National ACP/UKSMO Medical Oncology Residents' Survey 2025

Association of Cancer Physicians

UK Society for Medical Oncology

Table of Contents

Executive summary





Cancer care in 2025 is significantly different to cancer care a decade ago. There has been a significant increase in the number of anti-cancer therapies, and many new treatment combinations have become available. Systemic therapy is also becoming established at earlier stages of cancer treatment, with an increase in the number of indications for neo-adjuvant and adjuvant therapy. These developments provide new challenges for delivering safe and effective cancer treatment. As patients are living longer with their cancer, they receive more systemic anti-cancer therapy and are more likely to experience short- and long-term treatment-related toxicities. Cancer care is further complicated by treating an older population, with more comorbidities and polypharmacy. Although the future cancer workforce is likely to include a variety of different professionals, many from non-medical backgrounds, medical oncology consultants will still be central to delivering systemic anti-cancer therapy services. It is therefore essential that current medical oncology resident doctors have the training to deliver high quality cancer care as the consultants of tomorrow.

The Association of Cancer Physicians trainee committee (now known as the residents' committee) last conducted a national survey in 2019. Since then, training has changed significantly, with the introduction of the Oncology Combined Stem and new curriculum requirements relating to Acute Oncology. In addition, the impact of the Covid-19 pandemic has changed practice, with a move to more remote consultations, remote MDT working and flexible working. The effects of this on training have yet to be assessed. For these reasons, we launched the 2025 National ACP Medical Oncology Residents' survey, to gain an understanding of current issues with training, and any areas which could be improved. Although there are annual surveys from the GMC, and the National Education and Training survey, these are generic to all specialties, with only limited numbers of specialty-specific questions. There is value in a detailed survey of all aspects of medical oncology training.

We are pleased to present a summary of the findings of the survey, along with key recommendations that we believe will help improve the overall quality of the training programme nationally.

(Note on terminology- since 18th September 2024, the British Medical Association have referred to all doctors that have not reached consultant level as resident doctors. This covers doctors at all stages of training. The ACP currently represents doctors in higher specialty training only, although this will change with an update to the Constitution due to be launched in 2026. This survey was of current doctors in higher specialty training posts only, but for consistency with other documents/policy we will refer to them as residents. Also note that the ACP intends to be renamed as the UK Society for Medical Oncology from 2026).

Dr Richard Heywood, Dr Ella Daniels, Dr Joni Howells, Dr Paolo Davide D'Arienzo, Dr Karim H El-Shakankery
ACP Residents' Committee, Survey sub-committee

Abbreviations

ACP- Association of Cancer Physicians
ARCP- Annual Review of Competence for Progression
AO- Acute Oncology
CCT- Certificate of Completion of Training
CiP- Capability in Practice
CO- Clinical Oncology
CS- Clinical Supervisor
CUP- Cancer of Unknown Primary
DORPS- Direct Observation of Radiotherapy Planning Skills
DOST- Direct Observation of Systemic Therapy
ES – Educational Supervisor
GMC- General Medical Council
JRCPTB- Joint Royal Colleges of Physicians' Training Board
JSC- Joint Specialty Committee
LTFT- Less Than Full Time
MDT- Multi-disciplinary team
MO – Medical Oncology
MUO- Malignancy of Unknown Origin
NIHR- National Institute for Healthcare Research
NMP- Non-Medical Prescriber
OCS- Oncology Combined stem
OOP- Out of Programme
PI- Principal Investigator
QIP- Quality Improvement Project(s)
RCP- Royal College of Physicians
RCR- Royal College of Radiologists
SAC- Specialty Advisory Committee
SACT- Systemic Anti-Cancer Therapy
SCE- Specialty Certificate Examination
TPD- Training Programme Director
UKSMO – UK Society for Medical Oncology

Acknowledgements

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1. Medical Oncology Training in the UK

The medical oncology (MO) training programme lasts for 4 years (whole-time equivalent), with competitive national recruitment upon completion of the UK Internal Medicine Training programme or equivalent (after 2 or 3 years). Although not an essential requirement for progression, a high proportion of residents will take some time out of programme (OOP) to pursue research (including to gain higher degrees such as MD or PhD), leadership or teaching/education opportunities.

MO training is currently guided by the 2021 curriculum.[1] This curriculum identifies 18 Capabilities in Practice (CiPs) which need to be achieved for successful completion of training. Six of these CiPs are shared across other medical specialties, whilst twelve are specific to MO. At each Annual Review of Competency Progression (ARCP), each of these CiPs is assessed to ensure adequate progression is being made, and all 18 need to be signed off as completed (level 4 - entrusted to act unsupervised) to achieve a Certificate of Completion of Training (CCT). Progression in these competencies is assessed using a combination of workplace-based assessments (predominantly assessed by consultants), reflective practice, and attendance at formal teaching and associated training courses. Residents must have also passed the MO Specialty Certificate Examination (SCE) to complete the training programme successfully; it is recommended that residents attempt this at the end of their ST4 or start of ST5 year.

Upon completion of training, a doctor will be issued with a Certificate of Completion of Training (CCT) and can join the GMC Specialty Register, which allows them to then practice as a consultant in the UK.

After the Shape of Training review and the creation of Internal Medicine training in 2019, MO was designated a group 2 specialty, meaning that residents do not require dual training in Internal Medicine.[2] Instead, MO training places greater emphasis on delivering acute oncology (AO) services (managing admissions for cancer-related complications or treatment-related toxicity). In addition, the 2021 curriculum introduced the Oncology Combined Stem (OCS), a joint training programme for MO residents (under the supervision of the Royal College of Physicians) and clinical oncology (CO) residents (under the supervision of the Royal College of Radiologists). The OCS year is designed to give residents in both specialties experience in delivering both systemic anti-cancer therapy (SACT) and radiotherapy, alongside the shared competencies in AO. At present, residents who complete the OCS and wish to transfer can apply to do so (through national selection), with a view to being able to start at ST4 level in their new programme. We have not surveyed how many residents completing the survey had switched from CO to MO, but anecdotally, this is uncommon.

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2. Methods

A survey comprising 23 sections (all included in the appendix) was designed by a subcommittee of four members of the ACP Residents' Committee (Dr Richard Heywood, Dr Ella Daniels, Dr Joni Howells, and Dr Paolo Davide d'Arienzo). Some of the questions were also asked in the 2019 ACP survey,[3] allowing direct comparisons, but additional questions were added to comprehensively cover all relevant aspects of training. Members of the ACP Executive Committee reviewed the survey before publication, and approval by the Executive Committee to proceed with the survey was granted.

The survey was launched as a Google Forms document from 21st May 2025 to 11th July 2025. The survey was publicised to all UK MO residents in training posts, by the ACP newsletter and standalone emails to all ACP members. In addition, all deanery TPDs were asked to disseminate the survey to their residents, and the ACP Resident Committee regional representatives also regularly publicised the survey.

After the survey was closed, all data were downloaded from Google Forms into an Excel spreadsheet. The subcommittee has analysed the data.

3. Key findings and recommendations

- Overall satisfaction with training remains high, despite some of the challenges of working in the modern NHS.
- The majority of respondents plan to apply for NHS consultant medical oncologist posts, and 40% of respondents would be interested in consultant jobs that include AO activity.
- A significantly higher proportion of MO resident doctors are now in Less Than Full Time (LTFT) training (35% compared to 16% in 2019). Furthermore, approximately one-third of current full-time (FT) residents are planning to apply for LTFT training.
- Many LTFT residents report difficulties arranging flexible working and frequently having to carry out work on their non-working days. Additionally, their clinic workload is often similar to that of their FT colleagues.
- Since the implementation of the 2021 curriculum, with a renewed emphasis on AO, the majority of respondents agree that they have enough AO exposure to meet curriculum requirements. This has improved since the 2019 survey. However, one-third of residents reported insufficient exposure to cancer of unknown primary (CUP).
- The OCS has had variable implementation across the country, with some residents having very little formalised training in radiotherapy.
- Some residents report no or limited exposure to clinical trials as part of their training, and residents in non-academic training pathways report difficulties in engaging in research. We recommend that all units promote active involvement of residents in clinical trial activity.

- Residents often struggle to obtain funding for training opportunities such as external meetings and conferences. This has meant that many miss out on training opportunities due to costs.
- Resources to help prepare for the SCE remain scarce, and an increasing proportion of residents feel that the questions are not based on up-to-date practice. We recommend that the MO SCE Exam Board and Question Writing Group undertake significant work to address this issue.
- Residents report difficulties in providing evidence for CiP 16 "Managing the training and supervision of non-medical prescribers of SACT".
- Residents are frequently expected to request cross-sectional imaging on behalf of non-medical prescribers (NMPs).
- Access to mentorship schemes varies for resident MO doctors.

RECOMMENDATION 1: We call on all relevant bodies involved in workforce planning to work together to reduce bottlenecks at consultant level from the expansion of higher specialty training places in MO.

RECOMMENDATION 2: We recommend taking clinical experience and workload into account, rather than just "time in training," when considering ARCP and CCT dates.

RECOMMENDATION 3: TPDs and college tutors can refer to the newly published clinical timetable guidance for medical oncology residents (2025), available on the JRCPTB website.[4]. The ACP residents' committee has compiled information for LTFT residents, which can be disseminated through the ACP and via TPDs.

RECOMMENDATION 4: AO training should remain an important focus, and exposure to CUP should be specifically considered when designing training rotations.

RECOMMENDATION 5: We recommend that the Specialty Advisory Committee (SAC) provide clarification on expectations for the OCS, in conjunction with colleagues from the RCR. This should include guidance on expectations regarding clinic experience, planning experience, and what would be expected at ARCP to change to CO (for trainees who wish to switch).

RECOMMENDATION 6: Experience in radiotherapy (to the levels recommended above) should be recognised as an essential part of training in the OCS and incorporated into job plans and timetables. Residents should never have to seek out training experiences in their own time.

RECOMMENDATION 7: We encourage all residents and supervisors to consider the Associate PI scheme.

RECOMMENDATION 8: We recommend that the ACP/UKSMO consider developing resources to support residents taking the exam.

RECOMMENDATION 9: Access to mentors should be encouraged for all residents, either through their deanery or through the ACP/UKSMO mentorship scheme.

4. Respondents' demographics

A total of 103 responses were received (in comparison to 80 responses in 2019).

56% of respondents were female (66% in 2019), 38% male (34% in 2019), and the remaining 6% preferred not to disclose their gender identity.

83% of respondents reported that "heterosexual or straight" best represented their sexual orientation, 6% identified as "gay or lesbian", 1% "bisexual", and 11% preferred not to disclose.

49% of respondents reported their ethnicity was White (41% White English, Welsh, Scottish, Northern Irish, 4% White Irish and 4% white other), 25% of respondents reported their ethnicity was Asian or Asian British (8% Chinese, 6% Indian, 6% any other, 5% Pakistani, 1% Bangladeshi), 6% reported Black, Black British, Caribbean or African-American ethnicity, 4% Arab ethnicity, 3% mixed or multiple ethnic groups, 2% other and 12% preferred not to disclose.

38% of respondents reported having no religion, 27% were Christian, 15% were Muslim, 6% were Hindu, 4% were Buddhist, and 11% preferred not to disclose.

74% of respondents obtained their primary medical qualification in the UK, and the remaining 26% are International Medical Graduates.

5. Stages of training and LTFT status

Responses were evenly distributed across training stages (Figure A), with more ST3 respondents than in 2019 (Figure 1). More respondents were in programme than OOP (73% and 27%, respectively); this is similar to the 2019 survey (69% vs 29%, respectively), demonstrating a similar proportion of residents seeking OOP opportunities (Figure 2)

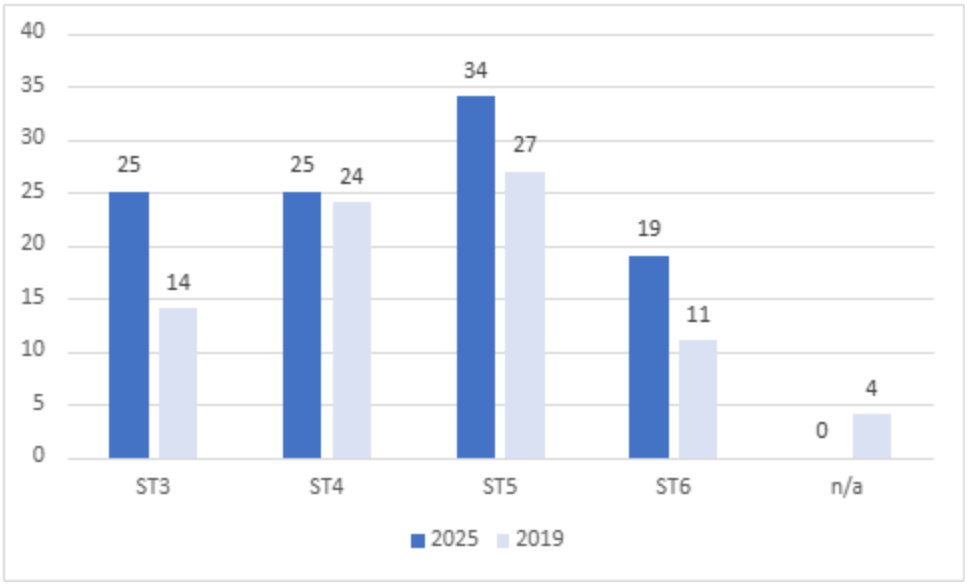

Figure 1. Current status of respondents. % of respondents at each stage of training on y-axis. Number of respondents written within the bars.

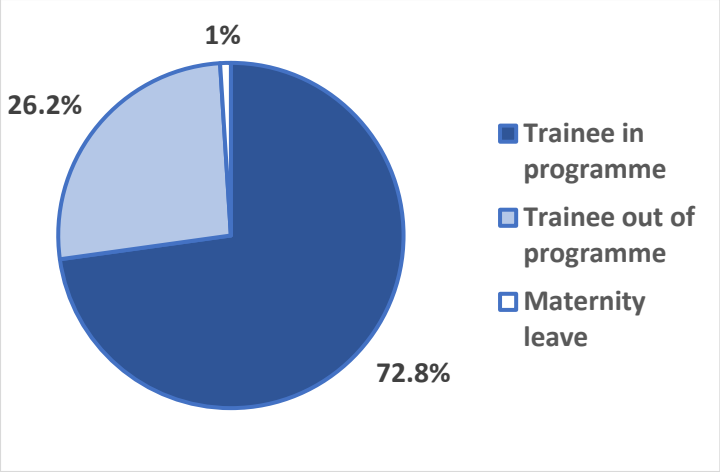

Figure 2. Proportion of respondents in and out of programme.

36 respondents (35%) are LTFT, which has more than doubled from 16% in 2019 (Figure 3). Of those working LTFT, most (78%; 28 respondents) are at 80% whole-time equivalent (WTE). Of those currently working FT, 22 (33%) plan to change to LTFT and 20 (30%) are unsure of whether they will change their working pattern. Further details on LTFT working are reported in section 5.9.

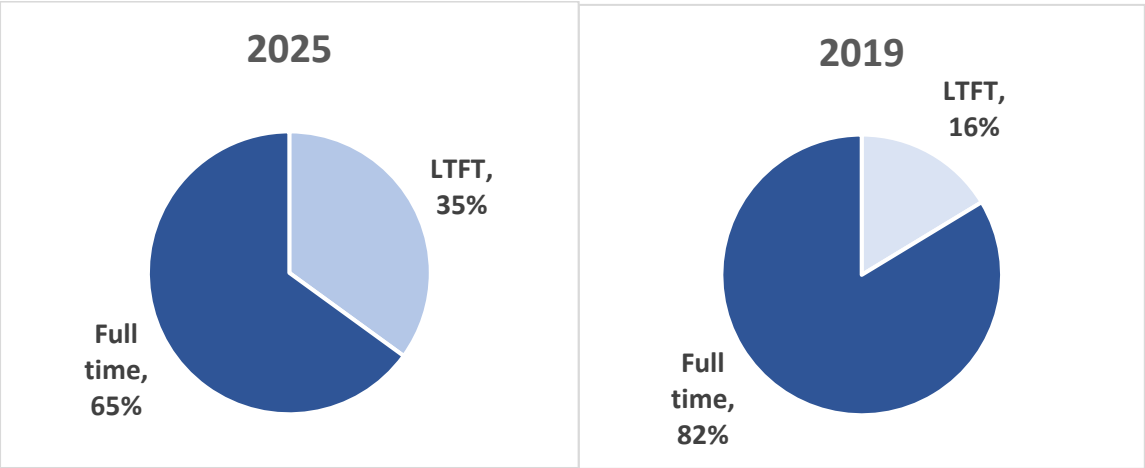

Figure 3. Proportions of FT respondents and LTFT respondents in 2025 compared to 2019.

6. Clinical experience and exposure

6.1. Inpatient management experience

The majority of respondents felt that arrangements for inpatient care allowed them to develop effectively and meet the curriculum requirements for CiP 9 (Providing continuity of care to oncology in-patients; 85.4% strongly agreed or agreed).

Similarly, 85.4% of respondents felt the level of support received from their consultants in managing oncology inpatients was commensurate with their grade. These results are very similar to the 2019 report.

6.2. Outpatient management experience

Most respondents (96.1%) reported regularly seeing newly referred patients in outpatient clinics, while the remaining 3.9% (4 respondents) reported not routinely seeing new patients. There was some variation in the number of new patients seen per week, as shown in Figure 4.

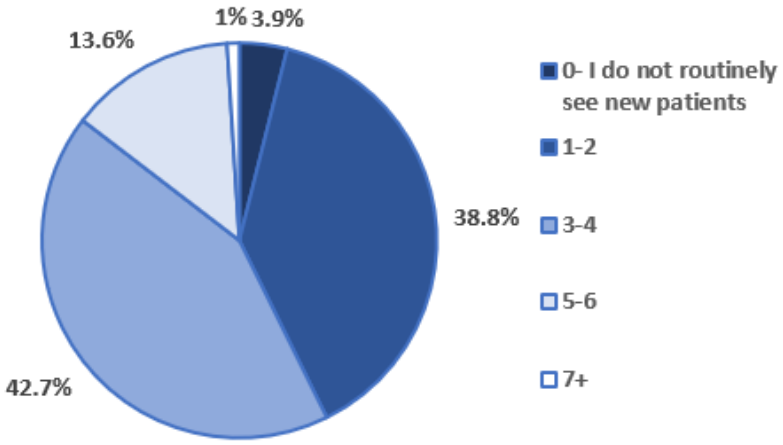

Figure 4. number of new patients seen per week in outpatient clinic

There was also variation in the overall number of patients seen on a weekly basis (Figure 5). Most respondents saw between 11 and 30 patients, but small numbers reported seeing very few (<10) or many (>40) patients.

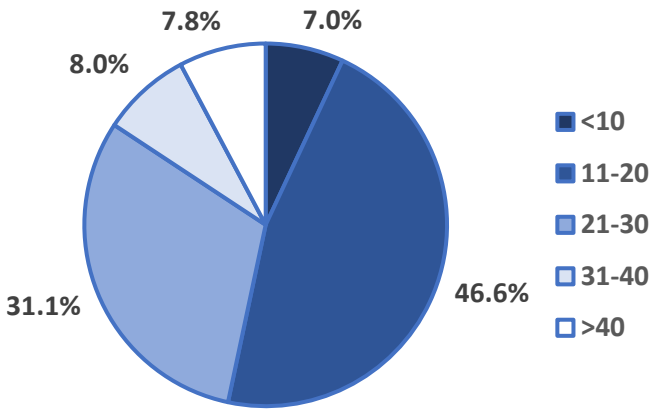

Figure 5. Number of patients seen overall per week in outpatient clinic

Approximately one-third of respondents felt their workload and their consultants' workload/availability always or almost always allowed for discussion of cases when required (34.0%), and this applied to approximately another third of respondents (31.1%). However, in the remaining third, this was true only occasionally (31.1%) or rarely (3.9%), indicating an issue with large workloads or reduced consultant availability for discussing all relevant cases for a proportion of respondents.

Recommendations:

- TPDs and college tutors can refer to the newly published clinical timetable guidance for MO residents (2025), available on the JRCPTB website.[4]
- Consideration should be given to allocating supervision time (e.g., blocked clinic slots or debrief time after clinic), for consultant reviews and for consultants to facilitate residents discussing patients.

6.3. MDT meetings

With regards to the value of participation in tumour-specific MDT meetings for their professional development, residents were asked to what extent they agreed with the statement 'Your experience of tumour-specific MDTs to date is providing adequate preparation to provide the MO opinion in MDT upon completion of training, as per CiP 10. Opinions here varied significantly, with only a narrow majority being convinced this is currently the case. A detailed breakdown of answers is provided in Table 1 below.

Table 1.

	Respondents (percentage)
Strongly agree	14/103 (13.6%)
Agree	43/103 (41.7%)
Neutral	26/103 (25.2%)
Disagree	16/103 (15.5%)
Strongly disagree	4/103 (3.9%)

This has not changed significantly since 2019, when 37% of respondents reported having no or rare opportunities to participate in MDT working.

The majority of respondents (70/103; 68%) reported no formal training experiences in effective MDT participation (e.g., mock MDTs or providing MO input to MDT discussions under direct/indirect consultant supervision).

28/103 (27.2%) of respondents answered the white-space question about the specific challenges they felt were associated with the MDT experience. Recurrent themes included:

- MDT being thought of as consultant-to-consultant discussions only and not a training opportunity for residents.
- Residents' role beyond case presentation and scribing is not encouraged.
- MDT not being a regular feature of residents' activities while attached to tumour site rotations.
- MDTs often occur simultaneously with outpatient clinics or consultant ward rounds, which take precedence.
- The standard format of MDTs in the post-COVID pandemic era being primarily Microsoft Teams meetings, rather than face-to-face meetings, limiting participation and interaction.
- The fast pace of MDTs impeding residents' participation and learning.

Recommendations:

- Residents should be encouraged and supported to take a more direct role in MDT discussions, beyond simply presenting and annotating outcomes. This is particularly relevant towards the end of training.
- Simulated MDTs (or similar MDT training) should be part of oncology residents' training.
- MDT attendance and involvement should be specified in resident job plans and recognised as a key part of training.

6.4. Tumour site experience

Experience per tumour site is shown in Table 2. Among the completed tumour sites, respondents reported an excellent or good experience 77% of the time. Poor experiences were only reported in 4 cases (0.7%).

Table 2.

Tumour site	Excellent	Good	Fair	Neutral	Poor	N/A – not yet completed
Breast	34	37	11	3	2	16
Lung	39	24	11	2	0	27
Lower GI	25	30	17	5	0	26
Upper GI	22	31	14	3	0	33
Urology	18	30	12	5	2	36
Gynae	19	34	10	2	0	38
Melanoma	34	18	10	1	0	40
Intensive therapies	11	20	17	1	0	52

Only 50% of respondents had completed an intensive therapies block before the survey. Tumour sites that counted towards intensive experience varied significantly nationally, but were reported as germ cell (76 responses), sarcoma (69), melanoma (40), lymphoma (36), early-phase trials (19), cellular therapies (7), and gestational trophoblastic disease (1).

Most respondents were made aware of local tumour site guidelines at the start of their rotation, with 33 (32%) receiving guidelines for all tumour sites completed, and a further 41 (40%) for some rotations.

Recommendations:

- The SAC has guidance in the Rough Guide regarding what tumour and treatment types can be used to achieve the curriculum requirements for the intensive therapies rotation.
- Residents should have access to tumour site-specific guidelines for each new tumour rotation.

6.5. Acute Oncology training

AO training has been a mandatory part of the curriculum since 2017; however, given the expansion of AO services throughout the UK, AO became an explicit high-level outcome in the 2021 update. Development in CiP 8 (Delivering the AO take, managing oncological emergencies, providing oncology advice to other healthcare professionals as part of an AO Service, and managing the AO service team) is expected throughout the training programme. Over time, residents are expected to become increasingly independent in investigating and managing patients in the acute setting, alongside gaining leadership capabilities such as managing an AO team.

Residents were asked their level of agreement with the statement that their AO experience to date has allowed them to meet the curriculum requirements for CiP 8. A large majority reported that this is currently the case (43/103, 41.7% strongly agree; 45/103, 43.7% agree), while a minority were ambivalent (7/103, 6.8%) or disagreed (8/103, 7.7%). Although the wording of the question differed, only 55% reported positive experiences (good or excellent), 13% reported poor experiences, and 33% reported neutral experiences. This suggests that the emphasis on AO training has improved residents' experience in this area.

Activities that commonly contributed to AO training included seeing patients in Oncology Assessment Units, outreach on medical wards and emergency departments, AO-specific teaching and involvement in immunotherapy toxicity clinics. A small proportion of respondents were involved in AO "hot" clinics, which represents a possible area for expanding training activity.

In view of the above-mentioned expansion of AOS services, we asked residents whether they would be interested in consultant jobs that specifically included programmed activities (PAs) relating to AO. The survey showed a relatively even split: 42/103 respondents (40.7%) answered yes, 28/103 (27.2%) answered no, and 33/103 (32.0%) stated they are unsure.

AO training includes a specific focus on developing relevant skills for the targeted investigation and rapid triage of patients presenting with a possible new diagnosis of malignancy, malignancy of unknown origin (MUO), or CUP. Residents were surveyed to determine whether the training

programme enables them to gain these skills. Approximately two-thirds (65/103, 63.1%) reported having adequate training, while the remaining 38/103 (36.9%) did not.

Recommendations:

- Residents should have exposure to patients with new presentations of malignancy, MUO and CUP throughout their training.
- For residents working exclusively in tertiary centres without general medicine, consideration should be given regarding opportunities to attend DGH AO outreach and CUP clinics.
- Exposure to CUP should be specifically considered when designing training rotations.
- AO "hot" clinics may represent a further area of expansion of training in AO.

7. Oncology combined stem

In 2021, the Oncology Combined Stem was introduced to training pathways for MO and CO. This was designed to promote closer working between the two specialties, provide MO residents with more experience in the delivery of radiotherapy, and increase the number of CO residents exposed to AO.

In terms of curriculum requirements, MO residents must complete 2 DORPS (direct observation of radiotherapy planning skills) assessments conducted by a CO consultant.

The MO rough guide recommends: 'As the OCS year is focussed on achieving common oncology CiPs (which includes exposure to radiotherapy, systemic therapy, AO and clinical trials), rotations for the ST3 OCS year are not prescribed, but a clinical rotation which reflects the balance of training in all these elements is required'.[5]

The minimum expectation of residents at the end of the OCS year is to have followed a patient's journey (including the planning and delivery of radiotherapy treatment) and illustrate an understanding of the assessment and management of treatment-associated toxicities.

ST3 OCS year rotations should include a tumour type where residents have adequate exposure to radiotherapy. For the radiotherapy element, clinical rotations in tumour types such as gastrointestinal, breast, and lung cancers, where more standard radiotherapy regimens are administered (including in palliative and acute settings), would be considered good examples of OCS rotations.

Of the survey respondents, 78 (75.7%) had either completed or were currently in the OCS year, reflecting the time elapsed since its introduction. Only respondents who answered yes to "were/are you on the OCS" were able to answer questions related to this.

The responses to our survey suggest that there is still variation in how the OCS has been implemented.

Although a majority of respondents attended clinics with patients undergoing radiotherapy (64.1% in some tumour sites but not others), just under a quarter (23.1%) reported not seeing any patients undergoing radiotherapy. It is possible that the timing of the survey (when some residents may still be in their OCS year and therefore may see radiotherapy patients after the survey completion) may slightly overestimate this proportion. Nevertheless, some residents do not routinely see radiotherapy patients throughout their OCS year.

Similarly, over half of respondents (57.7%) do not have any time allocated in their job plan for radiotherapy planning, and over half of respondents (56.4%) found it difficult or very difficult to obtain the required DORPS assessments.

As a result, there was very low agreement with the statement "You had the same training in radiotherapy delivery as ST3 Clinical Oncology trainees" with only 6.4% agreeing with this statement, and 79.5% disagreeing (Figure 6).

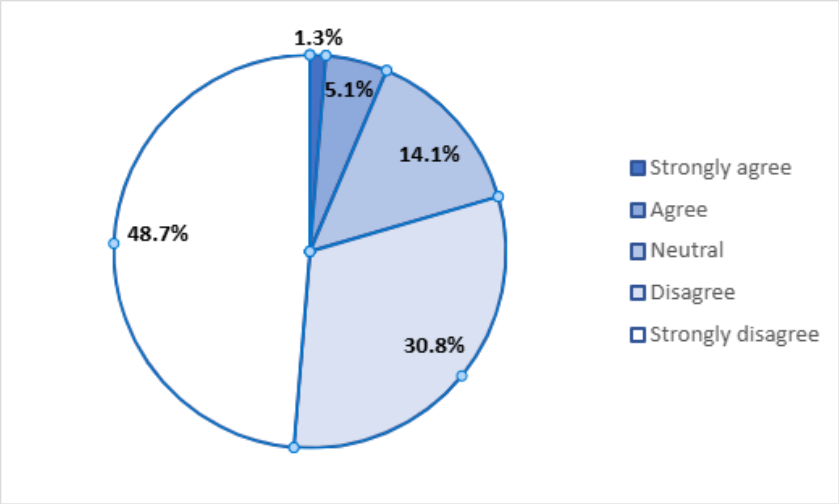

Figure 6. Response to question- To what extent do you agree with the following statement: You had the same training in radiotherapy delivery as ST3 CO residents

Despite reporting having different training experiences, a higher proportion of respondents felt that the OCS had improved their training (33.3%). Only around a quarter (25.7%) of respondents felt that the OCS did not improve their training, while the remainder were not sure.

Respondents were allowed to provide free comments about the OCS, and several concerns about its implementation arose:

- Variation in expectations from consultants – including MO consultants who are expecting their resident only to do MO clinics/wards, and CO consultants who are expecting the same time for radiotherapy clinics/planning as their own residents.
- Not having any radiotherapy clinics or planning integrated into a job plan, and therefore having to get these experiences in their "own" time (e.g. time that should be allocated to professional development or non-clinical days).
- Some ST3s are placed on rotations in centres without radiotherapy (and therefore have to travel to other trusts to gain experience).
- Some MO residents have their radiotherapy clinics cancelled (e.g. due to short staffing) because they are considered "extra".
- Training delivered solely by radiographers (and not by CO consultants).

Whilst free-text options will always introduce selection bias, there are clearly concerns about how the OCS has been understood and implemented.

The majority (79.5%) felt they received satisfactory teaching on radiotherapy principles, which is covered in most taught courses.

Recommendations:

- All OCS residents should be based at a centre that delivers radiotherapy for at least one rotation.
- Radiotherapy training through the OCS should be consultant-led. Teaching sessions from allied health professionals can be useful as part of a consultant-led training programme. However, MO residents on the OCS should have regular contact with a CO consultant.
- OCS residents must have protected time in their job plan to attend radiotherapy clinics and planning. Their attendance for these must not be viewed as "optional" or "extra", but a key part of meeting curriculum requirements. Consequently, they should not be cancelled except under extreme circumstances (as with other clinics), and any cancellation should be exception reported.
- The SAC should provide clearer guidance on the expectations for training during the OCS, including clinics, radiotherapy planning, and the ability to consent to radiotherapy (e.g., for palliative radiotherapy), and this should be included in an updated rough guide.
- All residents should be able to attend a taught oncology course that includes radiotherapy teaching funded through study leave budget.

8. SACT prescribing

38 respondents (37%) reported that training in SACT prescribing was required before being able to perform unsupervised in all rotations/tumour sites. This has improved from 32% in 2019. A further 28 (27%) reported that SACT prescribing training was required only for some tumour sites, compared to 32% in 2019.

29% reported no training being required locally before prescribing SACT unsupervised, decreasing from 36% in 2019. 6 respondents did not respond as they are currently OOP.

SACT prescribing training is delivered in various forms, as shown in Table 3. Formal training has improved from 21% in 2019 to 43% in 2025, and workplace-based assessments have improved from 37% to 82%.

Table 3.

Training type	Responses
Workplace-based assessments	84
Informal discussions	79
Formal training	44
Prescribing course	20
None	4

32 respondents (31%) reported that their current post used a formal record of SACT prescribing training, such as a "SACT passport" or similar competency document. Only 9 residents (9%) reported not having SACT prescribing guidelines or protocols to follow, compared to 19% in 2019.

Recommendations:

- Formalised training in safe SACT prescribing should be delivered under appropriate supervision (in most cases, by consultants and/or senior pharmacists).
- SACT prescribing should be formally assessed through workplace-based assessments, in line with national frameworks and competency levels.
- All residents should have access to tumour site-specific management guidelines and SACT protocols. Where these cannot be provided locally, national or other relevant guidelines/protocols should be easily accessible.

9. Research experience

MO has a track record as an academic specialty in a rapidly evolving field, about both the scientific understanding of disease and the ever-increasing therapeutic repertoire. As the 2021 curriculum states, 'Medical Oncologists are trained to participate in clinical research, leading the development and delivery of cancer trial protocols', and 'this requires specialist training in research methodology as well as the time and resources to implement clinical trials'.[1]

Residents were asked whether they had undertaken or had plans to undertake an OOP experience. 59/103 answered yes (57.3%), 26/103 answered no (26/103), and 18/103 were unsure (17.5%). There was a broad range of opinions regarding the opportunities for OOP schemes (Table 4). Breakdown of deaneries within or outside London did not show any significant difference in this domain (data not shown).

Table 4 includes a detailed breakdown of respondents' ratings of the availability of opportunities for OOP schemes within their deanery/geographical region.

Table 4.

How would you rate the opportunities for out-of-programme schemes available within your deanery or geographical region?	Very good	18/103 (17.5%)
	Good	27/103 (26.2%)
	Average	29/103 (28.2%)
	Poor	19/103 (18.4%)
	Very poor	10/103 (9.7%)

With specific reference to postgraduate research degrees, around half of respondents had no formal research-related postgraduate degree (51/103, 49.5%), with 31.3% having or working towards a PhD, and 20.3% having or working towards a Master's degree.

Clinical academic residents (15/103 respondents, 14.6%) have dedicated time for research activities. Therefore, we asked residents in non-academic training pathways (n = 88) whether they felt they had adequate opportunities to get involved in research while on the training programme (if they so wished). Just above one-quarter of non-academic residents reported this is currently the case (26/88, 29.5%), while half reported this is not the case (44/88, 50.0%), and 16.7% (18/108) were unsure.

10. Clinical trials training

The 2021 curriculum states that the training programme should allow residents to develop skills to 'implement clinical trials of systemic anticancer treatments at investigator level for all phases, with the skills to lead late phase (Phase III) trials as Principal Investigator' (CiP 18).[1]

First, we surveyed residents to determine whether they had had the opportunity to participate in clinical trial-related work across tumour rotations. 42/103 (40.8%) answered that this is the case in all tumour rotations, 55/103 (53.4%) reported this to be the case only in some tumour rotations, but not in others, and 6/103 (5.8%) reported that involvement in clinical trial work is rare/absent in their training programme.

Residents were asked whether they agreed that exposure to clinical trial work during their training programme would allow them to take on Principal Investigator (PI) roles for clinical or observational trials upon completion of training (they were explicitly advised to disregard any relevant experience gained during OOP periods); respondents had a wide split of opinions, as shown in Table 5.

Table 5.

To what extent do you agree with the statement- Exposure to clinical trial work during your training programme will allow you to take on the principal investigator role for clinical or observational trials upon completion of training?	Strongly agree	23/103 (22.3%)
	Agree	32/103 (31.1%)
	Neither agree nor disagree	22/103 (21.4%)
	Disagree	21/103 (20.4%)
	Strongly disagree	5/103 (4.9%)

The NIHR Associate PI Scheme is a programme that provides healthcare professionals with hands-on experience in leading the delivery of NIHR portfolio clinical trials under the mentorship of a local PI.[6] Of the respondents, 36/103 (35.0%) have completed the scheme to date, 43/103 (41.7%) have not yet done so but plan to do so in the future, 12/103 (11.7%) were aware of the scheme but were not planning to complete it, and 12/103 (11.7%) were unaware of the scheme.

Recommendations:

- Involvement in clinical trials is an essential part of training in MO, and so every resident should have exposure to at least some rotations (acknowledging that this may not always be possible for every rotation, based on the number of active trials).
- Enrolment in the NIHR Associate PI scheme should be encouraged, both to meet curriculum requirements and for professional development.
- For residents on non-academic training schemes, there should be pathways for engagement in research if they wish to pursue it.

11. Teaching

11.1. Local teaching

Structured teaching is essential for developing the clinical knowledge required for MO training and for preparing for the MO Specialty Certificate Exam.

Most respondents (86%) attend local structured teaching, such as journal club or departmental teaching. 39% of respondents attend between two and four hours of structured teaching per month, and 17% report more than four hours per month. Of those residents who did not attend local teaching (14%), 29% were OOP, 21% were LTFT, and 29% were senior residents (ST6).

The 2019 survey reported 70% of respondents attended 1-2 hours of teaching per week. Although we cannot directly compare, this appears to be a reduction in local teaching, as our survey showed that only 56% of respondents attended 2 or more hours of structured teaching per month.

These local teaching sessions were mostly delivered by a combination of consultants, specialty residents and other members of the MDT. Feedback on the quality of these sessions was positive, with 67% of respondents finding these sessions useful or very useful.

11.2. Regional teaching

Regional and supra-regional (cross-deanery) teaching sessions can support local teaching sessions and are more likely to focus on the knowledge required for oncology residents. Regional teaching sessions were attended by 79% of respondents, and supra-regional sessions by 32%. 25% of these respondents attended both regional and supra-regional teaching. 15% of respondents did not attend regional or supra-regional teaching and included residents from deaneries where regional teaching is offered.

Regional or supra-regional teaching sessions were delivered monthly for 30% of respondents, two- or three-monthly for 47%. This is broadly in line with the 2019 survey. These teaching sessions were

delivered exclusively by consultants to 50% of respondents, while the others received teaching from a combination of consultants, residents, and other members of the MDT. Only 5% received teaching exclusively from fellow resident colleagues. This has changed from the 2019 survey, where consultants predominantly delivered 94%; more sessions now include residents and members of the wider MDT in their teaching.

91% of respondents felt these teaching sessions were useful or very useful, a proportion similar to that in the 2019 resident survey. 59% of respondents were asked to miss regional or supra-regional teaching at least once due to clinical obligations. The proportion of respondents who have been asked to miss these sessions on more than one occasion has increased to 38%, up from 11% in the 2019 survey.

Recommendations:

- All residents should have opportunities to attend both local and regional/supra-regional teaching sessions.
- The teaching sessions should be discussed at local hospital inductions, to make new and rotating residents aware of the available teaching.
- Where teaching is not available, opportunities for virtual combined-hospital teaching or combined regional teaching (supra-regional) should be explored.
- We recognise the reduction in time attending teaching sessions and increased clinical commitments. TPDs/SAC to agree on the importance and benefits of regional and supra-regional teaching within deaneries and support resident applications for study leave to release them from clinics. It may be necessary for residents to miss teaching to maintain clinical safety; however, consideration should be given to this being allocated fairly amongst residents to avoid individual residents repeatedly missing sessions.
- We did not collect data on virtual attendance or in-person teaching; this could be explored in the next survey.

12. Courses

Formal postgraduate teaching courses on the scientific basis of cancer and its treatments are recommended to gain competencies to achieve the MO curriculum requirements. Examples include: the Christie - Biological Basis of Cancer Course; Institute of Cancer Research MSC in Oncology - London; Newcastle MSc/PGDip/PGcert; Bristol Basic Science Course; Leeds ST3 teaching programme.

Most respondents (87%) enrolled on or completed a formal postgraduate teaching course on the scientific basis of cancer and its treatments; this has increased from 62% in the 2019 resident survey.

56% enrolled on, or completed, a course that will lead to a formal qualification, e.g. MSc, PGDip or PGcert. This is a reduction from the 2019 survey, where 81% were taking a course that led to a formal qualification.

The majority of respondents (79%) were permitted to take study leave for the duration of the course, and 18% for part of the course. 80% of respondents who completed a course that did not lead to a

qualification were permitted to take study leave for the duration of the course, compared with 70% of those who completed a course that did lead to a qualification.

The course was completely funded for 66% of respondents and partly funded for 20%. Of the residents who partly funded or self-funded their course, 75% gained an additional qualification.

Residents described barriers to enrolling on courses, such as being unable to attend due to clinical commitments, lack of funding, or courses not being supported by their deanery. 54% of these were senior residents (ST5-6).

13. Study Leave

Approximately half of respondents never or rarely encountered challenges in obtaining study leave to attend conferences or training courses. However, 42% reported this was an occasional or a more frequent challenge.

54% of respondents occasionally or frequently experienced difficulties securing funding from their study budgets to attend conferences or training courses. 29% of these respondents reported they always or frequently encountered this challenge.

13% reported that they always seek funding from alternative sources (e.g. charitable funds, industry, scholarships, personal funding) to attend conferences, training courses or meetings. This issue was reported as occasional or frequent by 42% of respondents.

57% missed out on a course, conference or training opportunity due to out-of-pocket costs; this appears to be specific to a small number of regions.

Recommendation:

- The ACP/UKSMO are developing a list of recommended courses and conferences that would be beneficial for residents to attend with the aim of supporting applications for study leave and funding, alongside standardising resident expectations.

14. Audit and quality improvement

The ability to conduct high-quality audits and drive quality improvement (QI) is an essential skill for an oncology consultant and is a necessary part of training. For ST4-ST6, it is an ARCP requirement to have evidence of one audit or QIP per year.

Only a minority of respondents have time allocated in their job plan for professional development (28.2%), and a majority report having difficulty in being able to complete these projects in working hours (70% reporting either having to do most work in their own time, or not being able to do this at all).

The results of the 2019 were broadly more positive regarding professional development. Over half of respondents rated the training opportunities available for QIP, audit, teaching and presentation at conferences as good or excellent. Although the questions asked were different, there has clearly been a deterioration in the professional development experience, and this must be addressed.

Recommendation:

- All MO residents should have time allocated in their job plans for professional development (as is the case for consultants), as recommended in the clinical timetabling guidance document. We suggest that MO residents keep a record of the work they have done during these sessions and exception report any interruptions by clinical care.

15. Specialty Certificate Examination

The SCE is a two-part written examination comprising two consecutive three-hour papers, each with 100 multiple-choice questions (200 in total).[7] The SCE must be completed to receive a CCT. Most MO residents will attempt this for the first time during ST4 or ST5 (to allow for a further attempt before CCT date in case of an unsuccessful first attempt).

At present, there are no specific, organised courses for exam preparation; some private courses are aimed at both MO and CO residents preparing for their examinations, which can cost hundreds of pounds. The RCP also has a question bank of ~100 mock questions.

Of the respondents, 37.9% had attempted the SCE to date. Most of the respondents felt that the exam preparation resources were fair or poor (69.2%; score 1-3 on a scale of 1 to 5, with 5 very good and 1 very poor), broadly similar to the 2019 survey (77% fair or poor)

There was a wide spread of opinions as to whether the exam was based on up-to-date guidelines and practice: 33.3% agreed, 33.3% or were neutral, and the remaining one-third disagreed. This is slightly down on the 2019 survey, where almost half (49.5%) felt the questions were up to date and only 21% disagreed.

Recommendations:

- The ACP/UKSMO should look to develop additional revision resources to support future candidates.
- The results of this survey will be shared with the MO SCE Exam board and Question Writing Group.

16. Service delivery and impact on training

16.1. Remote working

The majority of respondents (62%) reported that remote working is not encouraged; only 7% of residents worked in a setting where they regularly worked at home.

Recommendation:

- The RCP 2021 survey reported that 76% of doctors want to work more from home. Flexible working could be explored in more regions for MO residents, supporting remote working, reducing resident doctors' travel time and improving work-life balance.[8]

16.2. Out of hours working

Most MO residents (76%) participate in non-residential on-calls from home, where they are available to provide over-the-phone advice and return to the hospital if required. Only 7% of respondents were required to be on-site for their night shift duties; these residents were from two specific deaneries.

Of those respondents who participated in non-residential on-calls, 24% never returned to work at the end of their on-site shift, 72% rarely did, and only 4% reported that they quite often (>10% of on-calls) had to return to the hospital after the end of their on-site shift.

Most respondents (70%) reported receiving good or excellent out-of-hours supervision or support.

16.3. Working with allied health professionals

The contemporaneous oncology workforce in the UK is becoming more diverse (in terms of the number of professional roles), with increased work that doctors would have traditionally carried out being performed by pharmacists, advanced nurse practitioners/advanced care practitioners, specialist nurses, and physician associates.

Most of these allied health professionals require consultant supervision, and accordingly, it is a curriculum requirement of the training programme to be able to "Manage the training and supervision of non-medical prescribers of SACT" (CiP 16). Anecdotally, this is one of the more difficult CiPs to provide evidence for, and our survey supports this: only 17.5% of respondents found it easy or very easy, while 48.6% found it difficult or very difficult.

The survey results demonstrate the wide variety of roles in current oncology teams. Almost all respondents work closely with clinical nurse specialists and pharmacists, and approximately three-quarters also work with advanced nurse practitioners (nurses with several years of experience who have received training to deliver SACT).

Despite almost universally working with these professional groups, over half reported "never" or "rarely" supervising SACT prescribing by NMPs (though this varies by stage of training: 76% of ST3 respondents reported never or rarely supervising, compared to 26% of ST6 respondents).

Alongside prescribing SACT, a key component of oncology practice is requesting imaging for patients. Medical imaging requesting is regulated by the IRMER regulations, and there are some professionals who are able to prescribe SACT but may not be able to request cross-sectional imaging. Requests for imaging then need to be requested by (usually) medical colleagues, and our survey has identified that a majority (71.9%) of respondents have had to request imaging for NMPs, with 40.8% doing this frequently. This may increase residents' workloads and should not be a routine accepted practice.

Recommendations:

- Provision of supporting resources to explain how evidence can be provided to meet the curriculum CiP 16.
- Oncology departments should establish guidelines for non-medical referrers regarding cross-sectional imaging and identify pathways for requesting imaging that do not require residents to make requests on behalf of other professionals.

17. LTFT working

As outlined in Section 6, the proportion of MO Residents who are LTFT has increased from 16% in 2019 to 35% respondents in this survey. An additional 33% of respondents intend to work LTFT at some point in their career. This could lead to more than 60% of MO residents being LTFT in the future.

42% of respondents reported difficulties in arranging flexible working in their teams. Of those residents currently working LTFT, only 17% felt their workload was adjusted to LTFT status. 47% reported it was somewhat adjusted, while 36% felt it was not adjusted at all.

69% of LTFT respondents reported that they often or frequently need to do work-related activities on non-working days, beyond their contracted hours to complete essential clinical duties.

83% worked the same number of clinics as their FT colleagues at some point in their training, of which 39% do the same number of clinics on all rotations.

Recommendations:

- The ACP/SAC have produced a timetable document that could support residents in planning timetables that are appropriately adjusted to LTFT status.
- With the potential increase in LTFT residents, local teams need to plan for flexible training, ensuring fair training opportunities and supporting residents to complete essential clinical tasks within contracted working hours.

- We would recommend taking clinical experience and workload into account, rather than just "time in training," when considering ARCP and CCT dates.
- The ACP/UKSMO residents' committee has compiled information for LTFT residents on the resident website, which can be disseminated through the ACP/UKSMO and via TPDs.[9]

18. Support and mentorship

51% of respondents reported having access to a mentor during their training, with 39% having a mentor within their deanery, 9% having a mentor outside their deanery but within the NHS, and 3% having mentors outside the NHS.

Table 6 shows the support that respondents feel they receive from supervisors. Overall, 85% of respondents feel supported by their TPD and 80% by their ES. Ten respondents felt that if they had concerns about their training, they would not be able to approach their CS, ES or TPD in the first instance, with one respondent reporting that they would discuss concerns with colleagues and nine with other consultants who are not formal supervisors. 83% of respondents felt that if they had concerns, they would be listened to, 17% felt neutral, and 1% felt that their concerns would not be addressed.

Table 6.

	"I feel well supported by my supervisor" (%)				
Supervisor	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
Training Programme Director	48%	37%	11%	3%	2%
Educational Supervisor	50%	30%	14%	5%	1%

Recommendation:

- MO residents should have access to a mentor during their training, either locally through the deanery or via a national mentorship scheme (such as the ACP/UKSMO mentorship scheme, introduced in 2025).

19. Overall experience and future planning

Despite some of the challenges associated with training in today's NHS, and despite some of the issues raised in this survey, it is important to note that overall satisfaction with MO training remains high – 66% gave scores of 4 or 5 (scale of 1 to 5, 1 – very poor, 5- very good). Only 6.8% gave scores 1 or 2.

When asked about plans, 71.8% of respondents plan to take up a consultant post in the NHS (similar to 2019 - 68%), with the remainder planning combined NHS and private work/industry or research. A small proportion (12.8%) is currently undecided. It is essential that consultant posts are available for these residents to contribute to and improve UK oncology care.

Recommendation:

- Liaison between JSC/SAC and NHS England/Health Education England/Health Education and improvement Wales (HEIW)/NHS Education for Scotland/Northern Ireland Medical and Dental Training Agency (NIMDTA)/Royal Colleges, to ensure that the expansion of higher specialty training posts does not lead to bottlenecks at consultant level.

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