

Rough Guide to Medical Oncology Training Guidance for training programme directors, supervisors and trainees

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Introduction

This guide to the new curriculum for Medical Oncology Training is to help training programme directors (TPDs), supervisors, trainees and others with the practicalities of implementing the [Medical Oncology 2021 curriculum](#), including the ST3 Oncology Common Stem. It is intended to supplement rather than replace the curriculum document itself. It is appreciated that all regional schools of medicine will be issuing their own guidance to take account of local resources and constraints, but it was felt that central guidance would be helpful.

The Rough Guide has been put together by members of the Medical Oncology Specialty Advisory Committee at the JRCPTB including trainee representatives, with input from clinical oncology colleagues at the Royal College of Radiologists. It is intended to be a 'living document' and we value feedback via curriculum@jrcptb.org.uk.

What is different in the 2021 Medical Oncology Curriculum?

The new 2021 curriculum for medical oncology is structured around high-level learning outcomes, called [capabilities in practice \(CiPs\)](#), which describe clearly and at a high level what a doctor will be able to do independently on completion of training. These outcomes are assessed against new anchor statements and [entrustment levels](#) for specialty specific CiPs; this is detailed in the [assessments and progression section](#) of this document. Along with CiPs, there is new terminology that trainees and trainers will need to familiarise themselves with; we would encourage you to refer to the [terminology guide in appendix 1](#) as a useful starting point.

A main change in the 2021 curriculum is the introduction of an [oncology common stem \(OCS\)](#) year with shared outcomes with clinical oncology trainees. This reflects the closer working relationship between the two specialties and aims to ensure all ST3 level trainees gain a breadth of experience in oncology. There is also an increased emphasis on training in acute oncology throughout training. New and repurposed work-place based assessments support the development of CiPs throughout training, including the [ACAT, DOST and DORPS](#). These changes do not extend the total duration of training in medical oncology but provide more flexibility.

Oncology Common Stem (OCS) year

Medical oncologists and clinical oncologists work very closely together within MDTs to provide holistic care of the cancer patient and deliver elements of the non-surgical cancer treatments. Medical oncologists specialise particularly in the development, implementation and delivery of systemic anti-cancer therapies and routinely lead on delivering clinical research, with many extending this to active laboratory-based research, and involvement in the development, as well as the delivery of clinical trials. Clinical oncologists have a specific and unique remit for the development and delivery of radiotherapy treatments. The new curricular structure with the common oncology stem ST3 year means that trainees successfully completing ST3 in either medical or clinical oncology will have gained the necessary competencies to progress to ST4 in either specialty, subject to appointment to that specialty in open competition via national recruitment processes.

Training in site-specific tumour types

The 2021 medical oncology curriculum provides a list of indicative time periods for site-specific tumour types. Whilst this has previously been more prescriptive, the new curriculum reflects requirements from the GMC curricula reforms that are outcome rather than time-based and acknowledges that trainees may develop certain site-specific capabilities in practice at different rates and that rotations nationally do not necessarily fall into definitive 4 or 6 month blocks of one tumour type.

As the OCS year is focussed on achieving common oncology CiPs (which includes exposure to radiotherapy, systemic therapy, acute oncology 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.

Trainees later in their training pathway are likely to develop tumour-specific capabilities at a faster rate than an ST3 level trainee. It is also acknowledged that clinical rotations may include exposure to multiple tumour types at any one time. For example, an ST5 level trainee undertaking a 6-month rotation in melanoma and urological cancers (which both have indicative times of 4 months each) may be able to achieve capability in both tumour types within the 6-month period. For this to be the case, trainees must be able to demonstrate capabilities through engagement with regular outpatient clinics, MDTs and inpatient ward management for each tumour type, however the inpatient element may not be contemporaneous. The curriculum does not stipulate minimum requirements for the number of outpatient clinics (new patients, patients on follow-up and clinical trials as appropriate) or MDTs for each tumour type.

Training in Acute Oncology

Whilst training in acute oncology was a mandatory part of the 2017 curriculum, with the expansion of acute oncology services throughout the UK, training in acute oncology is now an explicit high-level outcome. Trainees should develop capabilities in practice (CiP) in acute oncology longitudinally throughout training from ST3-ST6. It is not expected that trainees will develop the ability to practise independently in all aspects of this CiP in the OCS year alone.

Acute oncology service (AOS) models vary according to regional service configurations and resources. They are delivered by multi-professional teams in a wide variety of settings from specialist teams in tertiary cancer centres, to supporting acute and general medical teams in district general hospitals. Acute oncology training may be delivered in this full range of settings, supervised and assessed by any appropriately qualified member of the acute oncology team. This is not limited to clinical oncology or medical oncology consultants provided that there are clear educational objectives linked to this CiP, effective feedback to trainees and opportunity for development in this area of practice.

Ring-fenced time for acute oncology training should be included in trainees' timetables. On call provision alone is not sufficient to constitute acute oncology training. Ideally, trainees should have exposure to different models of AOS with at least one rotation at a clinical site with acute admissions from an A+E department and/or selected take. Training in AOS should include initial assessment of a patient, including investigation and management in the acute setting. Following initial assessment / investigation, there should be follow-up of the patient pathway, which may include post-take ward rounds, ambulatory care, and/or outreach to

non-oncology settings. Follow-up of the patient pathway should provide opportunities to learn from feedback with the trainee receiving regular and structured feedback from senior decision makers, including consultant and acute oncology CNS's. More information on what training in acute oncology can and should look like can be found in the [FAQs section](#).

A joint publication from the Royal College of Physicians (RCP), Association of Cancer Physicians (ACP) and The Royal College of Radiologists (RCR) titled "[Acute oncology: increasing engagement and visibility in acute care settings](#)," sets out some useful recommendations for training in acute oncology. The medical oncology curriculum sets out what is currently mandated, whilst the strategic document is aspirational but an extremely useful resource for trainers and trainees alike.

For further information on training in acute oncology, refer to the [common oncology CiP 8](#) below.

Training in radiotherapy

Training in medical oncology has previously required trainees to develop an understanding of the principals of radiotherapy along with its indication and managing the side-effects. The 2021 medical oncology curriculum formalises basic training in radiotherapy principles, including the processes involved in radiotherapy planning. A new assessment to medical oncology called the direct observation of radiotherapy planning skills ([DORPS](#)) has been introduced for OCS trainees. The minimum expectation of trainees 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 associated toxicities. Whilst a DORPS assessment is not required for ST4-6 trainees (including those that transition to the new curriculum), the same level of evidence in a trainee's portfolio by CCT would be expected.

ST3 OCS year rotations should include a tumour type where trainees 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.

Training structure

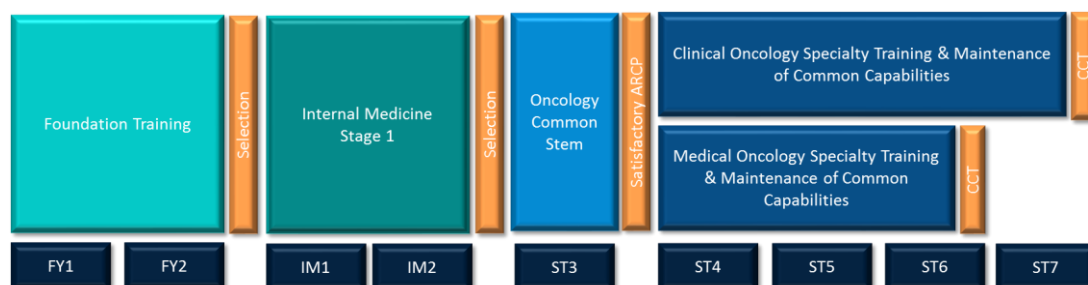


Figure 1: Training pathway for clinical oncology and medical oncology

The full eligibility criteria to apply for higher specialty training in medical oncology are detailed in the [Medical Oncology curriculum](#) document. Trainees may have gained additional experience in other programmes before commencing higher training in either medical or clinical oncology.

The curricula for medical and clinical oncology have been aligned to reflect closer working relationships between the two specialties and include aspects of common training that constitute the Oncology Common Stem (OCS). This will improve transferability and flexibility for trainees wishing to move between the two specialties, with full recognition of training during the OCS year.²

Medical oncology higher specialty training (including OCS) will be in total an indicative four-year clinical training programme leading to single accreditation in the specialty, with no critical progression points other than CCT.

There will be options for those trainees who demonstrate exceptionally rapid development and acquisition of capabilities to complete training sooner than the current indicative time. Guidance on completing training in less than 48 months is available on the [JRCPTB website](#). However, as development as a medical oncologist requires a level of experience, as well as specific training, it is very unlikely that training could be completed in less than 42 months. There may also be a small number of trainees who develop more slowly and will require an extension of training as indicated in the Reference Guide for Postgraduate Specialty Training in the UK ([The Gold Guide](#)). Any changes in the duration of training will occur as part of the ARCP process.

Flexibility and Accreditation of Transferable Capabilities

The curriculum supports flexibility and transferability of outcomes across related specialties and disciplines, reflecting key interdependencies between this curriculum and other training programmes, outlined below.

The curriculum incorporates and emphasises the importance of the generic professional capabilities (GPCs). These common capabilities can be transferred from specialty to specialty and therefore promote flexibility in postgraduate training.

With the introduction of the Oncology Common Stem and alignment of common areas throughout the medical oncology and clinical oncology curricula, transferability between medical oncology and clinical oncology at any stage of training will be facilitated.

At the end of the OCS year, any trainee who wishes to transfer from one specialty to the other may enter at ST4 level with full recognition of the capabilities already achieved during that year. Trainees wishing to transfer beyond end of OCS year will need to map their competencies in all CiPs (generic, common oncology and specialty specific) to determine outstanding training requirements via a gap analysis process. Transferring to the other specialty will necessitate a new application through the national recruitment process and appointment via open competition. Trainees should refer to the [ST3 recruitment webpage](#) for the most up to date information regarding recruitment.

Less Than Full Time Training (LTFT)

Trainees are entitled to opt for less than full time training within programmes as per eligibility criteria within the [Gold Guide](#). More information can be found in the relevant section of the [curriculum](#).

Academic Training Pathway

Trainees on the academic trainee pathway (i.e. ACF, ACL) should meet with both their academic and clinical supervisors early in their training programme and at the start of each rotation within that programme to set out what and how capabilities in practice will be achieved during each training period. There should be regular review of the overall balance of training to ensure that clinical exposure is adequate to meet training within specified periods, i.e. to prevent disproportionate cumulative time spent in a particular tumour-specific area. As with all trainees, relevant capabilities may be gained in different training periods. For example, if during a ward placement time is spent caring for patients with tumours requiring intensive SACT, this may count towards intensive therapies capabilities. ARCPs should evaluate capabilities gained in a tumour-specific area throughout the training programme period and not just in tumour-specific rotations.

Out-of-Programme (OOP) Opportunities

Trainees should continue to be supported to take time out-of-programme for research (OOPR) or additional experiences (OOPE), e.g. leadership, management, education. If a trainee expects to gain relevant capabilities during OOP, to count time/clinical experience gained towards their overall training time, this must be done prospectively and they must be able to demonstrate training requirements during this period (e.g. active participation in MDT and outpatient clinics).

Specific information regarding the guidelines concerning OOP opportunities can be found in the [Gold Guide](#).

Capabilities in Practice (CiPs)

Capabilities in practice (CiPs) are the high-level learning outcomes that describe what a trainee is expected to know and be able to reliably demonstrate by the time of CCT. The CiPs are underpinned by descriptors, which provide guidance on the range of clinical contexts that may support their achievement.

The six generic CiPs cover the universal requirements of all specialties as described in the [GPC framework](#). Assessment of the generic CiPs will be underpinned by the GPC descriptors. Satisfactory sign off will indicate that there are no concerns.

The seven common oncology and five medical oncology CiPs describe the clinical tasks or activities which are essential to the practice of medical oncology.

Learning outcomes – capabilities in practice (CiPs)
Generic CiPs
<ol style="list-style-type: none"> 1. Able to successfully function within NHS organisational and management systems 2. Able to deal with ethical and legal issues related to clinical practice 3. Communicates effectively and is able to share decision making, while maintaining appropriate situational awareness, professional behaviour and professional judgement 4. Is focussed on patient safety and delivers effective quality improvement in patient care 5. Carrying out research and managing data appropriately 6. Acting as a clinical teacher and clinical supervisor
Oncology CiPs - Shared with Clinical Oncology
<ol style="list-style-type: none"> 7. Applying knowledge and understanding of the scientific principles that underpin malignancy for the provision of high quality and safe patient-centred care 8. Delivering the acute oncology take, manage oncological emergencies, provide advice to the other healthcare professionals as part of an Acute Oncology Service (AOS) and manage the AOS team and the palliative care/ end-of-life needs of those with advanced cancer 9. Providing continuity of care to oncology in-patients to include the effective management of disease and treatment-related complications, medical conditions, the acutely deteriorating patient 10. Working effectively within, and contribute expert opinion to the tumour-site specific multi-disciplinary team meeting (MDT) to inform evidence-based management plans individualised to the needs of each patient, leading discussions where appropriate 11. Assessing patients at all stages of the cancer pathway, from diagnosis to end of life care, considering the holistic needs of individuals and the additional needs of vulnerable groups to formulate patient-centred management plans 12. Safely and effectively delivering, and managing patients receiving, standard systemic anticancer therapy (SACT) in the curative, neo-adjuvant, adjuvant and palliative settings 13. Acting as an advocate for health promotion and high-quality cancer survivorship, advise on cancer prevention, management of long-term treatment-related sequelae and patient self-management strategies
Medical Oncology CiPs
<ol style="list-style-type: none"> 14. Safely and effectively deliver, and manage patients receiving, intensive complex systemic anti-cancer therapies 15. Developing guidelines and protocols to safely implement new and emerging diagnostic and systemic anticancer therapeutic approaches 16. Managing the training and supervision of non-medical prescribers of systemic anticancer therapies 17. Integrating biomarkers and genomic information to refine diagnosis and develop personalised treatment plans for cancer patients 18. 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.

Generic CiPs

The six generic CiPs cover the universal requirements of all specialties as described in the [GPC framework](#). Further information including descriptors of these CiPs can be found in the [curriculum](#), which can be found on the [JRCPTB website](#).

Oncology CiPs

Medical oncology trainees are expected to develop capabilities in the biological principles, role and delivery of radiotherapy in the management of oncology patients. This may be a feature of oncology CiPs 9, 10 and 11. The minimum expectation of trainees 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 associated toxicities. Refer to the [assessments and progression section](#) and the [ARCP decision grid](#) for further information.

7. Application of the knowledge and understanding of the scientific principles that underpin malignancy.

Purpose

To enable trainees to gain an understanding of the scientific principles behind cancer development and treatment and apply these to provide high quality, safe, patient-centred care.

Learning Outcomes

To form the foundations for the scientific knowledge base for the [Medical Oncology Speciality Certificate Examination \(SCE\)](#) and the [FRCR examinations](#) (if applicable), trainees should gain knowledge of:

- the principles of cancer biology related to the development, diagnosis and treatment of malignancy
- the principles of physics in relation to radiotherapy treatment
- clinical pharmacology relating to systemic anti-cancer treatment
- clinical trials methodology
- cancer risk and screening
- scientific advances and new technology

Achieving the skills

All trainees should have access to an appropriate course delivering the foundations of the scientific knowledge underpinning malignancy. In some cases, this may form part of an MSc course and may be delivered, locally, regionally or via distance/remote learning. This should cover the breadth of knowledge but is not designed to be exhaustive. Trainees are encouraged to supplement the course materials with additional personal study and examination preparation where appropriate.

Training placements should be structured to provide regular opportunities for informal and formal discussion with trainees regarding the scientific foundations of cancer care. This includes case discussion in acute oncology, inpatient, outpatient and MDT settings. Trainees will have a formal opportunity to demonstrate this knowledge and identify areas of

development as part of their workplace-based assessments and clinical/educational supervisors can include this in their reports.

The application of the scientific knowledge base will also be tested as part of the Medical Oncology SCE and the FRCR examinations (if applicable, for those trainees who wish to transition to Clinical Oncology following the OCS year).

Demonstration of achieving the required CiP level may be shown using a mixture of the evidence given in the [CiP table found in the curriculum](#).

8. Managing patients within and delivering an Acute Oncology Service.

Delivering the acute oncology (AO) take, managing oncological emergencies and providing oncology advice to other healthcare professionals. Ideally this should be as part of an Acute Oncology Service (AOS) and managing the AOS team, although alternative settings where acute oncology is delivered would also be appropriate. TPD's are required to review the provision of training in acute oncology in all rotations to ensure that trainees can achieve the required capabilities.

Purpose

Trainees are required to develop the skills to manage acute complications of malignancy and cancer treatment, provide oncology liaison with other healthcare professionals as part of an acute oncology service and develop the leadership skills to effectively manage an AO team.

Learning Outcomes

The principal learning outcomes for the principles of AO delivery and management of patients and teams within this setting are covered in [clinical CiP 8](#) of the curriculum. There will also be the opportunity to develop and demonstrate other capabilities such as dealing with complexity and uncertainty, gaining knowledge, understanding legislation, leadership, communication skills and team-working (domains 1, 2, 3, and 5 of the GPCs).

Achieving the skills

The introduction of the Oncology Common Stem year allows for trainees to formalise their learning in this setting early in training and requires trainees to develop AO skills in a spiral fashion throughout training.

Trainees should have the opportunity to:

- assess, investigate and manage the acute complications of malignancy and its treatments
- take part in the discussions and management of patients with carcinoma of unknown primary (CUP)
- to work in liaison with non-oncology speciality teams to guide the diagnosis and management of patients with suspected cancer
- take part in AO service development and/or quality improvement activities

Acute oncology services are configured differently in different hospitals and regions. Training placements should be configured with the learning outcomes in mind so that trainees can gain the requisite experience, whatever the service model. This may include placements with certain site-specific teams who also deal with CUP/AO referrals (e.g. as part of a GI practice), allocation to AO teams that are AHP or nurse-led, or attachment to an outreach AO team. The

curriculum allows for flexibility for the TPD and trainee to maximise opportunities to evidence the experience and skills that the trainees are gaining.

Acute oncology training should be delivered longitudinally throughout training. During the OCS year, training should focus on the management of acutely presenting patients with cancer and trainees will be expected to achieve a [level 3](#) for this CiP (working with indirect supervision) by the end of the OCS year. In addition to continuing to develop these skills, training in acute oncology in ST4-6 should also include opportunities for service management, improving links with general medical services, as well as service development. Trainees will be required to achieve a [level 4](#) by the end of training when they can demonstrate leadership capabilities such as managing an AO team.

Demonstration of achieving the required CiP level may be shown using a mixture of the evidence given in the CiP table found in the [curriculum](#). Examples of evidence that can be used include [CbD](#) and [mini-CEX](#) for specific AO patient cases, [ACATs](#) on the AO ward round or oncology post take ward round (assessment by AHP/consultant as appropriate). Others include reflections and mini-CEX for MDT case discussions and a [QIPAT](#) in the acute oncology setting. The educational supervisor's report should detail the progress of the trainee against the CiP to inform the ARCP panel each year.

9. Providing continuity of care for patients with cancer

Purpose

Trainees should be involved in providing continuity of care for in-patients with cancer. This should involve the day-to-day effective management of disease and treatment-related complications, as well as managing the acutely deteriorating patient through to palliative care/end-of-life needs.

Learning outcomes

The principal learning outcome for inpatients experience is covered in [clinical CiP 9](#). There will also be the opportunity to develop and demonstrate other capabilities such as team-working and communication (domains 2 and 5 of the GPCs).

Achieving the skills

To achieve these outcomes, we recommend that trainees have dedicated blocks of continuing care experience throughout their training. These blocks will usually be tumour type-based rotations but individual programmes may vary.

Trainees should have the opportunity to:

- act as a senior decision maker, working with a consultant(s) to effectively manage an oncology ward team
- attend consultant-led ward rounds
- lead senior ward rounds with the junior team
- provide oversight for the day-to-day running of an oncology ward with the support of IMT and Foundation doctors, nursing and allied healthcare professional teams

Trainees should receive an induction to inpatient work in each block. Demonstration of achievement of the required CiP level may be shown using a mixture of the evidence given in the CiP table found in the [curriculum](#).

10. Working effectively within an MDT

Purpose

Trainees should be involved in working effectively within and contribute expert opinion to the tumour-site specific multi-disciplinary team meeting (MDT) to inform evidence-based management plans individualised to the needs of each patient, leading discussions where appropriate.

Learning outcomes

The principal learning outcome for MDT experience is covered in [clinical CiP 10](#). There will also be the opportunity to develop and demonstrated other capabilities such as team-working, communication and decision making (domains 3 and 5 of the GPCs).

Achieving the skills

To achieve this outcome, we recommend that trainees have the opportunity to consistently attend site specific MDTs throughout their training. It is expected that trainees primarily attend MDTs specifically linked to their outpatient clinical workload to maximise opportunities for active participation.

Trainees should be given the opportunity to:

- contribute to MDT meetings through case presentation
- being actively involved in decision-making under supervision
- attend specialist MDTs (e.g. Cyberknife, cancer of unknown primary, palliative care) as a means of exposure to an area of personal interest/ prior lack of clinical experience

Demonstration of achieving the required CiP level may be shown using a mixture of the evidence given in the CiP table found in the [curriculum](#).

11. Patient-centred management and holistic care throughout the cancer journey

Purpose

Trainees should be involved in the overall cancer patient pathway, with significant experience in the outpatient setting and in working with the wider MDT to provide holistic and patient-centred care plans.

Learning outcomes

The principal learning outcome for outpatient experience and holistic patient management is covered in [clinical CiP 11](#). There will also be the opportunity to develop and demonstrate other capabilities such as professional behaviours, knowledge, safeguarding, team-working and communication (domains 1, 2, 3, 5, 7, and 9 of the GPCs).

Achieving the skills

To achieve these outcomes, we recommend that trainees have dedicated blocks with substantial outpatient experience throughout their training. It is expected that these blocks will be tumour type-based rotations but that individual programmes may vary.

Trainees should have regular opportunities to:

- see new patients, working with consultant(s) and allied healthcare professionals to produce holistic patient-centred investigation and management plans
- discuss cases and their decision-making with senior colleagues, with a focus on feedback related to oncology specific and professional development
- work with cancer specialist nurses and the wider MDT to perform holistic patient assessments

- contribute to MDT meetings through case presentation, and with adequate progression, be actively involved in decision-making regarding investigation and management, under supervision.

Demonstration of achieving the required CiP level may be shown using a mixture of the evidence given in the CiP table found in the [curriculum](#).

12. Safe and effective delivery of standard SACT

Purpose

Trainees should be involved in the safe and effective delivery and management of patients receiving standard systemic anti-cancer therapies (SACT) in the curative, neo-adjuvant, adjuvant and palliative settings.

Learning outcomes

The principal learning outcome for SACT delivery and management is covered in [clinical CiP 12](#). There will also be the opportunity to develop and demonstrate other capabilities such as dealing with complexity and uncertainty, gaining knowledge, understanding legislation, leadership, team-working, patient safety and research (domains 1, 2, 3, 5, 6, and 9 of the GPCs).

Achieving the skills

To achieve these outcomes, we recommend that trainees have dedicated tumour type blocks of training, with significant outpatient and inpatient SACT experience. An ideal OCS rotation will include a common tumour type that involves the delivery of both SACT and radiotherapy. Medical oncology specific (ST4-6) rotations should include extensive SACT experience, including of more advanced regimens and clinical trials.

Trainees should have the opportunity to:

- undertake oncology specific courses to develop the pharmacological and scientific basis for these therapies
- prescribe SACT, from safely continuing a prescription, through to safely initiating therapy according to standard guidelines / approaches
- evaluate patients on SACT and make appropriate supportive or SACT adjustment measures to enable safe and effective treatment

Trainees should receive an induction to and formal training in tumour specific SACT prescribing in each block. Demonstration of achieving the required CiP level may be shown using a mixture of the evidence given in the CiP table found in the [curriculum](#). Trainees must demonstrate an appropriate level of SACT prescribing for their stage of training through formal [DOST](#) assessments, as set out in the [ARCP decision aid](#).

13. Health promotion and cancer survivorship

Purpose

Trainees should be involved in acting as an advocates for health promotion and high-quality cancer survivorship. They should be able to advise on cancer prevention, as well as having an awareness of cancer screening programmes, management of long-term treatment-related sequelae and patient self-management strategies.

Learning outcomes

The principal learning outcome for health promotion and cancer survivorship is covered in [clinical CiP 13](#). There will also be the opportunity to develop and demonstrate other capabilities such as professional skills, communication, education and training (domains 1, 2, 3, 4, 5, 6, 7, 8 of the GPCs).

Achieving the skills

To achieve this outcome, we recommend that trainees have dedicated blocks of continuing care experience throughout their training, thereby fostering the opportunity to act as senior decision makers, working with consultant(s) to effectively manage long-term treatment-related sequelae. Trainees should have the opportunity to work with cancer specialist nurses and geneticists to further their knowledge base in this specialist area.

Demonstration of achieving the required CiP level may be shown using a mixture of the evidence given in the CiP table found in the [curriculum](#).

Medical Oncology Specific CiPs

14. Safely and effectively deliver, and manage patients receiving, intensive complex systemic anti-cancer therapies

Purpose

Trainees should be involved in the holistic management of patients receiving intensive complex systemic anti-cancer therapies. These should include the day-to-day management of intensive SACT delivery and the side effects and sequelae.

Learning Outcomes

The principle learning outcomes for the management of intensive and complex anti-cancer therapies are covered in [CiP 14](#). There will also be the opportunity to develop and demonstrate other capabilities such as communication and interpersonal skills, understanding legislative requirements, leadership and team working, quality improvement and safeguarding vulnerable groups (domains 1, 2, 3, 4, 5, 6, and 7 of GCP).

Achieving the skills

Trainees should have the opportunity to work with teams that deliver complex and intensive SACT. There are various settings where these capabilities can be achieved, including working with Teenage and Young Adult cancer teams delivering SACT for sarcomas and rare cancers, paediatric cancer teams, adult bone or soft tissue sarcomas, haematology placements including bone-marrow transplantations, cellular therapies e.g. CAR-T and stem cell therapy, as well as urology site-specific placements that include germ cell cancers.

Services for the delivery of intensive and complex therapies may be configured differently across different hospitals and regions therefore TPDs need to ensure that training placements reflect the capabilities that need to be gained. The indicative time for achieving this CiP is six months although there is flexibility within the curriculum for the trainees to achieve this in a shorter time provided the criteria have been met. Often these treatments are delivered in younger patients and the trainee needs to gain experience and holistic understanding of the

long-term sequelae and late effects of these cancers and therapeutic modalities, including effects on fertility.

Trainees should have the opportunity to

- work as part of the wider multidisciplinary team planning and delivering intensive and complex SACT as part of multimodality therapy
- discuss the benefits and risks of intensive SACT including long term sequelae with patients and their families
- manage the care of inpatients receiving intensive SACT or experiencing acute toxicities including pancytopenia and its sequelae
- liaise effectively with other teams to optimise patient care and support for the social, financial and psychological effects of complex and intensive SACT
- take part in quality improvement projects, service review and audit

Demonstration of achievement of the required CiP level may be shown using a mixture of the evidence given in the CiP table found in the [curriculum](#).

15. Developing guidelines and protocols to safely implement diagnostic and systemic anticancer therapeutic (SACT) approaches

Purpose

The trainee should be able to review the evidence base for new and developing diagnostic and systemic anticancer therapies in order to develop guidelines and protocols for their implementation, prioritising patient safety.

Learning Outcomes

The principle learning outcomes for this CiP are covered in clinical [CiP 15](#) of the new curriculum. There will also be the opportunity to develop and demonstrate other capabilities such in dealing with complexity and uncertainty, communication and interpersonal skills, understanding legislation, patient safety and quality improvement (domains 1, 2, 3, 5 and 6 of GPC).

Achieving the skills

This is a cross cutting CiP that can be achieved in multiple tumour site specific placements.

The trainee should have the opportunity to:

- be involved in the introduction of new diagnostic and SACT approaches to the oncology department. Examples of this are the introduction of a new NICE approved therapy in a tumour site specific area or an industry-led expanded access to therapy scheme
- review the evidence base for these approaches
- review the service capacity and resource requirements for new approaches and therapies
- understand the roles of local and national regulatory agencies in the approval of novel therapeutic and diagnostic technologies for cancer treatment
- participate in the review and development of protocols and guidelines as part of a multidisciplinary team
- develop patient- centred information resources to provide information about new therapies and interventions

- participate in evaluation of SACT protocols using audit/quality improvement methodology and adapt protocols in response to emerging data

Demonstration of achievement of the required CiP level may be shown using a mixture of the evidence given in the CiP table found in the [curriculum](#). This may include demonstration of level 5 SACT prescribing.

16. Managing the training and supervision of non-medical prescribers of systemic anticancer therapies

Purpose

Trainees should be able to support and oversee the training of non-medical prescribers (NMPs) of SACT, with an understanding of the governance and training pathways related to the different professional bodies.

Learning Outcomes

The learning outcomes are detailed in [CiP 17](#) of the curriculum. There will also be the opportunity to develop and demonstrate other capabilities such as in communication and interpersonal skills, understanding legislation, patient safety and quality improvement, leadership and team working and education/training (domains 1, 2, 3, 5, 6 and 8 of GPC).

Achieving the skills

There are a wide range of NMPs that may require support varying on training locations, this may include physician associates, specialist nurses, advanced clinical practitioners or pharmacists. Trainees should discuss with their clinical or educational supervisors early in their rotation to identify opportunities for meeting this training requirement. Trainees may support NMPs with the formative assessments required of their training e.g. case-based discussions and prescribing mini-CEX, to feed into their formal supervision. This may not necessarily involve direct supervision of NMPs, considering limitations of a trainee's own clinical rotations, but may involve supporting supervision already provided by senior colleagues. Trainees should also seek opportunities for delivering inter-professional teaching and education. To support this, trainees are encouraged to undertake a teaching skills course or experience (e.g. teaching the teacher course), which may include specific training in supervision.

Demonstration of achieving the required CiP level may be shown using a mixture of the evidence given in the CiP table found in the [curriculum](#). Evidence may include reflection, clinical and/or education supervisor's reports, NMPs being invited to participate in a trainee's MSF, teaching observation. Supporting documentation, including for example anonymised assessments, feedback etc. can be uploaded into a trainee's personal library as evidence.

17. Integrating biomarkers and genomic information to refine diagnosis and develop personalised treatment plans for cancer patients.

Purpose

Trainees should be able to use validated biomarkers and genomic information to deliver a personalised medicine approach to patient care. They should demonstrate the ability to keep up to date with developments in the field and be able to apply this clinically.

Learning outcomes

The principal learning outcome for integration of biomarkers and genomics into clinical practice is covered in specialty-specific [CiP 17](#). There will also be the opportunity to develop and demonstrate other capabilities such as professional skills, including communication and working with the wider MDT (domains 1, 2, 3, 5 of the GPCs).

Achieving the skills

This is a cross-theme CiP that can be achieved in multiple tumour site specific placements, through oncology specific courses and continued professional development.

Trainees should have the opportunity to:

- attend an appropriate course that delivers the foundations of scientific knowledge specific to biomarkers and genomics
- participate in locoregional, national or international meetings and/or educational sessions to keep up-to-date with emerging biomarkers/genomics
- use biomarker and/or genomic information in the clinical assessment of patients to provide a personalised approach to treatment
- have the opportunity to discuss biomarker and genomic results with patients, including in the context of cancer risk and where appropriate inherited cancer predisposition /screening
- discuss cases and their decision-making with senior colleagues, with a focus on feedback related to development in this area
- attend and contribute to MDTs and molecular tumour boards where this information is used to help direct personalised patient management

Demonstration of the achievement of the required CiP level may be shown using a mixture of the evidence given in the CiP table found in the [curriculum](#). Trainees will have a formal opportunity to demonstrate this knowledge and identify areas of development as part of their workplace-based assessments and clinical/educational supervisors can include this in their reports.

18. 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 (PI)

Purpose

Trainees should be able to demonstrate capability in the delivery of clinical trials within a sub-investigator role and achieve the skills to lead clinical trials as a PI by CCT. Trainees should also be able to demonstrate an understanding of the processes of setting up a clinical trial and where appropriate working with third parties, such as pharmaceutical sponsors.

Learning Outcomes

The learning outcomes are detailed in CiP 19 of the [curriculum](#). There is also an opportunity to achieve additional capabilities (such as GPC domains 1, 2, 3, 4, 5, 6, 9).

Achieving the skills

Trainees should actively participate in the delivery of clinical trials throughout their training including from patient consent, on-trial assessments and management of investigational medicinal product (IMP)-related toxicities. Trainees should be able to assess, record and report adverse events including serious adverse events (SAEs) / suspected unexpected serious

adverse reactions (SUSARs) and have an awareness of adverse events reported externally that impact the delivery of the trial locally.

Trainees should proactively seek opportunities to be involved in trial set-up and governance. This may include helping develop and review protocols, attending site initiation visits (SIV), feasibility and capacity meetings, and assisting principal investigators (PIs) in the expression of interest of new trials. Additionally, trainees should maintain their [Good Clinical Practice \(GCP\) certification](#) throughout their training to keep up-to-date with key ethical and regular processes. Other opportunities may include attending trust governance meetings and local/regional research ethics committee (REC) and/or Health Research Authority (HRA) meetings.

Demonstration of the achievement of the required CiP level may be shown using a mixture of the evidence given in the CiP table found in the [curriculum](#). Examples might include mini-CEX or CbDs looking at the consent procedure and role of trial options within the patient's care, as well as assessment of trial-related AEs. Trainees should also upload their GCP training certificate to their personal library and document reflections on research processes, governance and clinical management/cases throughout training. Many of these skills may be gained by trainees during OOP(R) and trainees are encouraged to document this capability development through uploading relevant evidence to the eportfolio personal library prospectively.

Trainees will not be expected to have acted as a PI by CCT, but should be able to evidence they have the skills necessary to set up and run a clinical trial as a PI at consultant level.

Assessments and progression

In the 2021 medical oncology curriculum, there are some new and repurposed WPBAs and SLEs (these include the ACAT, DORPS and DOST). The overall number of assessments has not significantly changed and the details can be found in the [ARCP decision aid](#). There are no changes to the critical progression points in medical oncology nor the ARCP process (more information in the [Gold Guide](#)).

This section will introduce some of the changes to assessment and progression in the new curriculum, but further information can also be found in [appendix 2](#).

What the Educational Supervisor (ES) needs to do

Medical oncology training has a new requirement for how trainees and supervisors should interact; with the need to plan evidence to be acquired across the training year that can be used by the ES to write an important and substantial ES report (ESR).

The ESR will be the central piece of evidence considered by the ARCP Panel when assessing whether the trainee has attained the required standard as set out in the Decision Aid. As such, both time and planning will need to be given to writing it; this process will need to start at the beginning of the training year.

Educational Supervisor Report (ESR)

The ESR should be written ahead of the ARCP and discussed between the supervisor and the trainee before the ARCP, with any aspects likely to result in a non-standard outcome at ARCP made clear. This conversation should be documented. The report documents the entrustment decisions made by the supervisor for all the CiPs set out in the curriculum. The decisions should be based on evidence gathered across the training year as planned at the Induction Meeting with the trainee and modified through subsequent, regular, professional development meetings. The evidence should be gathered from several sources as appropriate for the particular CiP.

In completing the ESR, assessments are made for each [generic CiP](#) using the following anchor statements:

Below expectations for this year of training; may not meet the requirements for critical progression point
Meeting expectations for this year of training; expected to progress to next stage of training
Above expectations for this year of training; expected to progress to next stage of training

Comments must be made, as a minimum, **for any rating of below expectation**. It is good practice to narrate all decisions. The narration should include:

- Source of the evidence and its context, outlining contradicting evidence if appropriate
- Examples (of statements)
- Direction for future development/improvement

For the [specialty CiPs](#), the ES makes a judgement using the levels of entrustment in the table below:

Level 1: Entrusted to observe only – no provision of clinical care
Level 2: Entrusted to act with direct supervision: The trainee may provide clinical care, but the supervising physician is physically within the hospital or other site of patient care and is immediately available if required to provide direct bedside supervision
Level 3: Entrusted to act with indirect supervision: The trainee may provide clinical care when the supervising physician is not physically present within the hospital or other site of patient care, but is available by means of telephone and/or electronic media to provide advice, and can attend at the bedside if required to provide direct supervision
Level 4: Entrusted to act unsupervised

Only the ES makes entrustment decisions. Detailed comments must be given to support entrustment decisions that are below the level expected. As above, it is good practice to provide a narrative for all ratings given. The JRCPTB have published specific training on entrustment levels for internal medicine and higher specialty training; these can be found on the [JRCPTB website](#).

Important Points

- Plan the evidence strategy from the beginning of the training year
- Write the report in good time ahead of the ARCP
- Discuss the ESR with the trainee before the ARCP
- Give specific, examples and directive narration for each entrustment decision

New Supervised Learning Events

Acute Care Assessment Tool (ACAT)

The ACAT is used to provide feedback on a trainee's performance when undertaking acute care, particularly acute oncology. Its main focus is on multi-tasking, prioritisation and organisational skills. It should not be used to produce a "multiple Case Based Discussion". The Decision Aid requires a minimum of 1 per year undertaken by consultant assessors, and for example, include the management of acute cancer presentations and complications, acute treatment toxicities, oncological emergencies, pain management.

New Workplace-Based Assessments

Direct Observation of Systemic Therapy (DOST)

The DOST is an assessment tool designed to assess the performance of a trainee in undertaking, authorising, prescribing and taking consent for systemic therapy, against a structured checklist. The trainee receives immediate feedback to identify strengths and areas for development. DOSTs should include treatment choice discussions with patients, informed consent process, review of prescription with dose adjustment as appropriate, review of toxicity and response. The DOST also assesses a trainee's prescribing skills against [the national SACT framework levels](#).

Documentation of level 4 SACT prescribing skills is required in ST4 and ST5, and level 5 SACT prescribing skills in ST6.

Direct Observation of Radiotherapy Planning Skills (DORPS)

The DORPS is a structured assessment for the performance of a trainee in undertaking radiotherapy planning. The minimum expectation of trainees 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 associated toxicities. The DORPS provides an opportunity to follow a patient during radiotherapy, observing the process of radiotherapy planning with structured feedback. Radiotherapy for palliative conditions, including metastatic spinal cord compression / haemoptysis, as well as standard radiotherapy regimens would be considered good learning opportunities for achieving capabilities in this domain. Assessors must be trained both in radiotherapy planning and feedback methodology. Trainees should agree the timing and assessor, although assessors may also carry out unscheduled assessments. Trainees should receive immediate feedback to identify strengths and areas for development.

Medical Oncology Training ARCP Decision Aid

The Medical Oncology ARCP decision aid provides guidance on the targets to be achieved for a satisfactory ARCP outcome at the end of each training year. This document is available on the JRCPTB website www.jrcptb.org.uk/training-certification/arcp-decision-aids. Individual progress will be monitored by an annual review, the annual review of competency progression (ARCP). This facilitates decisions regarding progression through the training programme, as well as identifying any requirements for targeted or additional training where necessary. The following decision aids offer guidance on the domains to be reviewed and minimum expectations for progress. The decision aids should be used alongside the progression grids detailing the expected level of progress for the capabilities in practice (CiPs) at each stage of training.

It is important to note that the decision aids describe the minimum requirements for progression, however ARCP panels should consider the quality of assessments as well as the quantity.

ARCP Decision Aid: Oncology Common Stem (OCS) Year

		<u>Oncology Common Stem</u>
Satisfactory workplace based assessments	MSF	1
	Mini-CEX	2
	CbD	2 including 1 involving a patient on a clinical trial
	DORPS	2
	DOST	2
	ACAT	1
	MCR	1 summary of 4-6 consultant reports (to include at least 1 medical oncology and 1 clinical oncology consultant)
MDT	Portfolio evidence of MDT participation	
Clinical research	Valid GCP certificate *	
Educational Supervisor's Report	1	

*Please note that at least one CbD involving a patient on a trial is required to provide evidence of clinical research, as detailed in the 'CbD' section above

ARCP Decision Aid: Medical Oncology ST4-6

		<u>ST4</u>	<u>ST5</u>	<u>ST6</u>
Satisfactory workplace based assessments	MSF	-	1	-
	Mini-CEX ^a	2	2	2
	CbD ^b	2	2	2
	DOST ^c	2	2	2
	ACAT ^d	1	1	1
	MCR	4-6	4-6	4-6
	TO	1	1	-
	Audit/QiPAT	1	1	1
	Patient survey/ feedback	1	-	1
MDT		Portfolio evidence of MDT participation		
Clinical research		GCP Personal reflections on contribution to clinical research, such as; recruitment, trial management, data analysis, presentation of data or project planning		
Educational Supervisor's		1	1	1

ARCP Decision Aid: Medical Oncology ST4-6 (cont.)

Report			
Management, Leadership and Governance	Portfolio evidence of management, leadership and governance and/or completion of a management course		
Reflective Practice	Personal reflections on issues, including complex clinical cases and interactions, governance and ethical issues, to highlight learning points and actions for personal development		
Examinations	-	-	Medical Oncology SCE

- a.** Mini-CEXs to include comprehensive assessment of a new patient, patient counselling and education
- b.** CBDs to include some/all of the following: review of presenting features, diagnostic reasoning, planning investigations, interpretation of clinical data and planning treatment or end of life care
- c.** DOSTs to include treatment choice discussion with patient, informed consent process, review of prescription with dose adjustment as appropriate, review of toxicity and response. Documentation of level 4 SACT prescribing skills in ST4 and ST5 and level 5 SACT prescribing skills in ST6.
- d.** ACAT to include the management of acute cancer presentations and complications, acute treatment toxicities, oncological emergencies, pain management.

Levels to be achieved by the end of each training year and by CCT for Oncology specialty CiPs

Level descriptors

Equal 1: Entrusted to observe only – no provision of clinical care

Level 2: Entrusted to act with direct supervision

Level 3: Entrusted to act with indirect supervision

Level 4: Entrusted to act unsupervised.

	OCS	Medical Oncology Training				
Oncology CiPs	ST3	ST4	ST5	ST6	CCT	
7. Applying knowledge and understanding of the scientific principles that underpin malignancy for the provision of high-quality and safe patient-centred cancer care.	2	3	3	4		
8. Delivering the acute oncology take, managing oncological emergencies and providing oncology advice to other healthcare professionals as part of an Acute Oncology Service and managing the AOS team	3	3	3	4		
9. Providing continuity of care to oncology in-patients to include the effective management of disease and treatment-related complications, the acutely deteriorating patient and the palliative care/end-of-life needs of those with advanced cancer	3	4	4	4		
10. Working effectively within and contributing expert opinion to the tumour site-specific multi-disciplinary team (MDT) meeting to inform evidence-based management plans individualised to the needs of each patient, leading discussions where appropriate	2	3	3	4		

11. Assessing patients at all stages of the cancer pathway from diagnosis to end-of-life care, considering the holistic needs of individuals and the additional needs of vulnerable groups to formulate patient-centred management plans	2	3	3	4	
12. Safely and effectively delivering, and managing patients receiving, standard systemic anticancer therapies (SACT) in the curative, neo-adjuvant, adjuvant and palliative settings	2	3	3	4	
13. Acting as an advocate for health promotion and high-quality cancer survivorship, advising on cancer prevention, management of long-term treatment-related sequelae and patient self-management strategies	2	3	4	4	

Levels to be achieved by the end of each training year and by CCT for Medical Oncology specialty CiPs

Level descriptors

Equal 1: Entrusted to observe only – no provision of clinical care

Level 2: Entrusted to act with direct supervision

Level 3: Entrusted to act with indirect supervision

Level 4: Entrusted to act unsupervised.

Medical Oncology CiPs	OCS	Medical Oncology Training				CCT
	ST3	ST4	ST5	ST6		
14. Safely and effectively delivering, and managing patients receiving, intensive complex systemic anti-cancer therapies	2	2	3	4	CCT	
15. Developing guidelines and protocols to safely implement new and emerging diagnostic and systemic anticancer therapeutic approaches	2	2	3	4		
16. Managing the training and supervision of non-medical prescribers of systemic anticancer therapies	2	2	3	4		
17. Integrating biomarkers and genomic information to refine diagnosis and develop personalised treatment plans for cancer patients	2	2	3	4		
18. 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.	2	2	3	4		

Medical Oncology Curriculum 2021 FAQs

Why has the curriculum changed?

Two major sets of reforms require that all postgraduate medical curricula are revised to be in line with these. Firstly, the release of [new standards for postgraduate medical curricula](#) by the GMC and secondly the [implementation report](#) from the UK Shape of Training Steering Group. These coupled with the fast-moving nature of the specialty required a full revision to ensure that the new curriculum will provide more flexibility, address new treatments and technologies and will better support patient, professional and service need.

What is different in the new curriculum?

The new curriculum for medical oncology is structured around high-level learning outcomes, called capabilities in practice (CiPs), which describe clearly and at a high level what a doctor will be able to do independently on completion of training. There are 18 CiPs in the medical oncology curriculum, including 6 generic CiPs that apply to all doctors, 7 shared oncology CiPs that apply to both medical and clinical oncologists and 5 specialty-specific CiPs that are unique to medical oncology.

The CiPs are underpinned by descriptors that provide guidance on the clinical context which supports their achievement and by a table that provides a brief outline of common presentations and conditions in different groups of acute oncology patient. This approach makes the curriculum much more concise and user friendly.

Emerging technologies, such as genomics and AI, are addressed in the descriptors and in dedicated sections of the curriculum, allowing the curriculum to be future-proof and to effectively prepare trainees for the future demands of a changing service.

Trainees may demonstrate their progress against the CiPs in a variety of different ways, reflecting their strengths, areas of interest and the resources available to them. This, along with the inclusion of generic and common oncology CiPs, and the introduction of the oncology common stem, creates a flexible curriculum that can both be tailored to individual trainees and meet local service needs.

Progress against the CiPs is assessed using a scale based on the concept of [entrustable professional activities](#), allowing holistic decisions about progress, supported by [progression grids](#) that clearly define the expected level of competence for each stage of training.

There are three new workplace-based assessments ([see above](#)). The minimum number of each assessment that is required for each stage of training has been amended so that the overall burden of assessment for trainees and supervisors is not significantly increased. Details of this can be seen on the [ARCP decision aids](#).

The training structure has changed with the introduction of the Oncology Common Stem year shared by medical and clinical oncology reflecting the close working and significant areas of overlap between the two specialties.

What is the Oncology Common Stem (OCS) year?

The oncology common stem (OCS) is the initial period of common training for medical and clinical oncology that constitutes the ST3 year for both specialties. The OCS has an indicative duration of one year, during which the focus will be on the development of the generic CiPs expected of all doctors

and the common CiPs relating to the key areas of overlap between medical oncology and clinical oncology.

Medical oncology and clinical oncology will retain individual entry points and trainees will have either a medical oncology or clinical oncology training number, however successful completion of the OCS will facilitate [flexibility and transferability](#) between medical oncology and clinical oncology by providing formal recognition of the attainment of oncology capabilities common to both specialties. Any trainee wishing to transfer specialty between medical and clinical oncology would be required to do so in open competition, through the existing national recruitment process. This applies to trainees at any stage of training, including those at the end of OCS. However, this curriculum promotes the recognition of capabilities, rather than simply time served, giving oncology trainees the confidence that were they to switch specialty there would be the appropriate acknowledgment of the relevance of their training thus far.

Are there any new assessments?

The new curriculum retains the same range of formative workplace-based assessment found in the 2017 medical oncology curriculum and there have been no significant changes to the [SCE examination](#). The use and structure of these assessments is well established, and they can easily be applied to the new curriculum.

In addition, three new WPBAs/SLEs, the direct observation of systemic therapy (DOST), direct observation of radiotherapy planning skills (DORPS) and the acute care assessment tool (ACAT) have been introduced.

The [DOST](#) has been introduced to assess the performance of a trainee in undertaking, authorising, prescribing and taking consent for systemic therapy, against a structured checklist. This assessment is an integral part of medical oncology training and a minimum of 2 assessments are required in each training year.

The [DORPS](#) assessment is a structured assessment for the performance of a trainee in undertaking radiotherapy planning; assessors must be trained in radiotherapy planning and feedback. The DORPS is a required assessment in the OCS year, but not in later years of medical oncology specific training (ST4-6). The DORPS in the OCS year ensures that medical oncology trainees are exposed to the radiotherapy planning environment and that they understand the processes involved; they are not expected to be able to undertake radiotherapy planning.

Use of the DOST and DORPS structured forms rather than the generic mini-CEX/CbD forms for these activities promotes consistency and comparability of assessment of the shared CiPs between medical and clinical oncology.

The [ACAT](#), familiar to most trainees from their core medical /internal medicine stage 1 training, is intended to be used here for providing feedback to trainees on supervised aspects of acute oncology provision. This may include an on-call shift, ward rounds, handover or in reach to the medical assessment unit (MAU) or covering a day's management of admissions and ward work. The ACAT looks at clinical assessment and management, decision making, team working, time management, record keeping and handover for the whole time period and multiple patients.

As a result of introducing additional assessments, the minimum number of each assessment that is required for each stage of training has been adjusted so that the overall burden of assessment for trainees and supervisors is not significantly increased.

More details on assessment requirements can be found in the curriculum and the [ARCP decision aid](#).

I'm a current medical oncology trainee, will I have to switch to the new curriculum?

All oncology trainees will be expected to transfer to the new curriculum, unless they are due to CCT before 8th September 2022. Current trainees will transfer to the new curriculum following their ARCP for the 2020/21 training year, normally by August 2021. All trainees transferring to the new curriculum will need to sit down with their ES, academic supervisor and/or TPD to ensure that a gap analysis is performed and future training can be focused on the outcome of this analysis.

Medical oncology trainees in their final year of training when the new curriculum is introduced in August 2021 will not be required to transfer to the new curriculum, provided that they are due to CCT before 8th September 2022. **NB** if the CCT is deferred beyond this date for any reason, trainees will then need to transfer to the new curriculum.

I'm a current medical oncology trainee, do I still have to complete a radiotherapy planning assessment (DORPS)?

The [DORPS](#) is a core assessment in the OCS year, but not in medical oncology specific training (ST4-6). However, those trainees transitioning on to the new curriculum will still need to demonstrate achievement in the radiotherapy components of the common oncology CiPs in order to achieve the CCT. The minimum expectation of trainees 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 associated toxicities. As such, it would be entirely reasonable to expect the same level of evidence in a transitioning trainee's portfolio by CCT. One way of evidencing this could include the completion of a DORPS assessment, however this is not mandated, and appropriate alternative evidence could include a CbD, mini-CEX, ACAT, or reflective practice on radiotherapy activities, along with achievement in an oncology course and/or the SCE.

Why isn't being 'on-call' adequate for training in acute oncology?

Being 'on-call' can form an important part of acute oncology training but is not sufficient in itself to constitute the whole of training in the Acute Oncology (AO) CiP. Depending on the setting, being on-call may not reflect the full array of acute care management and professional skills development that is required for training in the provision and management of AOS. In addition, often, there is no formal review or feedback from activities undertaken when on-call, required to constitute a training activity rather than pure service provision. In many instances, formal senior review of patients managed on-call is undertaken at a time when the on-call doctor is scheduled to be elsewhere, giving little opportunity for feedback and associated learning from those activities. Whilst 'on-call' can often include acute assessment and management of patients with cancer, it often also involves supporting outpatient services and providing non-acute inpatient care. As such, it is unlikely to provide a well-rounded training experience in AO.

Training in AOS should include initial assessment of a patient, including investigation and management in the acute setting. Following initial assessment / investigation, there should be follow-up of the patient pathway, which may include post-take ward rounds, ambulatory care, and/or outreach to non-oncology settings. Trainees should get regular and structured feedback from senior decision makers, including consultant and acute oncology CNS'. The CiP is also much broader than simply the direct management of patients presenting with acute complications of cancer and its treatments, requiring the ability to manage lead and develop a complex, multi-disciplinary service which interacts with other elements of the acute care services effectively.

To meet my training requirements in acute oncology, do I have to work on a clinical site that has an accident and emergency department?

This is not mandatory, though to be encouraged wherever feasible. AOS looks very different in different parts of the country reflecting regional service configurations and resources. Some stand-alone cancer centres have AOS that provide direct admission from outpatient settings, as well as from local healthcare service providers. Oncology services within hospitals may accept referrals directly, via oncology-specific assessment units or via their A+E department. AO training may be delivered in this full range of, and should ideally include a mixture of these settings.

I'm a trainee working less than full time (LTFT), when will I be transferred?

All trainees (except those due to CCT before 8th September 2022) will transfer to the new curriculum following their ARCP for the 2020/21 training year, including those working LTFT. Anyone due to CCT before this date, who then changes from FT to LTFT training and whose CCT date gets deferred beyond 8th September 2022 as a result, will also need to transition.

I'm a trainee and will be out-of-programme/on statutory leave during the transition period – when will I be transferred?

All trainees (except those due to CCT before 8th September 2022) will transfer to the new curriculum at the end of the 2020/21 training year. If you are out-of-programme or on statutory leave during this period you will follow the new curriculum when you return to training. Evidence collected while following the current curriculum can be used to show progress against the CiPs.

What support will there be for trainers and trainees?

Support will be available for trainees and trainers, including face-to-face training, short videos, and guidance documents. TPDs and trainee reps will provide a local point of contact and help to cascade training throughout the regions. The support can be found on the medical oncology specialty pages of the [JRCTPB website](#).

What should I be doing to prepare for this transition?

Make sure that you have familiarised yourself with the new medical oncology curriculum and that you look out for implementation updates in newsletters, e-bulletins and on the [JRCTPB website](#). The website will be kept up to date with resources to help you prepare for curriculum implementation.

How do I find out more?

There will be regular updates through newsletters, e-bulletins and the [curriculum website](#). You can also speak to your JRCTPB SAC TPD or trainee rep for information and advice – these will be your local experts on all things related to the new curriculum.

For specific queries not addressed on the website or by your regional TPD/SAC trainee rep, you can contact curriculum@jrcptb.org.uk.

Appendix 1. Terminology guide

The 2021 curriculum uses some terminology not present in the 2017 curriculum, reflecting the change from a competency-based curriculum to an outcomes-based curriculum and to assessment based on the concept of entrustable professional activities. This section explains some of the terminology used in the 2021 curriculum.

Assessment blueprint

An assessment blueprint defines the content of an exam or workplace-based assessment and shows which forms of assessment may be used to measure progress against each of the capabilities in practice (outcomes) given in the medical oncology curriculum.

Capability in Practice (CiP)

Capabilities in practice (CiPs) are the high-level learning outcomes that describe what a trainee is expected to know and be able to reliably demonstrate by the time of CCT. The CiPs are underpinned by descriptors, which provide guidance on the range of clinical contexts that may support achievement of the CiPs. The descriptors are not intended to be prescriptive and do not represent an exhaustive list. The medical oncology curriculum contains generic CiPs, which are common across all specialties, common oncology CiPs, which apply to both medical and clinical oncologists, and medical-oncology-specific CiPs, which apply only to medical oncology.

Critical progression point

A critical progression point is a point in training where a trainee transitions to higher levels of professional responsibility or enters a new or specialist area of practice, including successful completion of training. These transitions are often associated with an increase in potential risk to patients or those in training. Medical oncology training progresses in a spiral manner, therefore it is difficult to identify a set point where responsibility increases significantly. For this reason, completion of training is the only critical progression point in medical oncology training.

Entrustable professional activity (EPA)

An entrustable professional activity (EPA) is a key clinical or professional responsibility or task that can only be performed by an appropriately trained person, once sufficient competence has been demonstrated. The competence of a trainee to perform an EPA is assessed based on the supervisor's professional judgement of whether they trust the trainee to act with direct, minimal or no supervision for that EPA. The concept of entrustment allows trainers to make competency-based decisions on the level of supervision required by trainees.

Generic professional capabilities (GPCs)

[The Generic professional capabilities framework](#) describes the minimum GMC requirements underpinning professional practice in the UK. Along with [Good medical practice](#), they must be included in all postgraduate curricula approved by the GMC.

Good Medical Practice (GMP)

[Good medical practice](#) is the core GMC ethical guidance for doctors, which sets out the values and principles of good practice. It is the foundation on which all other GMC guidance is built and is used to inform the education, training and practice of all doctors in the UK.

High level learning outcome

High level learning outcomes describe what a trainee is expected to know and be able to reliably demonstrate by the time of CCT. They provide an overview rather than exhaustive detail and can be generic (common across all specialties), shared (common across groups or families of specialties) or specialty-specific. In the medical oncology curriculum the outcomes have been called capabilities in practice, or CiPs.

Oncology common stem (OCS)

The oncology common stem (OCS) is the initial period of common training for medical and clinical oncology that constitutes ST3 for both specialties. The OCS has an indicative duration of one year, during which the focus will be on the development of the generic CiPs expected of all doctors and the common CiPs relating to the key areas of overlap between the two specialties.

Outcomes-based curriculum

The curriculum sets out the intended aims, outcomes, content, teaching, learning, and assessment of training in medical oncology. The 2021 curriculum is outcomes-based, whereas the 2017 curriculum is competency based. Outcomes based education is a learner-centred approach that focuses on what a trainee is able to do on completion of training. An outcomes-based curriculum reflects the achievement of high-level learning and mastery rather than demonstration of detailed lists of knowledge, skills and behaviours as found in a competency-based curriculum.

Appendix 2. Assessment and Progression

Introduction

Decisions about a trainee's competence progression will be based on an assessment of how they are achieving their CiPs. For the generic CiPs this will be a straightforward statement as to whether they are operating at, above, or below their anticipated performance for the current year/level of training. However, for the clinical oncology and medical oncology specialty-specific CiPs there will be a judgement made about what level of supervision they require (i.e. unsupervised or with direct or indirect supervision). For each specialty-specific CiP there is a level that is to be achieved at the end of each year in order for a standard outcome to be achieved at the Annual Review of Competence Progression (ARCP). This level is specified in the curriculum and therefore can only be altered with the agreement of the GMC.

What the trainee needs to do

There is no major change in what the trainee needs to do in preparing for their ARCP in medical oncology specialty training compared to the previous curriculum. Trainees still need to do an appropriate number of supervised learning events (SLEs) and workplace based assessments (WPBAs). The requirements are documented in the [ARCP decision aid](#) but it should be appreciated by trainer and trainee that the decision aid sets out the absolute minimums. SLEs are not pass/fail summative assessments but should be seen by both trainer and trainee as learning opportunities for a trainee to have one-to-one teaching and receive helpful and supportive feedback from an experienced senior doctor. Trainees should therefore be seeking to have SLEs performed as often as practical. They also must continue to attend and document their teaching sessions and must continue to reflect (and

record that reflection) on teaching sessions, clinical incidents and any other situations that would aid their professional development.

Each trainee must ensure that they have acquired a complete multi-source feedback (MSF) or patient survey on their performance (as indicated in the ARCP decision aid) and that this feedback has been discussed with their ES and prompted appropriate reflection. They also need to ensure that they have received a minimum of four reports from consultants who are familiar with their work and who will contribute to the Multiple Consultant Report (MCR) including both medical and clinical oncologists (minimum of 1 of each) in the OCS year. Each consultant contributing to the MCR will give an advisory statement about the level at which they assess the trainee to be functioning for each specialty-specific CiP.

As the ARCP approaches, trainees need to arrange to see their ES to facilitate preparation of the ES report (ESR). They will have to self-assess the level at which they feel they are operating at for each CiP. In an analogous fashion to the MSF, this self-assessment allows the ES to see if the trainee's views are in accord with those of the trainers and will give an idea of the trainee's level of insight.

Interaction between trainer and trainee

Regular interaction between trainees and their trainers is critical to the trainee's development and progress through the programme. Trainees will need to engage with their clinical and educational supervisors.

At the beginning of the academic year there should be a meeting with the ES to map out a training plan for the year. This should include:

- how to meet the training requirements of the programme, addressing each CiP separately;
- a plan for taking the medical oncology SCE;
- a discussion about what resources are available to help with the programme;
- develop a set of SMART Personal Development Plans (PDPs) for the training year;
- a plan for using study leave;
- use of the various assessment/development tools.

The trainee should also meet with the clinical supervisor (CS) to discuss the opportunities in the current placement including:

- develop a PDP including SMART objectives for the placement;
- access to clinics, MDTs, teaching and how to meet the learning objectives;
- expectations for medical oncology on-calls and acute oncology;
- expectations for inpatient experience;
- expectations to gain experience in research, audit / quality improvement and management and leadership.

Depending on local arrangements there should be regular meetings during each clinical attachment for personalised, professional development discussions which may include:

- writing and updating the PDP;

- reviewing reflections and SLEs;
- reviewing MCR and other feedback;
- discussing leadership development;
- discussing the trainee's development as a physician and career goals;
- discussing things that went well or things that went not so well.

Self-assessment

Trainees are required to undertake a self-assessment of their engagement with the curriculum and in particular the CiPs. This is not a 'one-off' event but should be a continuous process from induction to the completion of the programme and is particularly important to have been updated ahead of the writing of the ES report and subsequent ARCP. Self-assessment for each of the CiPs should be recorded against the curriculum on the trainee's ePortfolio account. Self-assessment records a trainee's judgement on their entrustment level for each specialty-specific CiP and helps inform the ES in their assessment and in supporting a trainee's development.

The purpose of asking trainees to undertake this activity is:

- to guide trainees in completing what is required of them by the curriculum and helping to maintain focus of their own development. To initiate the process it is important that the induction meeting with a trainee's ES reviews how the trainee will use the opportunities of the coming academic year to best advantage in meeting the needs of the programme. It will allow them to reflect on how to tailor development to their own needs, over-and-above the strict requirements laid out in the curriculum
- to guide the ES and the ARCP panel as to how the trainee considers they have demonstrated the requirements of the curriculum as set out in the Decision Aid and where this evidence may be found in the trainee's portfolio. This will help the ARCP panel make a more informed judgement as to the trainee's progress and reduce the issuing of outcome 5s as a result of evidence not being available or found by the panel

What the Educational Supervisor (ES) needs to do

There are changes to the way in which trainees and their ES interact – more information is found in this document [above](#).

Types of Evidence

Local Faculty Groups (LFG)

This type of group has been recommended in training previously but is not universally implemented. If available this should be a group of cross-specialty (clinical and medical oncology) senior clinicians who get together to discuss trainees' progress. The purpose is not only to make an assessment of a trainee but to determine and plan on-going training, and could be particularly useful for supporting OCS trainees. It is recommended again as an optimal way of providing information about trainees' progress. This should be formative with outcomes fed back to a trainee's CS and ES – it is not a part of the ARCP process. The LFG set-up will depend on the circumstances of the organisation.

Multi-Source Feedback (MSF)

The MSF provides feedback on the trainee that covers areas such as communication and team working. It closely aligns to the Generic CiPs. Feedback should be discussed with the trainee. If a repeat MSF is required it should be undertaken in the subsequent placement.

Multiple Consultant Report (MCR)

The MCR captures the views of consultant (and other senior staff) based on observation of a trainee's performance in practice. The MCR feedback gives valuable insight into how well the trainee is performing, highlighting areas of excellence and areas of support required.

The *minimum* number of MCRs considered necessary is four (ideally one of these reports should reflect performance in the acute oncology setting). It is advised that more should be obtained to support the entrustment decisions made by the ES especially if the trainee is struggling. All those formally appointed as CS should complete a MCR but any other consultant with whom the trainee has had significant interaction can also complete one.

In completing the MCR assessments are made for each CiP using the global anchor statements (meets, below or above expectations). If it is not possible for an individual to give a rating for one or more of the CiPs they should record 'not observed'. Comments must be made, as a minimum, for any rating of below expectation. It is good practice to narrate all decisions. The narration should include:

- source of the evidence and its context, outlining contradicting evidence if appropriate
- examples (of statements)
- direction for future development/improvement

Supervised Learning Events

Acute Care Assessment Tool (ACAT)

See dedicated section [above](#).

Case based Discussion (CbD)

This tool is designed to provide feedback on discussions around elements of the care of a particular patient. This can include elements of the particular case and the general management of the condition. It is a good vehicle to discuss management decisions. CbDs could include some or all of the following: review of presenting features, diagnostic reasoning, planning investigations, interpretation of clinical data and planning treatment or end-of-life care.

Mini-Clinical Evaluation Exercise (mini-CEX)

This tool is designed to allow feedback on the directly observed management of a patient and can focus on the whole case or particular aspects. Mini-CEXs should include a comprehensive assessment of, for example, a new patient, including patient counselling and education. Mini-CEX may also be used for assessing capabilities in acute oncology and may include the assessment/management of patients with acute toxicities, disease complications, oncology emergencies and/or pain management.

Workplace-Based Assessments

Direct Observation of Systemic Therapy (DOST)

See dedicated section [above](#).

Direct Observation of Radiotherapy Planning Skills (DORPS)

See dedicated section [above](#).

Teaching Observation (TO)

The TO form is designed to provide structured, formative feedback to trainees on their competences at teaching. The TO form can be based on any instance of formalised teaching by the trainee which has been observed by the assessor. The process should be trainee-led (identifying appropriate teaching sessions and assessors). Trainees should also reflect on their skill development in this area, this may include reflections on content development, delivery of teaching, assessment or evaluation, as well as identifying areas for personal development.

Quality Improvement Project Assessment Tool (QIPAT)

The QIPAT is designed to assess a trainee's competence in completing a quality improvement project. The QIPAT can be based on a review of quality improvement documentation or on a presentation of the quality improvement project at a meeting. If possible, the trainee should be assessed on the quality improvement project by more than one assessor. Trainees are also encouraged to actively reflect on their development in this area, this may include reflections relating to audit/QIP design or implementation, analysis and presentation of results, and contribution to service development / guidelines.

Guidance on how to assess QI skills and behaviours has been developed by the Academy of Medical Royal Colleges and is available via this [link](#).

Multi-source feedback (MSF)

This tool is a method of assessing generic skills such as communication, leadership, team working, reliability etc, across the domains of Good Medical Practice. This provides systematic collection and feedback of performance data on a trainee, derived from a number of colleagues. 'Raters' are individuals with whom the trainee works, and includes doctors, administrative staff, and other allied professionals. Raters should be agreed with the educational supervisor at the start of the training year. The trainee will not see the individual responses by raters. Feedback is given to the trainee by the ES and trainees are encouraged to actively reflect on its findings and record this in their ePortfolio. More information is available on the [JRCPTB website](#).

Patient Survey (PS)

The PS addresses issues, including the behaviour of the doctor and effectiveness of the consultation, which are important to patients. It is intended to assess the trainee's performance in areas such as interpersonal skills, communication skills and professionalism by concentrating solely on their performance during one consultation. Feedback should be provided by the trainee's CS/ES and trainees are encouraged to actively reflect on its findings and record this in their ePortfolio. More information is available on the [JRCPTB website](#).

Reflection

Undertaking regular reflection is an important part of trainee development towards becoming a self-directed professional learner. Through reflection a trainee should develop SMART learning objectives related to the situation discussed. These should be subsequently incorporated into their PDP. Reflections are also useful to develop 'self-knowledge' to help trainees deal with challenging situations.

It is important to reflect on situations that went well in addition to those that went not so well. Trainees should be encouraged to reflect on their learning opportunities and not just clinical events.

Some examples of personal reflections include:

- MDT participation – preparation, referrals, case presentations, educational benefit, interprofessional difficulties
- audit/QIPAT - see above
- teaching – see above
- clinical research, ethics and economics – recruitment, trial management, data analysis, presentation, project planning
- medical leadership, management and governance – rota management, staff induction, departmental meetings, network meetings, shadowing senior managers, recruitment, development of business cases, risk management, governance, developing guidelines
- clinical practice – difficult conversations and/or cases, management outside of standard guidelines, critical incidents

Suggested evidence for each CiP

The suggested evidence to inform entrustment decisions is listed for each CiP in the curriculum and ePortfolio. However, it is critical that trainers appreciate that they do NOT have to supply evidence under each category listed. This list merely suggests the sort of information that could be used to evidence each CiP. Training programmes will vary but all should offer the trainees an opportunity to work within a team that takes acute admissions. This should be possible in most hospitals as the consultants in the majority of oncology wards have direct admission via outpatient settings, acute oncology and with outreach to other specialties/teams.

Relationship with Educational Supervisor (ES)

Each trainee should have an Educational Supervisor for a minimum of 12 months of medical oncology training. In reality, it is ideal if the trainee has the same ES throughout the whole of training but practical considerations (such as geographical locations) may sometimes mitigate against this. It is vital that the trainee and the ES develop a close working relationship and meet up as soon as possible after the start of training. At that meeting, the ES should discuss how the various curriculum requirements will be met (especially some of the mandatory learning experiences such as clinics and critical care) and how evidence will be recorded to ensure that it can be demonstrated that the Capabilities in Practice have been achieved at the appropriate level. This meeting should also result in the production of a Personal Development Plan (PDP) consisting of a number of SMART objectives that the trainee should seek to achieve during that training year. The trainee should meet up with their ES on a number of other occasions during the training year so that the ES can be reassured that appropriate evidence is being accumulated to facilitate production of a valid ES report towards the end of the year and guide the trainee as to further evidence that might be required.

Induction Meeting with ES: Planning the training year

Writing the ESR essentially starts with the induction meeting with the trainee at which the training year should be planned. The induction meeting between the ES and the trainee is pivotal to the success of the training year. It is the beginning of the training relationship between the two and needs both preparation and time. The induction meeting should be recorded formally in the trainee's ePortfolio. The meeting should be pre-planned and undertaken in a private setting where both can concentrate on the planning of the training year. This is also a time for ES and trainee to start to get to know each other.

Ahead of the meeting review:

- review Transfers of Information on the trainee
- review previous ES, ARCP etc. reports if available
- agree with the placement CSs how other support meetings will be arranged. Including;
 - arrangements for LFGs or equivalent
 - arrangements for professional development meetings

At the meeting the following need to be considered:

- review the placements for the year
- review the training year elements of the generic educational work schedule or its equivalent
- construct the personalized educational work schedule for the year or its equivalent
- construct the set of year-level SMART PDPs to include:
 - SCE PDP
 - QI PDP
 - GCP
 - Oncology courses and/or conferences
- discuss the trainee's career plans and help facilitate these
- discuss the use of reflection and make an assessment of how the trainee uses reflection and dynamic PDPs
- discuss the teaching programme
- discuss SACT prescribing competences and development
- discuss arrangements for LTFT training if appropriate
- plan additional meetings including the professional development meetings and the interaction with the placement CSs
- planning of SLEs and WPBA
- arrangements for MSF / patient survey
- review the ARCP decision aid
- arrangements for Penultimate Year Assessment (PYA) if appropriate
- arrangements for ARCP and the writing and discussion of the ESR
- pastoral support
- arrangements for reporting of concerns and exception reporting mechanisms
- plan study leave

At the end of the meeting the trainee should have a clear plan for providing the evidence needed by the ES to make the required entrustment decisions.

Important Points

- prepare for the meeting
- make sure that knowledge of the Medical Oncology curriculum is up-to-date
- set up a plan for the training year

Relationship with Clinical Supervisor (CS)

The trainee should have a Clinical Supervisor for each attachment and once again the trainee should meet up with the CS at the start of the attachment. Similar discussions should be held with the CS as have been held with the ES and once again, a PDP with SMART objectives should be constructed for each attachment. At the end of the attachment, the CS should be well placed to complete a Multiple Consultant Report (MCR) detailing how the trainee has developed towards developing each CiP. The CS should also document the progress that the trainee has made towards completing all the objectives of the PDP.

The trainee should provide a MCR from each designated CS as they are best placed to provide such a report but in addition should approach other consultants with whom they have had a significant clinical interaction and ask them also to provide a MCR. The MCR asks consultants to comment on performance towards each CiP although supervisors are not required to assign a specific entrustment level to the clinical CiPs. Throughout the attachment the trainee should be having SLEs completed by consultants and where appropriate, more senior trainees. The number of SLEs demanded by the decision aid should be regarded as an absolute minimum and additional ones should be sought because

- although they are formative, not summative assessments, they do provide additional evidence to show that a trainee is acquiring clinical (and generic) capabilities
- they may give the trainee the opportunity to have additional one to one clinical teaching from a senior colleague
- they allow the excuse for trainees to receive targeted and constructive feedback from a senior colleague.

Induction Meeting with Clinical Supervisor (CS)

The trainee should also have an induction meeting with their placement CS (who may also be their ES). The meeting should be pre-planned and undertaken in a private setting where both can concentrate on the planning of the placement. This is also a time for CS and trainee to start to get to know each other.

Ahead of the meeting review the following should be considered:

- review Transfers of Information on the trainee
- review previous ES, ARCP etc. reports if available
- arrangements for LFGs or equivalent

The following areas will need to be discussed, some of which will reinforce areas already covered by the ES but in the setting of the particular placement:

- review the training placement elements of the generic educational work schedule or its equivalent
- construct the personalized educational work schedule for the placement or its equivalent
- construct the set of placement-level SMART objectives in the PDP
- discuss the use of reflection and make an assessment of how the trainee uses reflection and dynamic PDPs
- discuss SACT prescribing competencies and development plan
- discuss arrangements for LTFT training if appropriate
- discuss arrangements for Academic training if appropriate
- plan additional meetings including professional development meetings and the interaction with the placement CS (depending on whether the ES or CS will be undertaking these)
- arrangements for MSF / patient survey
- review the ARCP decision aid
- pastoral support
- arrangements for reporting of concerns and exception reporting mechanisms
- plan study and annual leave

Professional Development Meetings

Trainers and trainees need to meet regularly across the training year. The GMC recommend an hour per week is made available for this activity. While it is not expected or possible for it to be an hour every week, the time not used for these meetings can be used to participate in LFG and ARCPs etc.

These meetings are important and should cover the following areas. This list is not exhaustive. Meet away from the clinical area regularly to:

- discuss cases
- provide feedback
- monitor progress of learning objectives
- discuss reflections
- provide careers advice
- monitor and update the trainee's PDP
- record meeting key discussion points and outcomes using the Educational Meeting form on the ePortfolio
- record progress against the CiPs by updating the comments in the CiP section of the portfolio (this will make writing the ESR at the end of the year much easier)
- provide support around other issues that the trainee may be encountering

Completing reports

When completing reports, all consultants should do more than just tick a box and make some generic comment such as “good trainee”. It is important that they make meaningful comments about why they have assigned that particular level of performance/behaviour to that particular trainee. In doing this, the descriptors assigned to each CiP should be especially useful as an *aide-memoire*. They should specifically not be used as a tick list that requires a comment for each descriptor but should just allow the senior doctor completing the report to reflect on what comments would be helpful to the ES for completion of their report and to the ARCP panel in determining whether the trainee can progress to the next year of training. Constructive comments are also of course valued by the trainee. It is very helpful if the trainee can have constructive comments if they are progressing along the “normal” trajectory and especially if they are exceeding expectations either globally or in certain areas. If a trainee is performing below expectations then it is absolutely mandatory that meaningful, insightful and precise comments are provided.

At ARCP

The ARCP is a procedure for assessing competence annually in all medical trainees across the UK. It is owned by the four Statutory Education Bodies (Health Education England, NHS Education for Scotland, Health Education and Improvement Wales and Northern Ireland Medical & Dental Training Agency) and governed by the regulations in the [Gold Guide](#). The JRCPTB can therefore not alter the way in which an ARCP is run but can provide guidance for trainees and trainers in preparing for it and guide panel members on interpretation of both curricular requirements and the decision aid when determining ARCP outcomes. Although receiving a non-standard ARCP outcome (i.e. anything but an outcome 1 or 6) should not be seen as failure, we know that many trainees are anxious about such an outcome and everything possible should be done to ensure that no trainee inappropriately receives a non-standard outcome.

The ARCP gives the final summative judgement about whether the trainee can progress into the subsequent year of training (or successfully complete training if in the final year). The panel will review the ePortfolio (especially the ES report) in conjunction with the decision aid for the appropriate year. The panel must assure itself that the ES has made the appropriate entrustment decisions for each CiP and that they are evidence based and defensible. The panel must also review the record of trainee experience to ensure that each trainee has completed (or is on track to complete over ensuing years) the various learning experiences mandated in the curriculum (e.g. outpatient clinics, critical care attachment, geriatrics and acute unselected take).

There are no critical progression points defined within the medical oncology curriculum, but completion of all training requirements and successful completion of the medical oncology SCE are necessary for CCT. A PYA meeting should be held within 12 months of CCT date, which provides trainees and trainers an opportunity to identify outstanding training needs prior to completion of training.

ARCP preparation

As the ARCP approaches, it is essential that the trainee reviews their ePortfolio and ensures that all requisite information is available in a logical and accessible format. In particular they should ensure that:

- all appropriate certificates (GCP, SCE certification, attendance at teaching and relevant courses/conferences etc.) have been uploaded to the personal library and are clearly signposted
- an appropriate amount of reflection has been documented

- as a bare minimum (see comments above), the requisite number of SLEs (as demanded by the annual decision aid) has been completed and recorded in the ePortfolio (it is especially important to ensure that the mandated number has been performed by consultant assessors)
- MSF or patient survey has been completed according to the ARCP decision aid and the results released by the ES. It is critical that appropriate discussion/reflection has occurred and been recorded in response to the MSF / patient survey
- MCR has been completed by each CS and additional ones have been completed by any supervisor with whom the trainee has had significant clinical/educational interaction
- trainees have self-rated themselves for each CiP on the curriculum page
- the SMART objectives documented in their PDP have been achieved and the evidence for that achievement has been clearly documented. If any objectives of the PDP have not been fully achieved, then the reasons for that have been clearly documented and evidenced.
- an appointment has been made with their ES to discuss the annual ES report that will inform the ARCP panel

The ES should review the portfolio to ensure that all the above requirements have been met and record a final rating for each CiP on the curriculum page. The ES should meet up with the trainee to discuss the ESR so that there are no surprises.

The ARCP

At the ARCP, the panel should review the ePortfolio and in particular it should focus on the ESR report but also review the MCRs, the MSF / patient survey, the PDPs and reflection. It should also reassure itself that all the mandatory courses and exams have been attended/passed (eg medical oncology SCE). If members of the panel have any concerns that the trainee under review is not eligible for a standard outcome (outcome 1 or outcome 6) then they should “drill down” deeper into the portfolio and review more of the SLEs and other subsidiary information. Once again it is stressed that the general default is towards a standard outcome and trainees should not be turned down for this just because (for example) 1 SLE is deficient in some way.

The ARCP process in 2020/1 has been affected by the COVID-19 pandemic and the approach to evaluating trainee progress has been modified. Guidance on the revised ARCP process is available on the JRCPTB website page www.jrcptb.org.uk/covid-19.

Post-ARCP follow-up for trainees affected by the COVID-19 pandemic

It will be important to follow up with trainees who have been given an outcome 10 because their progress was affected by the COVID-19 pandemic. It is recommended that a discussion with the trainee is arranged within two weeks of the ARCP and this should cover:

- curriculum requirements to be completed during medical oncology training including of mandatory training experiences
- adjustments to the trainee’s programme that may be required to meet the curriculum requirements.

The key actions arising from the discussion should be recorded in the ARCP form (the form should be saved as a draft for this purpose). The actions will inform the induction for the following training year and should be noted in the induction documentation.

Appendix 3. Implementation guidance for deaneries, TPDs and ARCP panels

When should trainees transfer to the 2021 curricula?

All medical oncology trainees will need to transfer to the new curriculum, unless they are due to CCT before 8th September 2022. Current trainees should transfer to the new curriculum following their 2020/21 ARCP, ideally by August 2021. There is flexibility for those who may have late ARCPs (for example in September or October), however in most cases trainees would be expected to begin working to the new curriculum by August 2021. Medical oncology trainees in ST6 will not be required to transfer to the new curriculum, provided that they are due to CCT before 8th September 2022.

How should trainees be assessed for their 2020/21 ARCP?

All trainees should be assessed against the requirements of the 2017 curricula at their 2020/21 ARCP. Following this, all trainees (except those due to CCT before 8th September 2022) should transfer to the new curriculum. We recommend that the transition to the new curriculum should be discussed with trainees as part of the 2020/21 ARCP process.

How should trainees be assessed for the 2021/22 ARCP?

Trainees due to CCT before 8th September 2022 will be assessed against the 2017 curriculum at their 2021/22 ARCP (they are not required to transfer to the new curricula). All other trainees should be assessed against the 2021 curriculum. There is flexibility for those who are due to CCT in 2022 but may have late ARCPs (for example in September or October), however in most cases trainees due to CCT after 8th September 2022 would be expected to be assessed against the new curriculum at their 2021/22 ARCP.

Are there any changes to assessment?

The 2021 curriculum is structured around high level outcomes known as capabilities in practice (CiP), which are assessed using a 4 point entrustment scale. Progression grids outline the minimum level expected in each CiP. The educational supervisor's structured report will be adapted to allow recording of a trainee's progress in each CiP, procedure, and milestone and these should all be considered as part of progression decisions made at ARCP. Further information on using entrustment scales for assessment can be found on the [JRCPTB webpage](#). The range of formative workplace based assessment and summative examinations found in the 2017 medical oncology curriculum have been retained. The use and structure of these assessments is well established and they can easily be applied to the new curriculum with little or no change.

Three additional types of WPBA, the direct observation of systemic therapy (DOST), direct observation of radiotherapy planning skills (DORPS) and the acute care assessment tool (ACAT) have been introduced. These reflect the increased emphasis on systemic prescribing, acute oncology and the closer relationship between the clinical and medical oncology curricula, including the oncology common stem.

The [DOST](#) has been introduced to assess the performance of a trainee in undertaking, authorising, prescribing and taking consent for systemic therapy, against a structured checklist. This assessment is an integral part of medical oncology training and 2 assessments are required in each training year.

The [DORPS](#) assessment is a structured checklist for assessing the performance of a trainee in undertaking radiotherapy planning; assessors must be trained in radiotherapy planning and feedback. The DORPS is a core assessment in the OCS year, but not in medical oncology specific training (ST4-6).

The [ACAT](#) is intended to be used for providing feedback to trainees on supervised aspects of acute oncology provision. This may include an on call shift, ward rounds, handover or in reach to the medical assessment unit (MAU) or covering a day's management of admissions and ward work. The ACAT looks at clinical assessment and management, decision making, team working, time management, record keeping and handover for the whole time period and multiple patients.

As a result of introducing additional assessments, the minimum number of each assessment that is required for each stage of training has been amended so that the overall burden of assessment is not increased. There will be no significant changes to the medical oncology specialty certificate examination (SCE). More details on assessment requirements can be found in the [curriculum](#) and the [ARCP decision aid](#).

How should trainees be assessed for the OCS year at the end of ST3?

The first year of training focuses on the development of the generic CiPs expected of all doctors, and of common CiPs relating to the key areas of overlap between medical oncology and clinical oncology. At the end of ST3, decisions about trainee progression should be based on progress against the generic and common oncology CiPs only, not against the medical oncology specific CiPs. Some trainees progressing at above the expected rate may have evidence of progress towards some specialty-specific CiPs in their ePortfolios, however this is not required for progression from ST3 to ST4.

What support is available for deaneries and ARCP panels?

The [JRCPTB website](#) provides the most up-to-date information and a range of tools for implementation, including videos, training slides, and guidance on using entrustable professional activities to assess progress. You can also contact the curriculum team with any questions: curriculum@jrcptb.org.uk.

Appendix 4. Glossary of abbreviations

ACAT	Acute Care Assessment Tool
ACF	Academic clinical fellow
ACL	Academic clinical lecturer
AHP	Allied healthcare professional
AO(S)	Acute oncology (services)
ARCP	Annual Review of Competence Progression
AUT	Acute Unselected Take
CaP	Capabilities in Practice
CbD	Case-based Discussion
CCT	Certificate of Completion of Training
CS	Clinical Supervisor
CUP	Carcinoma of unknown primary
DORPS	Direct observation of radiotherapy planning skills
DOST	Direct observation of systemic therapy
EPA	Entrustable Professional Activity
ES	Educational Supervisor
ESR	Educational supervisor report
FRCR	Fellow of the Royal College of Radiologists
GCP	Good Clinical Practice
GPC	Generic Professional Capabilities
GMC	General Medical Council
JRCPTB	Joint Royal Colleges of Physicians Training Board
LFG	Local Faculty Group
LTFT	Less Than Full-Time
MAU	Medical assessment unit
MDT	Multidisciplinary Team
MCR	Multiple consultant report
Mini CEX	Mini Clinical Evaluation Exercise
MSF	Multi-Source Feedback
NMP	Non-medical prescriber
OCS	Oncology common stem
OOP	Out-of-programme
OOPE	Out-of-programme experience
OOPR	Out-of-programme research
OOPT	Out-of-programme training
PDP	Professional Development Plan
PS	Patient Survey
PYA	Penultimate year assessment
QIPAT	Quality Improvement Project Assessment Tool
RCP	Royal College of Physicians
RCR	The Royal College of Radiologists
SACT	Systemic anti-cancer therapy
SCE	Specialty certificate examination
SLE	Supervised Learning Event
TO	Teaching Observation
TPD	Training programme director
WPBA	Workplace Based Assessment

JRCPTB

Joint Royal Colleges of Physicians Training Board



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