outcomes**
CCH								
CMH								
Clinical Pharm.								
Diab & Endo.	**1**	Approved						
Neonatal Med.								
Neph.			**1**	Approved				
Neurodis.								
Neuro.							**1**	Approved
Onc.			**3**	Approved (Inc. 1 re-review)			**4**	1 Approved 2 Rejected
PAIID							**1**	Approved
Pall.			**1**	Approved				
PEM								
PGHAN	**3**	2 Approved 1 Rejected	**1**	Approved				

PICM					**2**	Rejected	**2**	2 Approved
PIMM								
Resp.			**1**	Approved				
Rheum.	***2***	1 Approved 1 Rejected	**1**	Approved (Inc. 1 re-review)			**1**	Approved
Totals	**6**		**8**		**2**		**9**	

The issues pertaining to the PP review process continue to centre on the time required to review the extensive evidence bundles that are submitted. In some instances, the relevance of some supporting evidence has been questioned by CSACs, however it would appear from the reduction in feedback provided by the CSACs, that the current review process is working more effectively than previously reported. The introduction of the Subspecialty Specific Guidance (SSG) and review panels seem to have streamlined the process, although Diab & Endo did highlight 'concerns that some aspects of general paediatric curriculum need to be incorporated in the PP application and should ideally be jointly reviewed from a general paediatric and specialty perspective'.

TQB Response: Coordination of panels and scheduling has been working well with two additional staff members from Training Services joining Ben Harper to assess Portfolio Pathway applications.

Diab & Endo: The comment raised has been discussed in detail with the VP for Training and Assessment and the outgoing Officer for Training & Quality noting that general paediatrics is a separate curriculum to PDE. Differences of opinion as to what should be assessed as part of a PDE application were resolved in the latest subspecialty guidance document authored by PDE. This will need review in line with GMC comments on all SSGs.

Neurology: The College Portfolio Pathway team met with Dipak Ram and had a very positive discussion and agreement of best practice. The letter to the GMC concerned an application which was assessed by the GMC rather than the College and the CSAC wanted to ensure the CSAC are not omitted from the review process. In this instance, this was due to a historical misunderstanding between the College and the GMC about how we are notified of applications awaiting review. This was noticed in late 2024 and in early 2025, we completed a thorough review of our internal processes and Standard Operating Procedures. We also met with the GMC to discuss our SOPs and confirm how applications will be allocated to the College going forwards. With this new process, now embedded into Portfolio Pathway College process, we will only need to rely on the GMC Associates to review applications ***if*** there is no availability from CSAC colleagues to conduct a review or a panel cannot be convened soon enough for us to meet the GMC legal deadline.

Section 7: Careers, Recruitment & Workforce

Careers Promotion

CSACs continue to support the promotion of their subspecialties through RCPCH coordinated events, workshops, webinars, regional programmes and career and recruitment events. It was highlighted by many that current competition ratios for training posts and consultant roles are indicative of the increased interest and awareness of paediatrics and associated career pathways and opportunities.

Subspecialty Recruitment Process

Subspecialty recruitment continues to be a competitive process with the demand from trainees often outstripping the number of training posts available. The below table highlights the number of posts available alongside the fill rate and compares the results across the recruitment rounds for the 2024-25, 2025-26 and 2026-27 intakes.

	2023-2024: AFF Figures Recruiting 2024-25 intake		2024-2025: MY-AFF Figures Recruiting 2025-26 intake			2025-2026: MY-AFF Figures Recruiting 2025-26 intake		
CSAC	**No. of posts**	**Fill rate**	**No. of posts**	**Posts Filled**	**Fill rate**	**No. of posts**	**Posts Filled**	**Fill rate**
CCH	33	100%	40	39	97.5%	32	30	93.7%
CMH	0	N/A	0	0	N/A	0	0	N/A
Clinical Pharm.	0	N/A	1	1	100%	0	0	N/A
Diab & Endo.	3	100%	5	5	100%	5	5	100%
Neonatal Med.	36	100%	32	32	100%	32	32	100%
Neph.	2	100%	9	7	77.78%	5	5	100%
Neurodis.	10	90%	6	6	100%	4	4	100%
Neuro.	4	100%	11	11	100%	5	5	100%
Onc.	5	100%	8	8	100%	6	6	100%
PAIID – Allergy	5	100%	4	4	100%	2	2	100%
PAIID – IID			1	1	100%	6	6	100%
Pall.	3	100%	1	1	100%	2	1	50%
PEM	25	100%	17	17	100%	16	16	100%
PGHAN – Gastro.	6	100%	4	4	100%	7	6	85.7%
PGHAN – Hep.			3	3	100%	1	1	100%
PICM	15	100%	14	14	100%	18	18	100%
PIMM	0	N/A	3	3	100%	1	1	100%
Resp.	5	60%	11	11	100%	6	6	100%
Rheum.	4	100%	4	4	100%	3	3	100%
Totals	156	-	174	171	98.3%	**151**	**147**	**97.4%**

Minimal changes were made to the subspecialty recruitment processes this year as the College's work to align all medical recruitment to sit under MDRS governance and the National Recruitment Team is ongoing. As part of this move, it is anticipated that recruitment processes will need to be standardised further to fit under a national recruitment model. The recruitment team are mindful that distinctions between subspecialties will need to be made within this framework to support the successful recruitment of trainees to each unique subspecialty. To help inform this, the CSACs were asked to identify the most and least important assessment areas covered in the shortlisting and interview process for their subspecialty.

CSAC	Most Important	Least Important
CCH	*No response provided by the CSAC*	
Clin Pharm.	The most important is 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	The assessment areas that allow candidates to demonstrate their commitment to the specialty are probably most useful in both the shortlisting and interview process.	None provided
Neonatal Med.	All current assessment areas in shortlisting and interview are equally important to assess readiness for sub-specialty training as they encompass the holistic nature of the specialty – clinical, communication, MDT working, experience of evidence-based medicine, working with families. Interview: clinical and team working domains remain essential – we are a multi-disciplinary team-based speciality and working effectively as a team is key to safe and high-quality neonatal care.	Shortlisting: the research / academic domain.
Neph.	Interview - clinical question helps to differentiate candidates as it is not an answer that can be easily rehearsed like the motivation question prior to the interview	None
Neurodis.	Professional behaviour, passion for the specialty, communication skills and understanding complexity and ED+I. Knowledge in neurodisabling conditions can be	None provided

	taught. For that reason, 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.	Most important aspect is being able to read non-verbal cues, which is much harder virtually.	None provided
Onc.	None provided	None provided
PAIID	None provided	None provided
Pall.	None provided	None provided
PGHAN	*No response provided by the CSAC*	
PEM	We typically find the clinical and motivation elements are the most discriminatory. The research, publication question on the application is laborious to mark with scorers having to fact check references for validity of claims	The research/audit/QI question in the interview the least relevant.
PICM	Clinical experience, involvement in audit/QIP and leadership.	Research
PIMM	The two speciality-specific questions	Some of the generic questions have seemed very generic and we fear may not be discriminating
Resp.	All domains are important and so all need to be included.	None
Rheum.	The clinical question is the most important. The others are equally useful.	None

Although feedback regarding the recent recruitment round was not sought as part of the MY-AFF, some CSACs highlight the following challenges regarding the application, shortlisting and interview elements of the recruitment process.

Application

- **PAIID** - Application form has limited scope/scoring for postgrad qualifications (i.e. non-clinical, non-academic qualifications e.g. postgrad diploma). Over representation of academic achievements (score for publication & research achievements separately) Hard to assess "high-quality" audit/research from the trainee ticking a box & in only 50 words. Hard to assess what developing & leading a teaching session means (lots of ambiguity)
- **Rheum** - We are still concerned, following the recent recruitment round, that subspecialty trainees are applying too early in their training and may not have

had sufficient time to consider their subspecialty path... I appreciate this is not easily resolvable.

Shortlisting

- **CCH** - Reviewing 60 applicants takes significant amount of time by 6 consultants and then only 2 applicants were not shortlisted. This is not a sensible use of time. It would be a better use of time to interview additional 2 applicants.
- **Neuro** - Whilst the shortlisting process was more "time efficient" for short listers this year. It was less discriminating and biased. 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, has presented multiple posters at local and national conferences, or completed relevant governance projects and scores lower.
- **Onc** - Shortlisting is too generic and doesn't allow us to differentiate between candidates adequately. We would like more influence on the questions and mark schemes for the short listing and interviews to ensure we appoint the candidates we feel most appropriate for paediatric oncology.

Interview

- **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 (matters relating to child death procedures and education vary across the regions). Reviewing 60 applicants takes significant amount of time by 6 consultants and then only 2 applicants were not shortlisted. This is not a sensible use of time. It would be a better use of time to interview additional 2 applicants.

MRB Response: As outlined in the 3-year transition plan for sub-specialty recruitment, we are moving towards a system that does not involve shortlisting and puts greater emphasis on the interview by including additional elements/types of question/evidence.

We are aware that there still needs to be some form of vetting of applications to control numbers and ensure applicants applying are suitably prepared. The changes made this year to the Confirmation of Eligibility Form (CoE) , will continue to be refined as part of this work and we will continue to inform and guide Educational Supervisors, so that careers discussions are more structured and regular and allow for better and appropriate preparation for trainees. Planned changes for review, will be shared by around May 2026.

What areas do you feel you need to retain particular emphasis and are there still parts of the future planning that you need further clarification?

Competition ratios

- Disproportionately High Competition Ratio at interview. We already interview far more applicants than we have capacity to train, each year we have a large number of applicants who have met the threshold score for appointment, but do not

secure a place on the programme. These applicants are disappointed, require feedback and support; the number of individuals in this position would only increase by interviewing all applicants to the programme.- Shortlisting should continue to be used effectively to bring forward only the most competitive candidates to interview, thereby ensuring that the process is a fair, genuine and meaningful assessment rather than a formality for the majority who will not be appointed. **[Neonatal Med.]**

- Good competition ratio at the moment for ND posts. There is significant overlap with the applicants who apply to neurology, although the specialities are different. In future it might be helpful to ensure that the application and interview process successfully distinguishes between those who really wanted to be neurologists, but defaulted to ND as a 'backup'. This appears to be increasingly common when reviewing application forms. **[Neurodis.]**

LTFT Training

- More thought regarding number of trainees that wish to train LTFT **[Neph]**

Oversight/ Involvement in interviews

- We anticipate that it will be challenging to oversee the interview process with a greater volume of candidates and increased number of interview panels required. **[Diab & Edo]**
- Conducting 150 interviews would require a substantial number of consultants with appropriate expertise in neonatal medicine to serve as panel members. These individuals are already carrying significant clinical and academic commitments, and this volume of interviews would place an unacceptable burden on their time. There is a real risk that we will be unable to recruit sufficient suitable assessors, which would compromise the quality and consistency of the process. The College has found it challenging to provide a 4th panel member for the 9 panels we have run over the past 2 years (the CSAC has provided 3 members and ensured consistency in chairing the panels each day, which the College has commended us for). Interviewing 150 applicants will almost certainly take more than the 3 days; which will increase the workload of the CSAC members in terms of provision of questions, chairing panels etc. **[Neonatal med.]**
- Panel consistency over two days is important to be fair. More rigorous benchmarking and more time allocated to look through the interview questions. This could be achieved as a separate time to formulate a bank of questions at a different time of the year **[Resp.]**

Question Setting

- Specialities should be allowed to choose their questions as they are looking for different skill set. **[CCH]**
- The ability for ISAC to write and therefore quality assure the clinical questions is valuable. The current RCPCH process is not fit for purpose for PICM recruitment. ISAC feedback is that PICM recruitment should move to a recruitment process

akin to FICM with a robust evidential standard for activities used to influence shortlisting scores. **[PICM]**

Smaller Subspecialties

- PAIID is not well represented across the 4 nations, so local recruitment would be quite discriminatory. **[PAIID]**
- We still wish to be involved in subspeciality recruitment and do fear that devolving this to a "one size fits all" GMC process may limit our ability to choose the best trainees however we are a very small speciality with relatively few posts and applicants **[PIMM]**

Further clarification required

- Need further clarification on the impact for particular subspecialities. New shape of training meaning less trainees able to have experience of subspecialities before applying for subspeciality training. With Oncology being so competitive a lot of trainees are therefore taking OOPEs to give them this experience. **[Onc.]**

MRB Response: We are currently planning to implement format changes to the interview process, to introduce split panels, meaning more interviews can be managed in a shorter time. We have had a much higher number of available assessors, who are not CSAC members this year and must continue to encourage this, to allow for better interview capacity and less pressure on CSAC members. Not having enough interview space is not a valid reason to curtail interview opportunities on its own.

Plans to improve the range of questioning possible at interview are due to be shared in May 2026. To reiterate, we want specialties to have ownership of the question-writing and ensure that they are assessing candidates against the qualities that they feel are most important to them.

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 and if would there be any disadvantages to withdrawing this option and allowing all trainees two application attempts in total, once from ST4 and a second from ST5.

Evidencing Capabilities

- Reflections of skills learnt/ experience. Logbook if performed specific procedures (e.g. number of safeguarding medicals and reports written) **[CCH]**
- Allowing trainees to the subspecialty curriculum ahead would allow easier review of the evidence in relation to KCs. **[Neurodis. & Onc.]**
- If trainees are appointed to sub-specialty training at ST5 it is essential that they could have prior access to the subspecialty curriculum on their e-portfolios in order to evidence their experience. These trainees should have 'prospectively

approved' training posts within a neonatal care or approved allied specialty setting. **[Neonatal Med.]**

- Hard to link to capabilities as they need to ask for approval prospectively but would then have to assess it afterwards. (this needs a lot more discussion) **[PAIID]**
- Very difficult to link prior evidence to capabilities if these are not in the curriculum the trainee is tagging. **[PIMM]**
- Evidence bundle is key - the current format is too subjective. **[PICM]**
- Being able to link prior experience of respiratory related KC would be easier to assess in terms of prior experience. **[Resp.]**

MRB Response: We are considering how best to implement a change to the number of attempts and the current prior approval process, which is not fit for purpose. WRB have had initial discussions and changes will likely be implemented for the 2027-28 recruitment rounds, and CSAC will be consulted further in the meantime.

Multiple attempts at subspecialty applications

Withdrawing prior experience: potential disadvantages	Allowing trainees 2 application attempts in total: potential disadvantages	Allowing trainees 2 application attempts in total: potential advantages
Could result in some excellent trainees, particularly those where English is not their first language not being appointed **[Neph.]**	It would be important to ensure limiting trainees to applying only twice does not disadvantage either trainees who work FT and are progressed to ST5 early based on capability or those who working LTFT / go on parental leave in ST4/5 given the differences in timing of gateway to ST5 according to ARCP vs timing of application window in the calendar year **[Neonatal Medicine]**	All trainees should be allowed a maximum of two attempts in total towards subspecialty application for equity reasons. With the current system, well-timed parental leave and working less than full time allows some trainees 4 or 5 attempts which is clearly disadvantageous to full time trainees or those who are unable to time their parental leave **[CCH]**
Would disadvantage some trainees where they already might have quite a bit of experience and have developed some of the necessary skills, delaying completion of training **[Neurodis.]**	It is possible that there are a lot of excellent trainees applying at the same time when there are fewer posts and they miss out **[Neph.]**	We already accept 2 attempts at application at ST4 and ST5 level. We do not accept retrospective evidence prior to subspecialty training **[Diab & Endo]**
Some trainees should be allowed to use prior experience as some are taking OOPES in order to gain more experience **[Onc.]**	PAIID is a 3y programme, so how would this work if start at ST5 with no prior experience? **[PAIID]**	Two attempts is a good idea as previously trainees who have had multiple attempts have been unsuccessful. **[Resp.]**

	All trainees should still be allowed 2 attempts, paeds onc is so competitive that often good candidates may not get at first attempt **[Onc.]**	I would favour two attempts in total. Not all Schools have paediatric rheumatology. **[Rheum]**
	We wouldn't be against allowing all trainees the opportunity to reapply at ST5 provided it was understood that they would still be likely to need 2.5-3y of indicative training time **[PIMM]**	
MRB Response: As above - we are considering how best to implement a change to the number of attempts and the current prior approval process, which is not fit for purpose. WRB have had initial discussions and changes will likely be implemented for the 2027-28 recruitment rounds, and CSAC will be consulted further in the meantime.		

Workforce planning

When asked if the CSAC collect data and evidence to inform workforce planning Neurology, PICM and Palliative confirmed that they collect data. In addition to this the following CSACs have also established formal and informal methods for monitoring and collecting data;

- **Diab & Endo** - have plans to collect data
- **Neph. -** BAPN intermittently send out a questionnaire to units which the CSAC can access, including info re. future workforce plans, consultant posts and retirement
- **Neurodis.** - currently undertaking a mapping programme. This includes survey developed through BACD of current consultants and trainees.
- **Onc.** – monitor subspecialty training numbers but not consultant roles or other workforce planning. Also don't have an awareness of the numbers of candidates being signed off portfolio process.
- **PEM -** monitors numbers of trainees and posts
- **PIMM –** monitoring linked with BIMDG
- **Resp.** – monitor the outcome of trainees and encourage centres to go via AAC panel for consultant interview as this is helpful for workforce planning.
- **Rheum.** - review consultant posts at meetings but don't collect data officially

The workforce team asked CSACs to share any plans or concerns that they had regarding future workforce development. In addition to this, CSACs were asked to identify any specific areas where the College could support the CSACs to work with decision-makers and relevant stakeholders within the NHS around workforce and recruitment.

CSAC	Plans and/or concerns re. future workforce development	Areas the College can support CSACs to work with decision-makers and relevant stakeholders	E&T Boards Responses
CCH	The numbers of CCH workforce will decrease, a significant proportion of Consultants, Associate Specialists and Staff Grade doctors approaching retirement age. Recruiting more CCH clinicians is a priority.	No	No response required
CMH	Discussing subspecialty recruitment in CMH with college	No	No response required
Clinical Pharm.	This depends on the outcome of current discussions with the College about the shape of paeds clin pharm training.	These are currently being discussed with the College.	No response required
Diab & Endo.	The flow from subspec. training to Consultant posts seems to be working well.	No	No response required
Neonatal Med.	Ongoing concern within CSAC around availability of robust information to plan future workforce needs across the UK.	It would be helpful to have consistent liaison with the RCPCH AAC team on the number of Consultant Neonatal Medicine posts recruited to nationally, and similar for Paediatrics with a Special Interest in Neonatal Medicine. This would help to inform the numbers for subspecialty	**MRB Response:** As previously discussed with CSACs, the team would be happy to include ongoing data in a shared SharePoint folder. It will all come with the caveat that the picture will not be complete however, as it will only be able to cover those appointments made via the AAC process e.g. 25 AACs in neonatal medicine were conducted in 2025.

		recruitment to neonatal medicine (as recruitment generally reflects projected workforce needs).	
Neph.	Lack of consultant posts for trainees on completion of training. There may not be enough Consultant posts to meet demand in the next 1-2 years.	Plan for consultants who in the future want to work LTFT. Consider NHS Consultants having academic PA's - University funding is unreliable. Expansion of posts to ensure equitable on call Rota's between units.	**WPB Response:** Bottlenecks at both entry to the national training programme and at the post-CCT stage are of current concern across all specialties nationally. The RCPCH has produced Consultant and SAS doctors job planning toolkit | RCPCH and Flexible working in paediatrics: Insights and data, legislation and guidance | RCPCH with recommendations and guidance on flexible working at the consultant level. PAs and SPAs are currently part of ongoing negotiations between the UK government and the BMA on consultant contracts – this process is independent of Medical Royal Colleges.
Neurodis.	There is a significant shortage of trained ND consultants nationally, with many empty posts, and consultants in post having large caseloads.	The college could help in collecting evidence of workforce shortages in the specialty, and to look at how to increase the number of doctors completing training in ND.	**WPB Response:** A potential RCPCH State of the Nation workstream is being discussed internally for 2027, which may include data collation on the sub-specialty workforce and service configuration. The clinical network is key to accurate and effective workforce planning – advise scoping current shortages and workforce challenges (e.g. caseload per consultant) within the CSAC's network of Clinical Leads and/or specialty group.
Neuro.	No	Some centres may require additional training posts in neurology and the college could liaise	**MRB Response:** The College is not a decision-maker on the provision of additional training posts; funding is at

		with the deanery to support this.	local/regional Deanery level and independent of the College. If data is required to support requests for additional roles, please contact the Workforce and Recruitment team and we can discuss what might be available/obtainable.
Onc.	Need to ensure there are jobs for subspec. trainees when they complete training, and also those from portfolio system. No specific route for transplant consultants.	More overview of the number of portfolio and grid trainees completing training and the overall number of consultant posts.	**WPB Response:** Advise liaising with ODNs/Specialty Group and their wider clinical network on any specific activity in this area e.g. consider a CCLG-led workforce census and/or including a national workforce plan as part of CCLG's current call for a National Children and Young People's Cancer Plan. Overarching paediatrics workforce data is tracked by the Workforce and Recruitment Team via the online evidence library and there are ongoing discussions at the College around a State of the Nation publication for 2027, which may take a closer look at sub-specialty services and their current workforce.
PAIID	There is a disconnect between trusts having future cons jobs & Trust's training posts.	No	No response required
Pall.	Challenges around funding for consultant posts within PPM.	No	No response required
PEM	Ongoing discussion at joint college level - RCEM tasked to more robustly monitor trainee numbers.	Liaising with RCEM would be useful presently there is no active updated list of RCEM PEM sub specialising trainees	No response required

PGHAN	No response submitted		
PICM	PICM graduates cannot be matched to consultant jobs due to competition from other avenues such as PP.	RCPCH should lobby GMC and others to better regulate competition from residents without CCT who are currently able to apply for consultant posts.	This has been extensively discussed before. Portfolio Pathway is formal legislation for the regulator. As the Medical Training Review is considered how LEDs can have pathways to re-enter training, it would also be very unlikely this legislation would be restricted at this stage. It is the route doctors who trained overseas but have relocated to the UK can access the specialty register. This is the same as with adult ICM.
PIMM	Working with BIMDG for this	Very niche speciality and the BIMDG and NHS commissioners are the main stakeholders.	No response required
Resp.	Concerns that usually one applicant at one consultant interview only; not competitive enough. These aren't always subspec. trainees.	Keen to optimise utilisation of subspec. posts so that LTFT trainees can jointly take a full time slot.	**MRB Response:** We are actively monitoring the LTFT pilot that has been run for some national specialties, to see if there is anything we can learn to help progress this. At present, it is very difficult to facilitate fairly but we have allowed some ad hoc situations, where other applicants are clearly not disadvantaged.
Rheum.	No, but we have purposefully limited our subspec training posts.	Would be useful to have more information re Consultant posts and populations but not sure this would change anything.	**WPB Response:** Advise liaising with Specialty Group on any specific activity in this area e.g. consider a BSR-led census of its members and/or working with Leads on findings and recommendations from the recent GIRFT report - ref. Paediatric-Rheumatology-National-Report-FINAL-December-2025-exec-summary.pdf Overarching paediatrics workforce data is tracked by the Workforce and Recruitment

			Team via the online evidence library and there are ongoing discussions at the College around a State of the Nation publication for 2027, which may take a closer look at sub-specialty services and their current workforce.

Section 8: General Feedback

Is there anything that the RCPCH could do to support the CSAC better/ differently, if so, what?

CSAC	CSAC Response	E&T Boards Responses
Diab & Endo	Giving adequate notice for CSAC activities - to allow at least the minimum 6 weeks required for rescheduling clinical work to ensure appropriate attendance.	The CSAC Resources Hub: https://www.rcpch.ac.uk/education-careers/supporting-training/CSACs is kept up to date with information re. the Quality Review Cycle and CSAC Chairs Forum and Assembly dates. If sufficient notice is not being provided for other CSAC activity, please provide more information to the Quality & Training Projects Team.
PEM	This year there were some applications to PEM grid from RCEM trainees at least 1 was shortlisted to interview. None of us could recall this happening previously but it raises the issue of how rotations in gird would work as some would be expected to cover general paeds or neonates out of hours in some rotations which would not necessarily be appropriate from an EM trainee.	**MRB Response:** Following discussions with the PEM CSAC Chairs, this has been take to MRB. It has been agreed that this "back-door" recruitment route will be closed for 2027.
Resp.	Updated list of Subspec. and SPIN trainees every year and their contact.	**Subspecialty Trainee Data:** Trainee data for those who have been successfully recruited into the subspecialty is shared with all CSACs following the offers process. This happens on an annual basis. All CSAC members have access to the reporting functions on ePortfolio so will be able to pull a list of trainees in their subspecialty. TPDs can provide more detailed information for the trainees currently undertaking training within their region should CSACs need more detailed information about individual placements.

		SPIN: Each SPIN representative has access to the reports section on ePortfolio. From the reports section they can extract an Excel spreadsheet that lists all their SPIN doctors (Trainees and Post-CCT) with contact details (emails) included.