

# Medical Oncology UK Training Survey Report 2019



## Foreword

The Association of Cancer Physicians (ACP) is recognised by the Royal College of Physicians and the Department of Health as the specialist society for medical oncologists in the UK. In addition to developing and promoting the specialty of medical oncology, the ACP contributes to the education of trainees in the specialty and supports continuing professional development for consultant medical oncologists.

Cancer care has been revolutionised in the past decade. In 2019 alone there were a total of 57 positive recommendations/approvals for novel anti-cancer therapeutics and/or indications from the FDA and EMA<sup>1,2</sup>. Immunotherapeutics and targeted agents are now at the forefront of patient care, bringing with them new challenges. With an increasing number of complicated therapies, including combination and sequential regimens, cellular therapies and associated biomarkers, genomics and other emerging technologies - it's an exciting yet challenging time to be working in the field of medical oncology.

However, there are many challenges in the NHS, with an unprecedented workforce crisis and persistent funding issues, with the UK lagging behind other developed nations in terms of cancer outcomes<sup>3,4</sup>. Funding has a direct impact on the care provided for patients as many novel agents continue to fail the requirements of organisations such as NICE, despite both FDA and EMA approval. Medical oncologists have an important role in this process acting as advocates for patients and importantly ensure clinical trials are properly designed so that their outcomes are robust.



Acute oncology services have become a mainstay of clinical practice in medical oncology. Since publication of the NCEPOD 2008 and subsequent NCAG 2009 reports<sup>5,6</sup>, medical oncologists supported by a highly skilled set of specialist nurses have become increasingly involved in the selected take of oncology admissions and associated outpatient supportive care. Whilst this is likely to have increased the inpatient workload in particular, there is increasing evidence that patient length of stay is shortened and quality of care is improved. However, with widespread variation of services across all four nations it is difficult to audit such work with a consensus that *'no size fits all'* in terms of service delivery.



The Shape of Training independent review has had a significant impact on how general and specialty medical training is delivered in the UK<sup>7</sup>. Medical Oncology will be a Group 2 specialty, with no dual accreditation in general internal medicine. Instead, the updated 2021 curriculum with a shared component between medical and clinical oncology will have more focus and support in training in acute oncology.



In light of the changes and challenges faced by the specialty, the ACP trainees' sub-committee conducted a survey of training in medical oncology in the UK. We are pleased to present a report of those findings along with recommendations as we enter this new phase of training and practice in medical oncology.

Dr Daniel Johnathan Hughes  
ACP Trainees'  
Committee (Chair)

Dr Rachel Broadbent  
ACP Trainees'  
Committee (Welfare)

Professor David Cunningham  
ACP Chair

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**“ By supporting our trainees now, we are safeguarding the future of medical oncology and cancer care in the UK for many years to come. ”**

## 1. Executive summary

### 1.1 Objectives

The objectives of the Association of Cancer Physicians (ACP) UK Medical Oncology training survey are to:

1. Provide a comprehensive assessment of training in medical oncology in the UK;
2. Inform the future development of the training curriculum in medical oncology to address training needs.

It is hoped the data and information presented in this report will inform local, regional and national training and educational policy.

### 1.2 Key findings / recommendations

#### Clinical experience and exposure

Overall, respondents reported high satisfaction rates with training in both outpatient and inpatient patient management. Multi-disciplinary meetings (MDM) were not being utilised to their full potential as a learning tool. Time constraints in the clinic environment were felt to negatively impact the learning experience and potential opportunities.

- Trainee attendance and active participation at relevant MDM should be encouraged and facilitated at a local level.
- Trainers should aim to minimise the impact of service pressures on learning opportunities in the clinical environment.
- Trainers should recognise the benefits of and facilitate multi-disciplinary team working and interprofessional learning.

#### Acute oncology training

Overall, comments were suggestive of a perceived paucity of training, teaching and support in acute oncology, whilst recognising the significant benefits training could provide.

- Acute oncology should be further integrated into the medical oncology curriculum as an important training requirement with dedicated work-place based assessment(s).
- Training programme directors should assess local acute oncology services and the potential training opportunities they may provide.

## 1. Executive Summary (cont.)

### SACT prescribing

Training in systemic anti-cancer therapy (SACT) prescribing varied in quality across training programmes and individual posts. Respondents recognised the need for formal training in this area supported by adequate access to local or national tumour site-specific guidelines.

- Formalised training in safe SACT prescribing should be carried out with appropriate supervision (in most cases Consultants and/or senior pharmacists).
- SACT prescribing should be formally assessed through workplace-based assessments according to national frameworks and against national competency levels.

### Teaching

Local and regional teaching was delivered in varied models across the UK, with consultant and allied healthcare professional delivered sessions considered useful for training. Access to undertake and secure funding for oncology courses was variable throughout the UK.

- Both regional and local teaching should be delivered by consultants and appropriate allied healthcare professionals.
- There should be equal opportunities for all trainees to undertake a postgraduate course in oncology.

### Professional development

Overall, respondents reported good quality training in areas of professional development with opportunities to undertake, for example, service development and clinical governance. Support for improving academic and management and leadership skills could be improved. Educational support for trainees undertaking the Specialty Certificate Examination (SCE) in medical oncology was considered poor.

- Local training programme directors should review the opportunities for trainees to develop academic, leadership and management skills.
- A review of the support available to those undertaking the SCE in medical oncology should be conducted, with particular consideration to the availability of practice questions and a continuously updated list of learning resources and references consistent with changes in the SCE.

## 1. Executive Summary (cont.)

### Service delivery and impact on training

Respondents were positive about the consultant support they received whilst working on call and out-of-hours. Whilst 60% reported working beyond contracted hours on a regular basis, the vast majority had never completed an exception report.

- Local training programme directors should review their exception reporting processes, acting upon any issues raised with excess hours worked or missed educational sessions and their likely impact on training.

### Flexible working

Trainees working less than full-time (LTFT) felt supported in meeting their training requirements but reported some difficulties regarding rota management and academic opportunities. Job sharing was reported as a positive solution to rota management and thus experience of LTFT training.

- Arrangements for LTFT trainees should be reviewed locally ensuring an appropriate and fair balance between clinical commitments and training opportunities.

### Career planning

The vast majority of respondents planned on applying for a medical oncology consultant post in the NHS and UK following completion of training. Up to 15% remained undecided, with a further 10% planning to apply to a non-NHS academic post or industry.

## 1.3 Further actions

The ACP Trainees' Committee and ACP Executive Committee will endeavour to repeat the survey at least every 3 years. This allows review following the implementation of both the Internal Medicine Training (IMT) curriculum in 2019 and subsequently the new Medical Oncology Higher Specialty Training curriculum, which incorporates the Oncology Common Stem (OCS) ST3 year, from 2021.

Future surveys will also aim to collect data from Consultants, including Training Programme Directors, for a broader overview of training and implications for service delivery.

This is crucial to supporting trainees and ensuring training in medical oncology meets the ever-changing needs of cancer services in the UK.

## 2. Medical Oncology Training in the UK

Medical oncology training in the UK currently follows the completion of a total period of 4 years postgraduate foundation and core medical training (CMT). Trainees enter medical oncology at specialty trainee (ST) 3 level and complete 4 years of rotational based training in medical oncology. The specialty certificate examination (SCE) in medical oncology can be undertaken at any point during training but must be passed for Certificate of Completion of Training (CCT).

From 2021, the medical oncology training pathway will change with the introduction of a new curriculum. Trainees enter medical oncology at the same timepoint, i.e. at ST3 level following completion of foundation programme and stage 1 (years 1 and 2) of internal medicine training (IMT). This change has resulted from the recommendations of the Shape of Training review<sup>7</sup>. More information can be found on the GMC and JRCPTB websites<sup>8,9</sup>.

Trainees will apply to medical oncology directly with the ST3 year shared with clinical oncology within the Oncology Common Stem (OCS). The OCS year aims to deliver broader training with an emphasis on acute oncology and basic sciences including pharmacology, radiobiology and radiotherapy. Completion of the OCS year is transferable for those trainees wishing to transfer to alternative training pathway in clinical oncology from ST4 onwards (and vice versa).

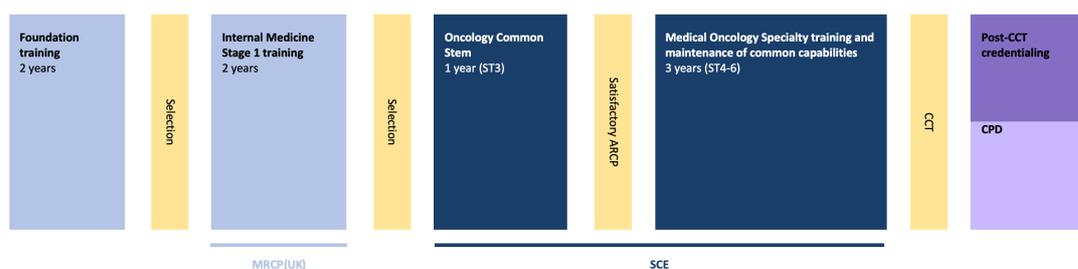


Figure 1. Medical Oncology (Group 2) training pathway including ST3 Oncology Common Stem (OCS)  
(adapted from [www.jrcptb.org.uk/specialties](http://www.jrcptb.org.uk/specialties))

Medical and clinical oncology are considered group 2 specialties taking account of the significant contribution of acute oncology services to the acute medical take and direct to specialty admissions that is common place across the four nations. As such, it is envisaged that training in acute oncology will be strengthened alongside the continuing growth of these services.

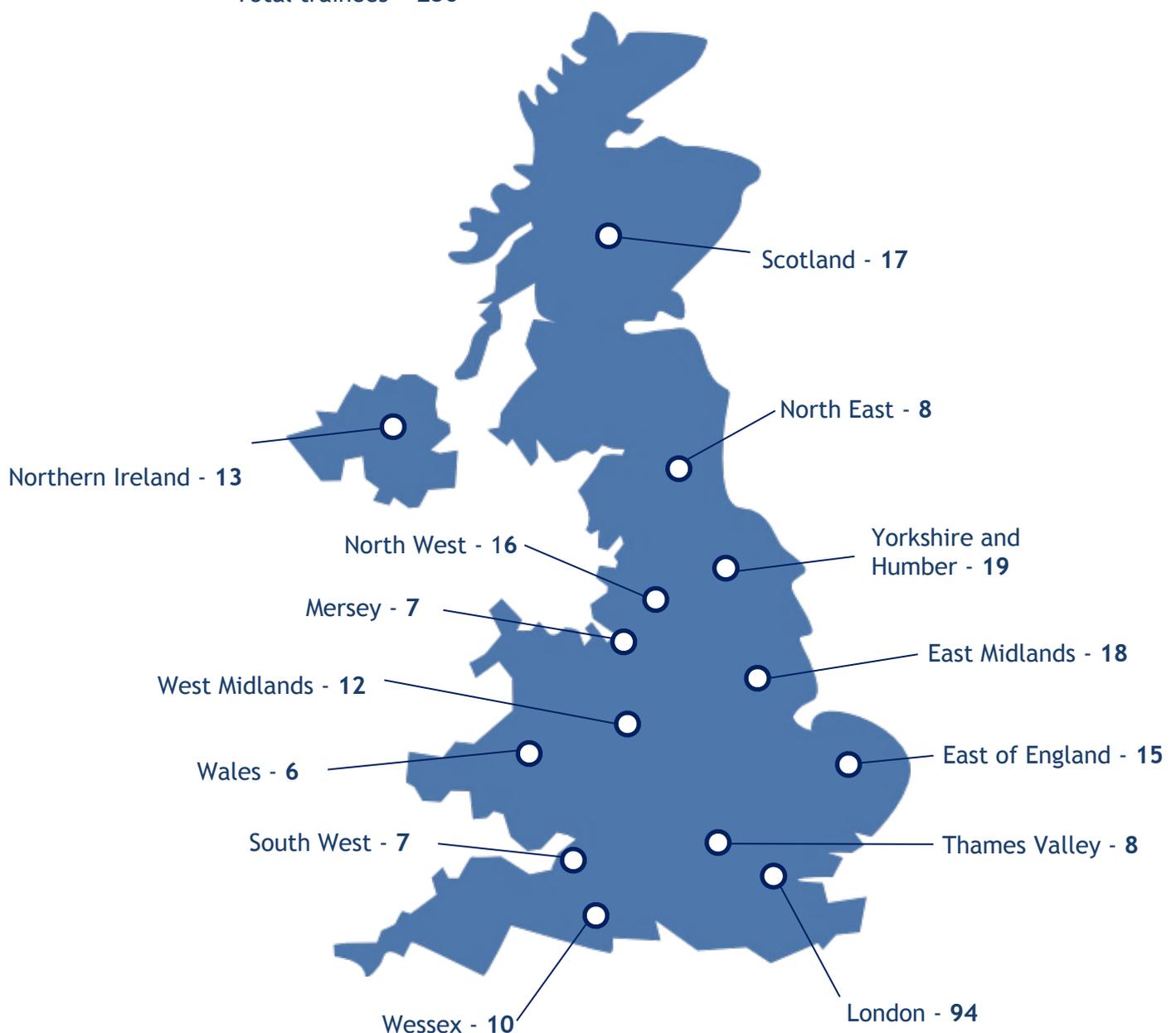
## 2. Medical Oncology Training in the UK (cont.)

At the time of this report, there were **250** trainees in Medical Oncology across all 4 nations across UK, of which **42** were registered as out-of-programme for research or experience\*. The distribution is summarised in *figure 2* below.

**Figure 2.** Distribution of trainees in medical oncology according to deanery/LETB.

\*Numbers obtained from the JRCPTB [13.02.20].

Total trainees = 250



### 3. Survey methods

An electronic link to the anonymous online survey was sent to all members of the ACP who were listed as a non-Consultant member in October 2019. All training programme directors (TPD) were also asked to circulate the invitation to all specialty, associate specialist and staff grade (SAS) doctors and trainees working in medical oncology.

The survey was open for a total of 6 weeks and a reminder email was sent to all non-Consultant members during that time.

Results were analysed using descriptive statistics. Results are not presented as individual trusts or deaneries in order to maintain anonymity in locations with small number(s) of trainees.

### 4. Respondent demographics

There were a total **80** respondents. The number of responses varied per question according to relevance of the question.

Two-thirds (66%) of the respondents were female.

69% (n=55) were trainees in programme, whilst 29% (n=23) of respondents were trainees out-of-programme at the time of the survey.

2% of participants were SAS doctors in medical oncology.

All respondents were asked to identify their training grade or equivalent at the time of completion of the survey. All grades were represented: ST3 18%; ST4 30%; ST5 34%; ST6 14% (N/A = 5%).

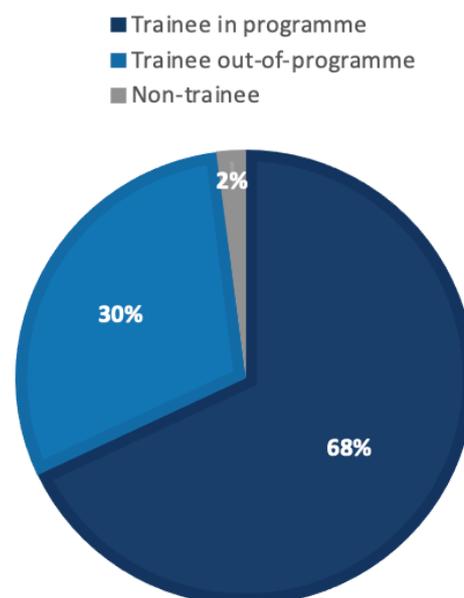


Figure 3. Distribution of trainee and SAS doctor respondents.

#### 4. Respondent demographics (cont.)

A breakdown of respondents by deanery / local education and training board (LETB) is presented in *table 1*.

Local response rates varied from 6 to 61%.

**Table 1.** Respondents by deanery/local education and training board.

Deanery / LETB	No. of trainees	No. of respondents	Response rate
East of England	15	3	20%
East Midlands	18	1	6%
London	94	34	36%
North East	8	2	25%
North West / Mersey	23	14	61%
South West	7	3	43%
Thames Valley	8	2	25%
Wessex	10	1	10%
West Midlands	12	3	25%
Yorkshire and Humber	19	9	47%
Northern Ireland	13	2	15%
Scotland	17	5	29%
Wales	6	1	17%
<b>Total</b>		<b>80</b>	

## 5. Survey findings

### 5.1 Clinical experience and exposure

The medical oncology training programme provides a breadth of experience across multiple tumour types and systemic anti-cancer therapies, in addition to providing opportunities for the development of a range of clinical skills and the professional capabilities required of a consultant medical oncologist. Training rotations are expected to provide experience in both outpatient and inpatient settings, as well as experience in the support of out-of-hours cancer care.

#### Overall clinical training experience

**92%** rated their overall training experience of managing outpatients as either **good or excellent**. Similarly, **93%** reported the consultant support they received managing outpatients as either **good or excellent**.

**89%** of respondents rated their overall experience of managing inpatients and **75%** the consultant support in doing so as either **good or excellent**.

Respondents on average saw **5** new patient cases each week (range 1 - 20).

**95%** of respondents reported (agree and strongly agree) that they were always given sufficient opportunity to discuss patient cases with a consultant colleague.

**Table 2.** Clinical training experience managing inpatients and outpatients.

Rating	Managing Outpatients n (%)		Managing Inpatients n (%)	
	Overall experience	Consultant support	Overall experience	Consultant support
Excellent	27 (41%)	29 (45%)	15 (23%)	19 (29%)
Good	33 (51%)	31 (48%)	43 (66%)	30 (46%)
Neutral	5 (8%)	2 (3%)	6 (9%)	12 (18%)
Fair	0 (0%)	2 (3%)	1 (2%)	4 (6%)
Poor	0 (0%)	0 (0%)	0 (0%)	0 (0%)

## 5. Survey findings (cont.)

### Multi-disciplinary meeting (MDM) as a training experience

86% of respondents reported attending an MDM at least weekly, however up to 10% attended an MDM monthly or less.

47% of respondents described opportunities to actively participate in an MDM as occurring frequently or very frequently. However, 29% reported opportunities as rare, whilst 8% described there being no opportunity to actively participate.

### Further comments on outpatient training opportunities

Respondents felt the outpatient setting provided good opportunities for learning when supported with timely feedback from their consultant or supervisor(s). Multi-disciplinary discussions before and after outpatient clinics were described as a useful learning tool. Time constraints in the outpatient clinic environment were felt to negatively impact the learning experience and potential opportunities.

### Recommendations

- Consultant support of inpatient management should be reviewed locally to ensure this is consistent with that provided in outpatient settings.
- Trainee attendance and active participation at relevant MDM should be encouraged and facilitated at a local level.
- Trainers should aim to minimise the impact of service pressures on learning opportunities in the clinical environment.
- Trainers should recognise the benefits of and facilitate multi-disciplinary team working and interprofessional learning.

## 5.2 Acute Oncology training

Acute oncology services (AOS) were borne out of recommendations made in the 2008 *National Confidential Enquiry into Patient Outcomes and Death (NCEPOD)* and subsequent 2009 *National Chemotherapy Advisory Group (NCAG)* report<sup>5,6</sup>. At this time, 42% of all unwell patients with cancer were admitted under general medical specialties, with over 40% of these patients experiencing a grade 3-4 treatment-

## 5. Survey findings (cont.)

associated side-effect on admission prior to death<sup>5</sup>. With improving cancer outcomes and year-on-year increases in the number and complexity of novel SACT regimens available, acute oncology has never been more crucial. AOS structures and their delivery are variable across the UK, with the needs and support services in a stand-alone cancer centre differing greatly from those services associated with an acute tertiary or district general hospital. AOS are often involved far beyond emergency presentations, helping to manage patients with treatment and disease-related complications as outpatients, facilitating diagnostic pathways and supporting patients with palliative care needs.

Trainees in medical oncology are expected to develop the broad skills needed to contribute to AOS, and where appropriate, support allied healthcare professionals in service delivery and training.

### Training in acute oncology

Respondents recorded an average **4 hours per week** contributing to AOS.

**54%** of respondents rated the quality of training in acute oncology as **good or excellent**. **33%** were neutral whilst **13%** rated the quality of training as fair or poor.

A common response from respondents was that there was no dedicated AOS team at their training location limiting the learning opportunities available. Some respondents perceived their on-call experience as training in acute oncology, including of post-take ward rounds, whilst others noted the likely benefits of time spent contributing to a dedicated service/team. Overall, comments were suggestive of a perceived lack of training, teaching and support in acute oncology, whilst recognising the significant benefits training could provide.

### Recommendations

- Acute oncology should be further integrated into the medical oncology curriculum as an important training requirement with dedicated work-place based assessment(s).
- Training programme directors should assess local acute oncology services and the potential training opportunities they may provide.
- ACP trainees' committee to appoint a dedicated Acute Oncology Officer for representation at and to communicate with relevant organisations and committees with the aim of facilitating / enhancing training opportunities.

## 5. Survey findings (cont.)

### 5.3 Systemic anti-cancer therapy (SACT) prescribing

Trainees in medical oncology are expected to develop the expertise and skills to manage a wide range of malignancies. This involves the prescribing of complex SACT, including cytotoxics, immunotherapies, targeted agents and novel agents. In addition, medical oncologists should be able to lead clinical trials of novel agents, combinations and/or new regimen approaches or therapeutic indications.

#### Training in SACT prescribing

**32%** of respondents reported that **training was required** in SACT prescribing before being able to perform unsupervised in **all** rotations/tumour sites. **32%** reported needing to undertake training in only some rotations/tumour sites.

**36%** reported no training being required locally before prescribing SACT unsupervised.

Training, where available/required, was delivered in various forms (*table 3*).

**Table 3.** Format of SACT prescribing training where available.

Training type	n (%)
Formal	13 (21%)
Workplace-based assessment	23 (37%)
Informal discussion	21 (33%)
None specific	2 (3%)
Other (specify)*	4 (6%)

\*Responses included: pharmacology module; chemotherapy log book; training in online prescribing.

#### Guidelines and protocols

**25%** of respondents reported not having tumour site specific management guidelines at their site and **19%** reported not having trust-specific SACT guidelines to follow.

## 5. Survey findings (cont.)

### Further comments on SACT prescribing training

Several respondents reported a lack of formal training in SACT prescribing, with considerable 'on-the-job' learning, including from other specialist trainee colleagues. Many described being taught how to use computer systems but did not find this useful training in safe SACT prescribing. Trainees felt training would be more beneficial if it focussed on clinically relevant prescribing issues, including dose capping, contraindications, area under the curve calculations etc.

### Recommendations

- Formalised training in safe SACT prescribing should be carried out with appropriate supervision (in most cases Consultants and/or senior pharmacists).
- SACT prescribing should be formally assessed through workplace-based assessments according to national frameworks and against national competency levels.
- All trainees should have access to tumour site specific management guidelines and SACT protocols - where this cannot be provided locally, national or other relevant guidelines/protocols should be made easily accessible.

### 5.4 Teaching

Teaching throughout medical oncology should take place to supplement and build upon a trainee's clinical experience. By the end of training, trainees should have considerable knowledge of all aspects of cancer care including of the therapeutics they deliver, as well as the biology of cancer, pharmacology, genomics etc.

#### Local teaching

**70%** of respondents reported regular local teaching of 1-2 hours per week, with **15%** reporting >2 hours per week but **15%** also reporting no regular local teaching.

Local teaching was most frequently delivered by a mixed model of consultants,

## 5. Survey findings (cont.)

fellow trainee and SAS doctors and allied healthcare professionals (**45%**) and by consultants only in **31%**. However, **24%** of respondents reported local teaching delivered by fellow trainee and SAS doctors only.

Overall, **75%** reported local teaching as being **useful or very useful** for their training in medical oncology. **81%** felt teaching was useful or very useful when consultants were involved, compared to only **66%** when there was no consultant involved.

Respondents noted that local teaching varied greatly between individual posts and training sites, with clinical work demands a common cause for non-attendance.

### Regional teaching

**24%** of respondents reported regional teaching occurring every month or less, with **54%** reporting a frequency of every 2-3 months and **22%** less frequent than every 3 months or not at all.

Regional teaching was mostly organised by trainee and SAS doctors (**63%**) but predominantly delivered by consultants (**94%**). Overall, **92%** of respondents rated regional teaching as **useful or very useful** for their training.

**96%** reported regional teaching being bleep-free and **89%** reported never or on just one occasion being asked to miss regional teaching due to clinical commitments.

### Oncology courses

**62%** of respondents reported as either already having done or currently doing an oncology specific course. Of these, **81%** were taking a course that led to a formal postgraduate qualification (e.g. PGDip).

Of those not undertaking or planning to undertake an oncology course, **40%** reported funding as a barrier, whilst **50%** were not aware of what courses were available.

Many trainees reported issues regarding funding of courses, with discrepancies between regions. Some trainees were limited by what course they were able to undertake, in some cases only being permitted to do a course which did not lead to a formal postgraduate qualification. Others reported only being allowed to undertake online distance learning courses but with some difficulties in taking protected study leave to complete these.

## 5. Survey findings (cont.)

### Recommendations

- As much as possible, local teaching should take place regularly and be consultant-led.
- Deaneries/LETBs should review their regional teaching programmes to ensure this is delivered at regular intervals and by consultants and appropriate allied healthcare professionals.
- Organisation of local and/regional teaching presents an opportunity for trainees to develop management and leadership skills; however, a consultant should have oversight to ensure curriculum requirements are being met.
- There should be equal opportunities for all trainees to undertake a postgraduate course in oncology. The ACP and JRCPTB SAC for medical oncology should continue to work with Health Education England, NHS Education for Scotland, Health Education and Improvement Wales and the Northern Ireland Dental and Medical Training Agency to ensure parity of access to funding.

### 5.5 Professional development

Throughout their training in medical oncology, trainees are expected to continue professional development, building on skills gained from earlier medical training. There is a significant focus on developing professional skills, including engagement in clinical governance, teaching / training and academic activities. This ensures medical oncology consultants are equipped with the skills for lifelong learning and development, able to meet the demands of an ever-evolving healthcare environment.

#### Overall supervision and support

**77%** of respondents felt supported by their training programme director (TPD) with **91%** stating they felt supported by their educational supervisor.

## 5. Survey findings (cont.)

### Wider training opportunities

A majority of respondents reported **good or excellent** training opportunities for undertaking audits / quality improvement projects (**82%**), teaching or training (**72%**) and presenting work at a conference (**53%**).

Respondents reported limited opportunities to contribute to publications and to develop skills in medical leadership and management, with **38%** and **20%** respectively reporting them as fair to poor.

**Table 4.** Quality of wider training opportunities available. % rounded to whole number.

Rating	How would you rate the training opportunities available for... n(%)				
	Audits / QIPs*	Teaching and Training	Present at conference	Publication	MLM*
Excellent	9 (14%)	13 (20%)	6 (9%)	5 (8%)	9 (14%)
Good	43 (68%)	34 (52%)	28 (44%)	18 (28%)	24 (36%)
Neutral	8 (13%)	12 (18%)	21 (33%)	17 (27%)	20 (30%)
Fair	1 (2%)	5 (8%)	4 (6%)	10 (16%)	7 (11%)
Poor	2 (3%)	2 (3%)	5 (8%)	14 (22%)	6 (9%)

\*QIPs = Quality improvement project(s); MLM = Medical leadership and management.

### Medical oncology specialty certificate exam

Most respondents had taken or planned to take the specialty certificate examination (SCE) in their penultimate year of training (ST5 equivalent).

**77%** of those who had attempted the SCE rated the availability of practice questions as fair to poor. **49%** agreed that the questions were based on up-to-date oncology guidelines and practice, whilst **30%** were unsure and **21%** disagreed.

Trainees reported significant variability in the availability of and access to specific oncology courses, which are advised for learning the basic sciences that underpin oncology, including pharmacology and the basics of radiation biology.

## 5. Survey findings (cont.)

### Recommendations

- Local training programme directors should review the opportunities for trainees to develop academic skills (e.g. (co)authorship of publications), as well as leadership and management and consider how this could be further facilitated locally.
- A review of the support available to those undertaking the SCE in medical oncology should be conducted, with particular consideration to the availability of practice questions and a continuously updated list of learning resources and references in line with any changes made to the SCE.

### 5.6 Service delivery and impact on training

The NHS is under significant pressures, including an increasing demand associated with an ageing population, as well as financial implications and issues around workforce recruitment, training and retention<sup>7</sup>. These issues are far-reaching with significant consequences for the delivery of cancer care in the UK. Consequently, these issues have a direct impact of training and its delivery. The introduction of the new junior doctor's contract and associated terms and conditions of service brought in changes to protect doctors from unsafe working hours and improve their training experience. The implementation of exception reporting and the guardian of safe working hours aimed to address these issues<sup>10</sup>.

#### Out-of-hours working

**77%** of respondents reported **good to excellent** level of consultant supervision and support whilst working on call and out-of-hours.

#### Working beyond contracted hours and exception reporting

**62%** of respondents reported working beyond their contracted hours **often** in order to complete essential clinical tasks.

Respondents also acknowledged an excess of administrative tasks with suboptimal administrative support and often absence of protected time for such tasks. In addition, audit or QIPs were mostly undertaken outside of contracted hours.

## 5. Survey findings (cont.)

Table 5. Working beyond contracted hours.

How often do you work beyond your contracted hours to complete essential clinical tasks? n(%)				
Very often	Quite often	Somewhat often	Rarely	Never
19 (35%)	15 (27%)	11 (20%)	9 (16%)	1 (2%)

Several respondents reported no experience or knowledge of the exception reporting process and many felt it was underutilised or did not work. This was supported by **83%** of respondents having **never** completed an exception report despite reporting working beyond contract hours often. **13%** reported having done so and receiving time in lieu whilst the remaining **4%** had done so and received additional pay.

Of concern, **6%** of trainees reported being actively discouraged from completing exception reports in their current post.

### Recommendations

- Exception reporting should be facilitated to promote safe working hours of junior doctors and in protecting their training opportunities.
- Local training programme directors should review their exception reporting processes, acting upon any issues raised with excess hours worked or missed educational sessions and their likely impact on training.

### 5.7 Flexible working.

#### Less than full-time (LTFT) training

**16%** of respondents reported working LTFT at the time of completing the survey. Of those currently working full-time, **23%** intended to work LTFT at some point during training.

**70%** of respondents working LTFT rated the support received in achieving their training competencies as **good to excellent**. However, **80%** of LTFT respondents reported from **some to a lot of difficulty** with rota management and/or pay.

## 5. Survey findings (cont.)

LTFT respondents also reported difficulty finding time for research and other professional development activities within normal contracted hours. Job sharing was reported as facilitating working LTFT and in protecting training opportunities.

### Recommendations

- Arrangements for LTFT trainees should be reviewed locally to ensure an appropriate and fair balance between clinical commitments and training opportunities, such as attending MDMs or contributing to clinical governance.

## 5.8 Career planning

### Time out-of-programme for research

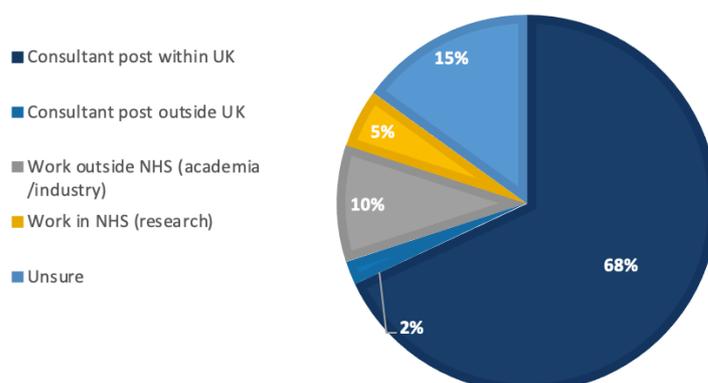
52% of trainee respondents reported having already taken time out-of-programme to complete a higher degree, whilst 30% intended on doing so.

### Intentions following completion of training

Most respondents (68%) reported their intention to apply for a consultant medical oncologist post within the UK, with only 2% wishing to apply for a post outside the UK.

10% intended to apply for work outside the NHS, for example, in academia or industry.

Figure 4. Intentions following completion of training.



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## Acknowledgements

The training survey and report was authored by Dr Rachel Broadbent and Dr Daniel Johnathan Hughes of the ACP Trainees' Committee with executive oversight from Professor David Cunningham, ACP Chair.

The following are acknowledged for their support and/or involvement in the 2019 training survey and report:

**Members of the ACP Trainees' Committee:** Dr Mark Baxter, Dr Alison Berner, Dr Jenny Cotton, Dr Laura Feeney, Dr Helen Hockings, Dr Adam Januszewski, Dr Hamzeh Kayhanian, Dr Jonathan Lim, Dr Leena Mukherjee, Dr Anna Olsson-Brown, Dr Mark Openshaw, Dr Nicola Thompson.

**Members of the ACP Executive Committee:** Dr Roshan Agarwal, Prof. Samreen Ahmed, Dr Caroline Archer, Dr Richard Baird, Dr Susana Banerjee, Dr Judith Carsar, Dr Graham Dark, Prof. Marcia Hall, Dr Mark Hill, Dr Adam Januszewski, Prof. Johnathan Joffe, Dr Alison Jones, Dr Rachel Jones, Dr Eleni Karapanagiotou, Dr Janine Mansi, Dr Caroline Michie, Dr Jackie Newby, Dr Gargi Patel, Prof. Andrew Protheroe, Dr Anne Rigg, Prof. Peter Selby, Dr Kai-Keen Shiu, Dr Tania Tillett, Prof. Andrew Wardley, Dr Alison Young.

**Special thanks to Mrs Alison Norton,** Administrator for the ACP, for her ongoing support and advice throughout the process.

