



The F3 phenomenon: Exploring a new norm and its implications

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Dr Ruth Silverton
Professor Della Freeth

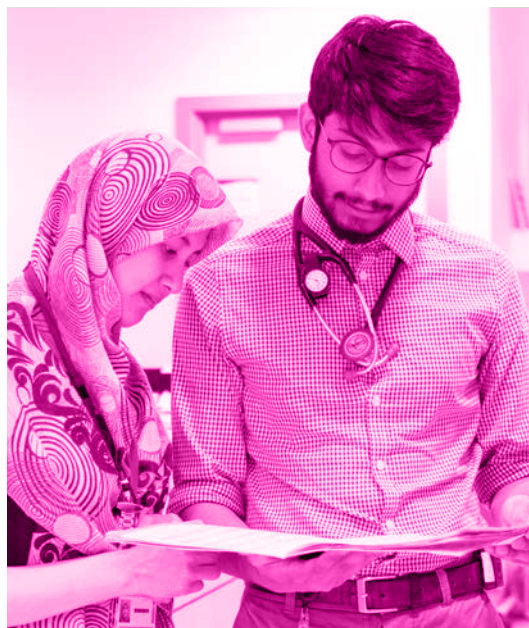


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Foreword

Over recent years we have seen an increase in the number of junior doctors choosing to take a break from training following completion of the Foundation Programme, with the vast majority returning at a later date. As this report identifies, there are numerous factors in why doctors choose to take this break, and the reasons are shaped by personal or professional circumstances. This programme, run jointly with the Royal College of Physicians was commissioned in order to build our understanding of what is regularly referred to as “the F3 phenomenon”, and what it means for individual doctors and for postgraduate training.

The report confirms our understanding that participation in an “F3 year” has risen substantially in the last decade (from 17% in 2010 to 65% in 2019), and identifies that this is due to a multitude of factors, from taking a break for greater autonomy, flexibility and certainty, to opportunities to enhance CVs. However this report also clearly identifies an interconnectedness of factors leading to doctors taking an F3 year.

This report confirms what we have previously observed; taking a break from training post foundation is becoming increasingly common. This clearly has implications for both how training is delivered and how doctors are supported, something which Health Education England is committed to continue exploring through its Medical Education Reform Programme. This will specifically be addressed further through our flexibility work in ‘Step out, step in’ which to date includes:

- our “Out of Programme Pause” initiative, which facilitates junior doctors stepping out of training, and
- our work with the Academy of Medical Royal Colleges, whose guidance for “Flexibility in postgraduate training and changing specialties” identifies post foundation doctors stepping back into training as a key behaviour that requires a clear pathway.

I would like to extend my sincere thanks to Dr Ruth Silverton who diligently and professionally undertook this research and wrote this informative report. It will provide a strong foundation for any future reforms.



Professor Sheona MacLeod
Deputy Medical Director,
Education Reform, HEE

1 Introduction

This study was commissioned by the Medical Education Reform Programme at Health Education England (HEE) and supported by the Royal College of Physicians (RCP). Its purpose was to collect and analyse the perspectives of junior doctors with respect to the increasingly common practice of pausing participation in the UK-wide series of postgraduate training programmes¹ after the initial two-year foundation programme. This pause is commonly termed a 'foundation year 3', usually abbreviated to FY3 or F3. Cultural norms, workforce planning and the provision of training posts traditionally expected continuous engagement with the 'standard' postgraduate training pathway through foundation and specialty training to certification of completion of training requirements for entry onto the UK Specialist Register held by the General Medical Council (GMC). Although provision for 'out of (training) programme' (OOP) years and alternative pathways to the specialist register are well-established.

Participation in an F3 year has risen substantially in the last decade, from 17% in 2010 to 65% in 2019². Change of this magnitude challenges traditional expectations and disrupts current planning models. The anticipated pipeline of trainee doctors contributing to the staffing of health services changes. This raises many potential questions, such as: Why is this happening? Is this, on balance, a good or bad thing for the future of healthcare and medical careers? Will the phenomenon continue to grow and at what point would we expect it to level off? How should training programmes and pathways respond? How should workforce planning respond? Whose voices have we heard and understood? This relatively small study could not address all these questions. It was designed to provide some useful pieces in a bigger jigsaw of data and insight from multiple sources, such as the annual F2 career destinations survey², the multicohort study from Cleland and colleagues³ and the recent scoping review from Church and Agius⁴. Data from the GMC⁵ demonstrated that, of the doctors that completed the foundation programme in 2012 and then took a break from the training pathway, 93% had returned to the training pathway within 5 years. The Findings and Discussion chapters of this report (Chapters 3 and 4) highlight that our study data suggests this proportion may drop for future cohorts, although the change is not anticipated to be as great as the increase in the proportion of doctors taking an F3 year.

¹ Foundation training programme followed by, for example, core specialty training plus higher specialty training, or 'run-through' specialty training.

² UK Foundation programme office, 2019 F2 career destinations survey, 2020, [Reports - UK Foundation Programme](#)

³ Cleland, J., Prescott, G., Walker, K., et al., 'Are there differences between those doctors who apply for a training post in Foundation Year 2 and those who take time out of the training pathway? A UK multicohort study'. *BMJ Open*, 2019; 9: e032021. doi:10.1136/bmjopen-2019-032021

⁴ Church HR, Agius SJ. The F3 phenomenon: Early-career training breaks in medical training. A scoping review. *Med Educ*. 2021 May 4. doi: 10.1111/medu.14543. Epub ahead of print. PMID: 33945168.

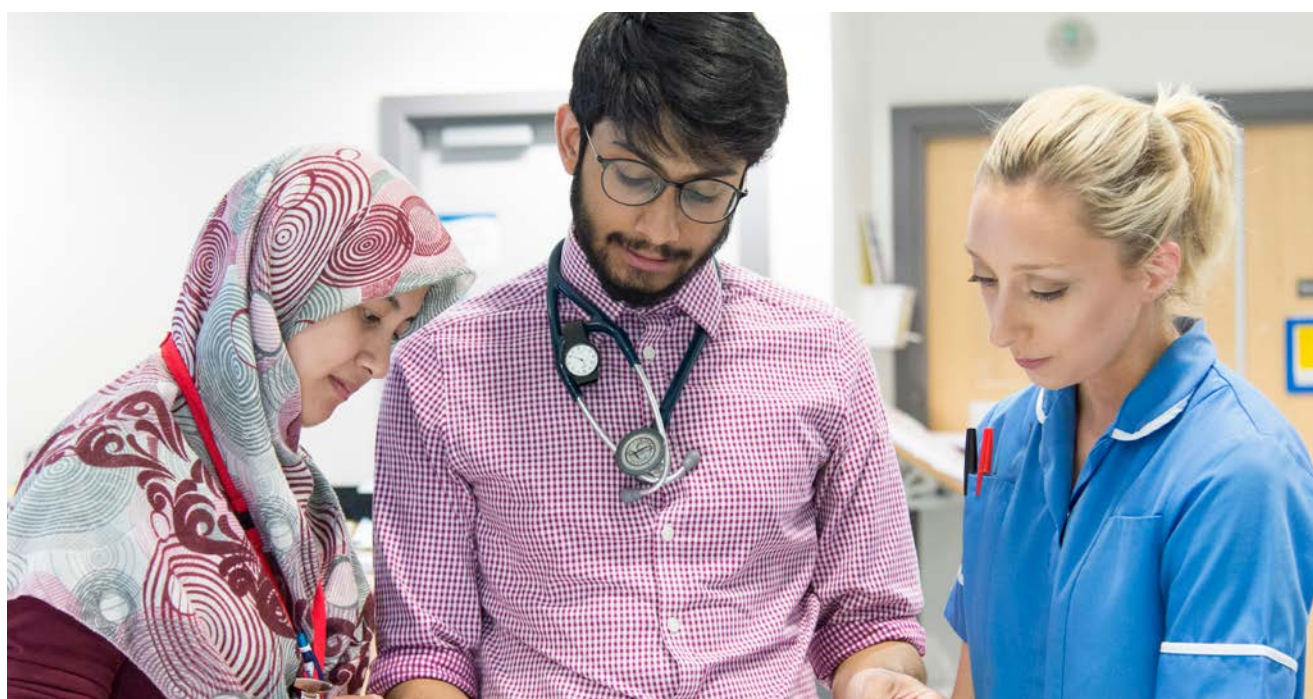
⁵ 2017 national training surveys summary report: initial results on doctors' training and progression, 2017, General Medical Council [GMC Council 180107 \(gmc-uk.org\)](#)

This qualitative study focused on a deepening of understanding of junior doctors' perspectives on the decision to take an F3 year, what the year provided, and the impact it had on future career planning. This adds reflection and individual contextualisation to complement the predominantly quantitative tracking of the phenomenon, largely from annual surveys. Insights from this study can contribute to discussions and planning, when set alongside other perspectives.

We will see in the study findings, Chapter 3, that whilst each study participant has a unique perspective, clear themes emerged across the data set. The F3 year is a break from continuous participation in the multi-stage postgraduate training pathway for doctors. We will show different facets of this break in sections which focus on 'a break from ...', 'a break because ...' and 'a break for ...', before turning to the influence of others on the decision to undertake an F3 year, followed by the reflections of doctors who have completed some, or all, of an F3 year. Chapter 3 concludes with exploration of metaphorical treadmills, mentioned by many study participants, and developed further in our analytical synthesis.

Through discussion of the three-dimensional interconnectedness of individual factors, external influences, and progressive legitimisation of the once 'alternative' pathway, Chapter 4 will contextualise the study findings within current and future training models and wider workforce planning, offering exploration of the F3 phenomenon and its impact. It will highlight alignment of the factors presented in this report with current workstreams and pose further questions designed to inspire wider discussion. We make a number of recommendations with respect to short- and longer-term work to continue to advance understanding of this phenomenon, and to support future reform.

This study was conducted during the COVID-19 pandemic and we will note the impacts of this at appropriate points in the report.



1.1 Background

There is a long history of reformation within UK medical training, adjustments which both respond to and anticipate changing contexts. After the Calman reforms⁶ that saw the amalgamation of the registrar and senior registrar grades into the specialty registrar role, it was expected that changes to the more junior grades of pre-registered house officer (PRHO) and senior house officer (SHO) were likely to ensue⁷. The 2002 report, Unfinished Business⁸, highlighted problems associated with the then termed 'SHO' grade, including poor job structure, lack of training and inadequate support. The report proposed a two-year foundation programme which moved away from mixed rotational and stand-alone posts, to an integrated 24-month educational programme. Recommendations in Unfinished Business, pertinent to this study, included the allowance of individually tailored and personal programmes, and facilitation of movement into and out of training and between training programmes. Of course, implementation and culture change take time.

The two-year foundation programme began in 2005, combined with the introduction of national application to specialty registrar posts through the 'medical training application service'(MTAS). Both were part of the modernising medical careers (MMC)⁹ reform, responding to Unfinished Business. Perceived failings of the foundation programme reform and specialty application process were wide ranging and resulted in an inquiry by Professor Sir John Tooke¹⁰. As discussed by Madden and Madden¹¹, concern at that time was twofold.

“The idea of individually tailored programmes seems to have been forgotten, career advice is lacking, and the provision for flexible training is uncertain” (p.427) and

“A workforce made up of doctors forced into specialties they do not really want is not a happy prospect either.” (p.428)

⁶ Calman report. Hospital doctors: training for the future. The report of the Working Group on Specialist Medical Training. London: HMSO, 1993

⁷ Paice, E et al. “Trainee satisfaction before and after the Calman reforms of specialist training: questionnaire survey.” BMJ (Clinical research ed.) vol. 320,7238 (2000): 832-6. doi:10.1136/bmj.320.7238.832

⁸ Department of Health. Unfinished business: proposals for reform of the senior house officer grade – a paper for consultation. London: DH, 2002.

⁹ Department of Health. Modernising medical careers: the response of the four UK Health Ministers to the consultation on unfinished business: proposals for reform of the senior house officer grade. London: DH, 2003

¹⁰ Tooke J. Aspiring to excellence: findings and recommendations of the independent inquiry into Modernising Medical Careers. London: MMC Inquiry, 2007.

www.mmcinquiry.org.uk

¹¹ Madden GB, Madden AP. Has Modernising Medical Careers lost its way?. BMJ. 2007;335(7617):426-428. doi:10.1136/bmj.39300.591632.DE

Since the Tooke report, and subsequent Collins report¹² which highlighted a lack of flexibility and pastoral support, onerous and excessive assessment and variability in the quality of education within the foundation programme, there have been ongoing moves to address these concerns (most recently outlined in the 2019 foundation programme review report¹³). More broadly, the 2016 junior doctors' contract dispute, and the associated first all-out strike in the history of the National Health Service¹⁴, demonstrated the depth of discontent among junior doctors. Parallel work between HEE, Postgraduate Deans, NHS Employers and the BMA Junior Doctors' Committee, which drew in many other stakeholders, produced multifaceted responses to the problems and a rapid progress report on efforts to enhance junior doctors' working lives.¹⁵ Commitment to enhancing working lives continues,¹⁶ linked to the NHS People Plan.¹⁷ There has been increased discourse, research and innovation around junior doctor wellbeing, burnout, substance misuse and suicide, alongside a broader awareness of the priorities of 'millennials' and 'generation Z' in terms of work-life balance and multi-hyphenated careers. Recently, this has included the context of and learning from the COVID-19 pandemic.¹⁸

1.2 A brief note on terms

Within the foundation programme the year of training labels, F1 and F2, (each of which may be over 12 months if training is less than full time), are also used to label the junior doctors themselves. They are routinely referred to as 'F1' and 'F2' doctors. A similar thing happens for activities and roles, other than specialty training, that may be undertaken in the year following completion of the foundation programme. The period of time, activities, roles, and the doctors themselves all tend to be labelled F3 or FY3. If the period of time extends beyond a year, people tend to refer to the following year and the activities and roles therein as F4. We did not come across any instance of a person framing an extended period of time as a less than full time F3 year.

Following the wider convention, in this report we will use the term 'F3' to refer to both the twelve-month time period following completion of the foundation programme, for those who do not progress immediately into specialty training, and also to refer to the junior doctors themselves. During the F3 year, F3 doctors may undertake clinical or non-clinical work within medicine, or (or in addition to) nonmedical endeavours, both personal and professional. Occasional reference to 'F4' in the report (mainly in data excerpts) represents the twelve-month period following F3 for those remaining out of specialty training.

Alternative terminology appears within the study data referring to the clinical posts some respondents take during the F3 year (and perhaps continuing as F4, F5, etc), which are termed 'fellow' or 'trust grade', both of which refer to a locally employed, clinical role unless otherwise specified.

¹² Foundation for Excellence An Evaluation of the Foundation Programme Professor John Collins 2010

https://www.copmed.org.uk/images/docs/1314194412_fhWH_foundation_for_excellence_an_evaluation_of_the_fou.pdf

¹³ The Postgraduate Medical Foundation Programme Review, Health Education England, 2019 [FoundationReview FINAL for web.pdf \(hee.nhs.uk\)](#)

¹⁴ Goddard AF. Lessons to Be Learned From the UK Junior Doctors' Strike. JAMA. 2016;316(14):1445–1446. doi:10.1001/jama.2016.12029

¹⁵ Enhancing junior doctors' working lives: a progress report. HEE 2017 [Enhancing Junior Doctors' Working Lives | Health Education England \(hee.nhs.uk\)](#)

¹⁶ Enhancing Working Lives Programme. HEE 2020 <https://www.hee.nhs.uk/our-work/doctors-training/enhancing-working-lives>

¹⁷ We are the NHS: People Plan for 2020/2021 – action for us all <https://www.england.nhs.uk/ournhspeople/>

¹⁸ Forsythe, R. O., & Suttie, S. A. (2020). Enhancing junior doctors' working lives. *Surgery (Oxford, Oxfordshire)*, 38(10), 607–611. <https://doi.org/10.1016/j.mpsur.2020.07.002>

2 Methodology

This qualitative study, within the interpretivist paradigm, focused on deepening understanding of the perspectives of doctors who consider or undertake an F3 year. This new knowledge is presented thematically in the next chapter.

Proportionate research ethics review of the study protocol and associated documents was conducted by two independent reviewers, in line with RCP policy for educational research.

The study was conducted in 2020-21, through peaks of the COVID-19 pandemic. Consequently, all data collection occurred remotely, via online surveys and video-linked interviews. Clinical service demands during the data collection period reduced the number of interviews conducted and may have limited engagement with the online surveys, although the impact on participation in short anonymous online surveys is more difficult to judge. The number of study participants (163) and the richness of the data provided are testaments to interest in the study topic. We acknowledge that participants were self-selected, and this should be expected to have some impact on the content of the data corpus. Consequently, we have been careful to avoid over-generalisation and to interpret findings cautiously. Nevertheless, much that illuminates influences on decisions to take an F3 year and the resultant experience and impact has emerged, and this can be set alongside other understandings of this phenomenon to inform debate and decisions.

2.1 Study questions

Broadly, the study questions were:

- Why are junior doctors choosing to take an F3 year?
- In retrospect, did it provide what they hoped?
- What are the implications for training systems and workforce planning?



2.2 Data collection

Primary data collection comprised anonymous online surveys (open during November 2020) and semi-structured interviews via video-link (recorded between November 2020 and January 2021). Wider contextual information was reviewed to inform the development of the study design and the data collection instruments (Chapter 6). This included published papers and reports, and online discussions specific to the F3 period via Facebook¹⁹ forums and Twitter²⁰ threads.

The use of anonymous online surveys was designed to enable participants to share their personal experience and comments in a way and at a time convenient to them. Two surveys were developed, one for F2 doctors considering an F3 year, the other for current or former F3s. These were accessed via links on the study 'landing' web page. After a short section of closed questions recording selected demographic, geographical and role descriptions, the online surveys used boxes provided for free text response to explore reasons behind the decision to take an F3, what was hoped and, for those beyond F2, what the F3 year provided (Chapter 6). SurveyMonkey²¹ was chosen as the platform to collect survey responses and to allow expression of interest for participation in a semi-structured interview. To ensure anonymity of the written survey responses, a separate link was created to collect identifiable contact details for interview participation. A call for participants was shared via Twitter. Provision had been made to share a call for participants via the Horus portfolio system and through the network of foundation training programme directors. However, given the pressures of COVID-19 during this time, and the high volume of response through Twitter, this was not deemed necessary.

Typically, typed free text data is less 'rich' than spoken contributions to discussion or in interviews. For example, brief linear description or bullet points rather than more complex, expansive, detailed, and reflexive expression of thoughts. Hence the study design complementing survey data with some interviews. However, we will see in Chapter 3, the findings, that the survey participants in this study provided unexpectedly rich data.

Travel to each Foundation school area within England to conduct face to face interviews with future, current and past F3 doctors was included within the initial study proposal. This was not possible due to COVID-19, and amendments to data collection were made. Interview data collection was flexible, acknowledging clinical service need, workforce capacity and necessary social distancing. Online video interviews were arranged via Microsoft Teams²² at a time convenient to both participant and interviewer (RS), with written participant information provided and written consent gained ahead of the scheduled interview (Chapter 6). All interviewees gave consent for their interview to be recorded within the Teams video software and for the recording to be retained on the secure RCP server until transcription was complete. The integral transcription feature of Microsoft Teams was used, and RS reviewed transcripts, if necessary, re-viewing video excerpts, to improve the accuracy of the transcripts.

¹⁹ Facebook.com

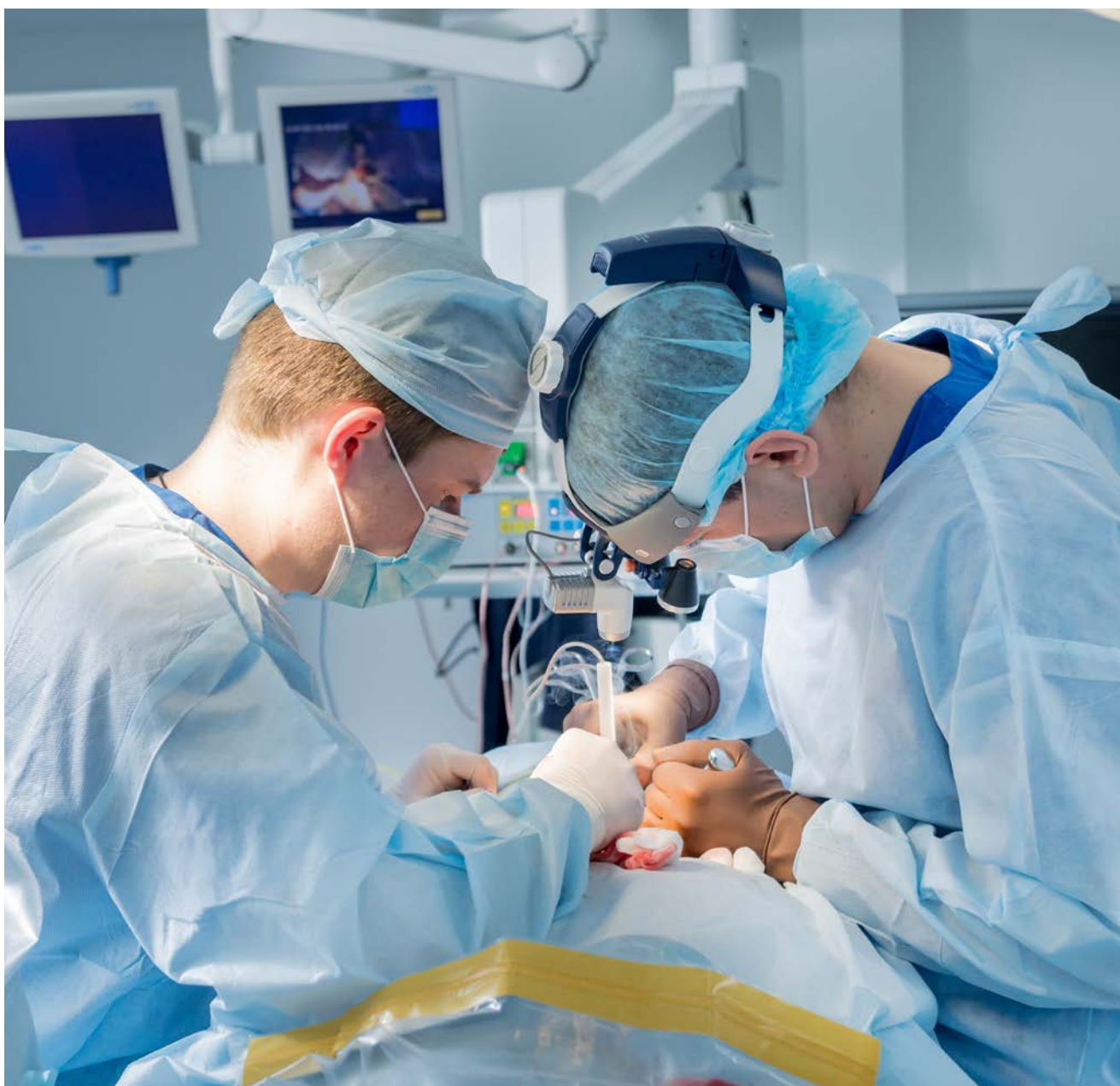
²⁰ Twitter.com

²¹ SurveyMonkey.co.uk

²² Microsoft.com

2.3 Data analysis

Cycles of inductive data analysis began with coding sections of interview transcripts thematically. The wider deductive framework for this inductive analysis was formed by the study questions in Section 2.1. The major themes and subthemes that emerged from the interview transcripts were then tested across the survey data which provided the necessary volume, richness of prose and diversity of perspectives, leading to elaboration, nuance and connection, or contraction and disconnection, as appropriate. The iterative analysis continued with discussion and cross-checking between authors. There was a search for 'disconfirming cases' – responses which challenged our understanding to date or challenged the emerging structure of the findings. Towards the end of the data analysis process, the analysis became more theoretical and contextualised in the wider literature: we compared and questioned our findings in relation to wider knowledge in relevant fields.



3 Findings

Section 3.1 provides a brief overview of the study participants and the written and spoken data.

The complex and interwoven influences on doctors considering or taking F3 years are synthesised in Section 3.2. The F3 year is always a break from continuous participation in the postgraduate training programme pathways described in the introduction to this report. Needs and desires for this break were central to the accounts provided by the study participants. The overarching concept 'a break' is structured into three main subsections (3.2.1-3.2.3): 'a break from', 'a break because' and 'a break for'.

Whilst individual experiences are never neatly clear cut, Section 3.2.1 acknowledges that some accounts emphasised a break from training programme requirements while others emphasised a break from providing clinical service in the context of a training programme. These accounts heralded some of the strong themes within Section 3.2.2, 'a break because' which develops understanding of why doctors felt they needed the F3 year, particularly the theme of burnout which also recurs in Section 3.2.3, 'a break for'.

Section 3.2.2, 'a break because', begins with specialty uncertainty which was the most frequently named contributor to the F3 decision (although only in one case the sole factor), then we turn to the recurrent theme of burnout before summarising three other subthemes: 'not yet ready for the next stage', 'no training post' and 'a natural break'.

Section 3.2.3, 'a break for' reflects the dominance of psychological needs and wellbeing factors with subthemes of 'autonomy' and 'headspace', the attractiveness of other opportunities, and a sense of needing to improve one's competitiveness for the next career stage. Whilst never the only influence, finance was also a contributory factor in the F3 decision for some study participants.

Section 3.3 explores the influence of others on study participants' F3 decisions. A variety of professional and personal advisors and influences played an important role in both the decision to undertake an F3 year, and the confidence in doing so.

Section 3.4 presents a summary of the reflections of current and past F3s in terms of what they gained from the year and what they would advise current foundation doctors, allowing for a retrospective viewpoint. Whether opting for F3 from choice or necessity, all reported the F3 year as a positive experience. The study participants' reflections on F3 also highlight the emergence of active and positive choice in their next career steps, whether that be joining specialty training or continuing to forge an 'out of programme' career trajectory for an indeterminate period.

Section 3.5 completes this chapter, expanding on the commonly contributed metaphor of 'the treadmill' as a means to visualise, synthesise and interpret the study participants' individual experiences and potential trajectories. This metaphor is carried through to the discussion, allowing for exploration of the current and future impact of the F3 phenomenon.

3.1 Overview of study participants and the data set

Written data [W] was provided by 155 doctors who followed the link to the anonymous online survey described in section 2.2. The survey participants included 122 current or former F3 doctors (79% of the study participants) and 33 F2 doctors who planned to complete an F3 year (21% of participants). The written data set provided unexpectedly rich content, with most responses extending to a paragraph length description containing multiple factors and associated sentiment. Whilst a self-selected group with a personal interest in F3 roles, these study participants exhibited broad diversity in terms of age, regional spread, and role during F3. Seventeen of the 18 foundation schools in England were represented, with South Thames providing the largest number of respondents and only South Yorkshire without any respondents.

A large proportion of the 122 current or former F3s undertook NHS clinical work in their F3 year (94, 78%). With a further 13 (11%) undertaking clinical work outside the NHS. Of those working clinically in the NHS, 32 (26%) worked full time for the entire year. A further 62 (51%) undertook clinical NHS work for part of the year, either through a block of full-time work, or on a part-time basis throughout. Teaching was the most common role to have in combination with part-time clinical work (11, 9%), followed by study (usually at masters-level) in areas such as medical education and tropical medicine (9, 7%), and travel (7, 6%). The remaining 15 study participants (12%) did not work in clinical posts²³ during their F3 year: they undertook full time teaching (9, 7%), full time study (2, 2%), full time research (2, 2%) or full time leadership roles (1, 1%).



²³ It is possible that these 15 study participants may have undertaken locum clinical work during the F3 year which was not captured in the survey response options: something we would rectify in any subsequent data collection.

Turning to the spoken data set [S], 17 doctors volunteered to contribute to semi-structured interviews and, in the context of high service demands due to a peak in COVID-19 admissions during data collection, eight interviews were completed: one current F2 doctor, three current F3 doctors and four former F3 doctors. At the time of interview, the current F3 doctors' roles were a teaching fellow post, a combined clinical, research and teaching post, and an ad hoc locum role. One of the former F3 doctors was in full time specialty training, one was undertaking research in an 'out of programme experience' (OOPE), one was working clinically having remained out of a training post, and one was on parental leave.

Most study participants identified themselves as female: 25 (76%) current F2 written responses, 82 (68%) of current and past F3 written responses and five (62%) interview participants.

All eight interviews revealed a multiplicity of factors resulting in the decision to take an F3 year. In the written data, 105 (86%) of current or former F3s revealed two or more factors that led to the decision to take an F3 year, with 23 (73%) of current F2s documenting two or more factors contributing to their consideration of an F3 year. We have avoided categorising factors within the dualism of positive or negative, due to the individual contexts and variation in perceived impact of similar matters.

3.2 A Break – from, because, for ...

Taking a break from continuous progress through the 'standard' series of UK medical training programmes, which is lengthy and involves substantial educational requirements alongside increasing responsibilities within clinical service, is universal for all doctors undertaking an F3 year. The break creates space and time away from this lengthy pathway, to recuperate from the stresses and strains to date, to plan for the future, and to pursue other opportunities. What the responses in this study have demonstrated is that what prompts this break and what fills it, is uniquely individual. However, recurrent themes are discernible within the uniqueness of many individual experiences.

Most of the study participants actively and positively chose to take a break. For a minority, the break felt more reactive and essential, less about positive freedom of choice.

First, we will explore findings around taking a break from the clinical training pathway, before turning to taking a break because, and then taking a break for.

3.2.1 A break from....

‘The hours and hoop-jumping were endless and traumatic’ [W]

Foundation training was widely regarded as very demanding and study participants anticipated that subsequent stages in postgraduate clinical training pathways would be equally as demanding, which caused them to think about taking a break at what some described as a ‘natural’ point (see section 3.2.2). Study participants varied in the extent to which they emphasised taking a break from training requirements and taking a break from the clinical service provision that is required within training programmes. These matters are intertwined, so the difference is in emphasis. We noted in section 3.1 above, that many participants worked clinically during their F3 period, and in section 3.2.3 below, we will see that many sought additional training opportunities, both clinical and non-clinical, during their F3 year. Thus, there was a message that the study participants were not rejecting learning and assessment, or clinical practice. Rather they were seeking respite from (and in some cases rejecting) the ways these are packaged in foundation and specialty training programmes.

3.2.1.1 A break from training programme requirements

The foundation programme was often discussed as if a continuation of the toll of medical school. A desire for a complete break from the multiple requirements of a formal clinical education pathway, in which the foundation programme represented one more rung in the ladder of a stepwise educational system, was clearly represented. Multiple respondents echoed the testament of this interviewee

‘I’ve gone straight from school, sixth form to Uni... it would be nice to have a little bit of a break.’ [S]



In addition, the more specific motivator for an educational break was commonly present as the desire for a break from the compulsory requirements of the UK medical training system such as workplace-based assessment, portfolio completion and the annual review of competence progression (ARCP). A spectrum of expression need exists in the data from a sense of removing an inconvenience, by being able to

‘do the same job as trainees without the requirement to meet arbitrary portfolio requirements’ [W]

or describing the broader impact of the pressure felt by the individual as a result of the educational targets, prompting the desire for

‘a short break from the demands of a training post’ [W]

More seriously, for some study participants, the educational requirements of training programmes represented one of many threads feeding into the need for prevention of burnout or amelioration of current experience of burnout, as discussed in section 3.2.2 below. Typical comments at this end of the spectrum included:

[a] ‘sense of ennui/burnout and disillusionment with the hoop jumping exercise of medical training’ [W]

Or emphasising the need for

‘a break from the pressure of a training pathway/portfolio/audits etc.’ [W]

3.2.1.2 A break from service delivery requirements and enervating experiences within training programmes

The physical and mental toll of the work of a doctor in training was clear in the written and spoken responses, with an F3 year seen as an opportunity for some respite and recuperation. This was mainly operationalised by limiting service delivery commitments during the F3 year in the various ways outlined below, not by ceasing clinical practice (see section 3.1).

For some, the toll of the clinical role within foundation training posts, particularly the shift patterns, prompted the need for

‘a break from training as I found the shifts exhausting’ [W]

And similarly,

[I] ‘wanted a break from the rotas/ nights/ weekends’ [W].

This combined with perceptions of inflexibility with many respondents echoing that they

‘found the rota to be exhausting and quite inflexible’ [W]



In some cases, the toll of service commitments was linked to interpersonal relationships as well as rota demands, for example:

[I was] 'so disenfranchised by terrible treatment and rostering' [W].

The timing of this study meant that COVID-19 was an additional contributory factor: one interview participant explained they

'wanted a bit of a break in that the on-call Rota in F2 is quite hard and especially with COVID, it was really hard' [S].

In the majority of responses, the cumulative toll during the foundation programme fed into the F3 decision in combination with the perceived intensity of specialty training, for example the interviewee quoted immediately above went on to explain that looking ahead to the next stage of medical training (the participant's preferred pathway):

'the IMT rota is very heavy, it's a lot of on call, not a lot of breaks, and the burnout from just speaking to colleagues is quite high. So I really wanted to have a year to think about my career, think about what I want out of life in general and that would be in a more 9-5, with not much on call context, just to give me the opportunity to have a bit more space.' [S]

3.2.2 A break because....

3.2.2.1 Specialty Uncertainty

The most widely mentioned impact factor throughout the data set was that of specialty uncertainty. Over a third of all written responses cited 'specialty uncertainty' in conjunction with one or more additional factors, with only one respondent presenting this uncertainty as the only factor in the decision to take an F3.

There was an awareness of the length of time doctors were likely to be in their chosen specialty career, with study participants feeling they needed

‘more time to commit [their] life to a specialty’ [W].

For a smaller proportion, rather than total uncertainty, there was the need to increase exposure to their probable specialty choice to

‘confirm the training scheme’ [W]

they were considering, prior to committing.

The cause of this uncertainty was often not expressed. When expressed, it was as a perceived lack of opportunity and exposure within the foundation programme, from a clinical or training perspective (or both), exemplified by the two comments below, drawn from the written data:

‘I didn’t get the experience or skills necessary to commit to a specialty during Foundation.’

‘there is very little focus on true development and a great focus on service provision in F1/2’

3.2.2.2 Burnout

Either overtly named by respondents or suggested through descriptive alignment with the accepted international classification of disease definition²⁴ of the term; a break because of current or predicted burnout was a major presence in the data, second only to specialty uncertainty. The reasons largely begin with those discussed in section 3.2.1, centring on the need for a break from training programme requirements and/or a break from the service delivery requirements and enervating experiences within training programmes, with burnout the resultant risk or circumstance.

Awareness of burnout, and the desire to prevent it was a strong presence in the data, particularly in study participants who were current F2s, for example the concern:

‘I will risk burnout if I don’t take a good break from clinical practice’ [W]

The repeatedly expressed need for “time out” was rooted both in system and service impacts prompting the heartfelt

‘need to not feel suffocated by the NHS, no matter how much I believe in it’ [W],

²⁴ ‘Burn-out is a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed. It is characterized by three dimensions: feelings of energy depletion or exhaustion; increased mental distance from one’s job, or feelings of negativism or cynicism related to one’s job; and reduced professional efficacy’ – ICD-11

and in the duration of study participants' educational journeys to date (in the context of several years of training ahead) resulting in:

[a]'feeling of burnout having been on an educational training treadmill from school, to A-Levels, through medical school and foundation training.' [W]

We will see at the end of this 'A break because' section that many study participants saw the end of Foundation training as "a natural break" in sequential clinical training programmes. Arguably, this would make the end of F2 a 'natural' point to acknowledge and address feelings of burnout.

3.2.2.3 Not yet ready for the next stage

In a variety of ways study participants felt they were not yet ready for the next stage and saw an F3 year as an opportunity to increase their readiness. Feeling unprepared had several dimensions. Specialty uncertainty (described above) was one kind of unreadiness, alongside (even for those confident in their specialty choice): feeling unready for the specialty application process, not yet ready to submit a competitive application for specialty training, and not yet ready to undertake the clinical responsibilities inherent in specialty training posts. This was expressed as, for example, feeling:

'so unprepared to apply for core training.' [W].

Or, as we will see in the 'portfolio and CV expansion' subsection of Section 3.2.3 below, more comparatively and highlighting the competitiveness of specialty training selection.



In relation to feeling unready for professional demands of a clinical training role, the study participants perceived a lack of experience and/or skill. For example, one participant expressed feeling that they did not:

‘have the required exposure or skills to be a CT1 doctor’ [W]

3.2.2.4 No training post

Lack of a training post was the least common factor influencing the F3 decision, reported by only two participants. One interview participant did not get into the specialty training programmes to which they applied, explaining that

‘it was less of a choice and more about circumstances because when I applied to specialty training I was not initially accepted into either of the two programmes that I applied for.’ [S]

A survey respondent demonstrated a plurality of factors present in addition to the lack of training post, explaining:

‘I did not get a training post in my chosen specialty. Wanted a year with kinder hours and opportunity to travel as a break after F1 and F2. Wanted a year to work on my CV’ [W]

The resultant reflection on, and impact of, this involuntary year in section 3.4 provides necessary insight into this additional mode of entry to the F3 path.

3.2.2.5 Natural break

The systemic split in the sequential training programmes pathway after the foundation programme is completed and a wide range of specialty training pathways commence, resulted in many respondents seeing the post-foundation period as being a natural break. This provided an additional sense of confidence in the weight of the influences presented in sections 3.2.1 and 3.2.3. With many feeling it:

‘would be an appropriate time because it’s a natural break’ [S]

highlighting the fact that:

‘nothing automatically rolls on from F2, and so is quite a simple time to take a break.’ [S]

The perception of ‘natural’ space between foundation and specialty training was amplified by the life stages of study participants (most being 24-30 at the end of F2) and a wider sense of long careers in a field where there will always be need. As one respondent put it,

‘only young once, and medicine is not going anywhere’ [W]

Section 3.3 outlines the influence of others, both individuals and organisations, on doctors’ confidence in choosing F3 as a natural break without fearing that it will be significantly career-limiting (but rather life and career enhancing).

3.2.3 A break for...

This prospective theme summarises hopes for F3 year experiences and includes remedies for many of the areas covered in sections 3.2.1 and 3.2.2, above, a break from and a break because. These hopes and remedies include control over various aspects of professional and personal life, 'headspace' to recover from and prevent burnout, and opportunities to grow and experience things within both work and life that are felt to be unavailable or inaccessible when within the training programme.

3.2.3.1 Autonomy, flexibility and certainty

'To have more control over my working hours and working week' [W]

There was a strong subtheme around needs for autonomy, flexibility and certainty in a number areas, with these needs often overlapping.

The desire for flexibility and freedom were the most prevalent factors influencing the F3 decision; presented as goals in relation to 'flexible working', with the opportunity for autonomy over rota or shift patterns to align with individual needs. This was expressed broadly as

'the opportunity to work on my terms' [W]

and more specifically as, for example,

'not having to do night shifts' [W]

or flexibility allowing weeks or months away for alternative opportunities such as expedition medicine. It was felt that:

'you just don't get that sort of flexibility when you're on a training program' ... (you could)

'take an OOPE,²⁵ but the reality is that early on in the career of expedition medicine, you have to be quite available quite last minute and very flexible.' [S].

²⁵ Out of programme experience

We will see in section 3.3 that interpersonal relationships, life events and family responsibilities were important influences on desires for autonomy, flexibility and certainty. And that personal and professional desires and needs are intertwined. For example, one participant explained

'I could pick up antisocial shifts when it suited me, but I could guarantee availability for friends' weddings and other important events.'

There was a widespread desire for certainty in specialty rotation, team and location, with the drivers being personal and/or professional (which we will explore further in section 3.3 below). Looking ahead from F2 and F3, perceived lack of certainty in rotation and location within specialty training was felt to be intrinsically linked to the competitive application process. For example, one respondent described this perception as follows:

'You don't have a lot of choice of rotations. You don't have a lot of choice in location..... and you can work hard to get the points but there's a low degree of certainty unless you're really exceptional' [S]

3.2.3.2 Headspace

The thread from taking a break from the demands of education and service provision (section 3.2.1 above), which progress through in the resultant burnout reported in section 3.2.2, continues and weaves into this section, a break for headspace.

Some study participants used the term 'headspace' overtly, such as in this quotation describing having:

'gone straight through the system and came out the other side feeling a little bit lost and just needing a bit of headspace and time to consider your thoughts.' [S]

Much of the discussion around headspace was not confined to work alone, and expanded from the causative factors of burnout to include non-work life, with many echoing the response below:

'I needed a break to step away and consider my goals in and out of medicine' [W].

Summarising need for time and space to both recover and consider work within the broader construct of life, one interview participant stated:

'I wanted a year to think about my career, think about what I wanted out of life in general ... with not much on call content, to give an opportunity to have a bit more space.' [S]

3.2.3.3 Opportunities

There was an awareness of opportunities, and motivation to experience them. The break for these opportunities was sought to confirm specialty choice, provide clinical or educational enjoyment, enhance the participant's CV, give life enriching episodes, or any combination of these goals. For example, a break for travel was presented as both an opportunity for personal growth,

(to) 'develop a bit more of my life out of medicine' [S],

and in conjunction with the opportunity for professional experience

'to see how other countries, particularly ones that are not as rich as the UK, manage a full range of different things.' [S].

In section 3.2.2 above, we summarised the common subtheme, specialty uncertainty. Linked to this, study participants saw an F3 year as providing opportunity to

'gain clinical experience in different specialties' [W]

And thus help confirm their future clinical career trajectory.

Opportunity to gain clinical experience during an F3 year was also linked to the competitiveness of specialty training selection and a consequent desire to enhance one's experience and CV (see section 3.2.2.3 above and section 3.2.3.4 below). For example, one study participant described this driver as follows:

'knowing that the jobs were available at leading hospitals...that would be very hard to get into as an IMT trainee.' [S].

In addition to training post specialties, there was appetite for the opportunity to explore broader professional avenues, sometimes presented alongside their impact on improving specialty application calibre. Participants sought experience in teaching, research, business and technology, as well as progressing through further study and working in less commonly encountered clinical areas.

Intrinsically linked with the influence of others (see section 3.3 below), the opportunity to prioritise personal needs and events such as illness, bereavement and marriage, was also frequently presented.

3.2.3.4 Portfolio and CV expansion for competitive specialty training application

The awareness of competition and point requirements for specialty training selection was clear in the interview data. This was closely associated with the perceived opportunities available within F3 that could facilitate additional application points.

'Applications are so competitive, I wanted to have some projects finished before applying for specialty (to get the points).' [W]

Within this subtheme there was variation between the F2 and F3 written responses. With a far higher proportion of F2 respondents citing portfolio and CV improvement as a motivating factor for taking an F3. The F2 data suggested a perceived normality and necessity for the addition of experience and portfolio development prior to application. With one respondent explaining it as a

'chance to build a portfolio for IMT application' [W]

The perception of an F3 year being necessary for specialty application purposes is revisited in section 3.3 below, which focuses on the influence of other people and organisational or structural influences.



3.2.3.5 Finance

The remuneration of locum work and the ratio of income to hours featured in both spoken and written responses. Whilst never representing a sole motivator, money was a further area of direct comparison between opportunities within F3 and specialty training. Largely referred to briefly by respondents as an opportunity to 'save up' or 'earn more money', the specific financial benefits of locum work were occasionally described in combination with the autonomy of specialty, location, and shift choice that locum work offers. When explored more deeply by respondents, the property ladder, medical courses, family commitments and travel were the drivers for seeking increased remuneration. For example, one interview participant expanded on the financial potential of the year, gaining financial independence, and explaining specifically that:

'a year of locumming and being a bit frugal with your savings, you can more or less get enough to save up for a deposit on a house.' [S]

3.3 The influence of others

Peers, clinical seniors, family members and professional organisations were all highlighted as influences on the decision to take an F3 year. Through both advice and indirect impact, the majority of these influences presented as motivators toward an F3.

The shared experiences previously discussed in section 3.2 produced a sense of comradery, with individuals presenting themselves as part of a cohort within the data. Two examples from the interviews demonstrate the combined desire for a break:

'we all had this shared sense of we want a break from this, we don't want to go into more on call, we want to just grow our careers, but in a in kind of a way that we can choose a little bit' [S]

There was confidence and legitimacy gained through overt discussions:

'all the way through its been a feature of don't worry guys, if it gets too much, let's just take an F3' [S]

Seniors, from near peers to consultants, had an influence from the early stages of medical training through to the foundation programme, with one interviewee recalling:

'in 4th and 5th year of medical school I came across junior doctors who were doing F3s or had already done one and no one really had any bad things to say about it. Everyone who'd done it didn't have any regrets.' [S]

'I came across junior doctors who were doing F3s or had already done one and no one had any bad things to say about it.....everyone who'd done it didn't have any regrets.' [S]

Much of the specific opinion and advice that participants recalled receiving from near peers related directly to the factors in sections 3.2.1 - 3.2.3 (A break - from, because, for ...), with the promise of opportunities, improved wellbeing and finances during an F3 in comparison to specialty training.

'My friend is doing her F3 in a major trauma centre, it sounds amazing, and her department is basically solely run on trust grades it's really hard to get that opportunity unless you're a trust grade' [S]

I had a colleague who said "You will earn so much more money being a locum, do it, you will earn so much more and you will be so much happier." [S]

The impact of the increase in F3 applicants to specialty training posts, and their comparatively higher scores, was an influence. With responses such as:

'Either you have to have been exceptional in your foundation training, or you're going to have to sit an F3 because there's no way you're going to have gained the experience that everybody else who has done an F3 has.' [S]

and

'You almost have to do an F3 just to get a competitive portfolio.' [W]

This suggests a feedback loop that will fuel the F3 phenomenon.

The stance of consultants varied, from discouraging to encouraging foundation doctors to take an F3. Two interview participants shared the caution and concern raised by consultants during F2:

'I often, more than once, had consultants say "you'll never get a job if you don't just carry straight on" [S]

'Some of the consultants were super cautious in their advice to me and some people said that it might not look very good on my CV or might make me look not committed to medicine.' [S]

However, the majority of data around the influence of consultants reinforced that of the respondent's peers and close seniors, advocating an F3 from their perspective:

'saying "there is no rush to become a consultant, just take years out whenever you want.' [S]

The influence of family was evident through advice and additional support, such as:

'My mum was really encouraging because she had taken an F3 back in the seventies.... she basically told me there'd always be jobs.' [S]

Or, more prominently, in the form of prioritisation; a sense of both necessary and coveted flexibility and certainty for those closest to them (see also section 3.2.3 above). Specific events, particularly weddings, were highlighted, with one interview participant explaining the historic impact of their training on their partner and explaining that taking an F3 allowed the opportunity to prioritise their partner for an important period:

‘...this one time I’m going to choose him (fiancé) and choose focussing on the wedding.’
[S]

The longer-term impacts of a training programme on others were also evident influences. Location uncertainty impacting partner’s employment, proximity to friends and family in need and educational stability for children were all important. One respondent explaining they were:

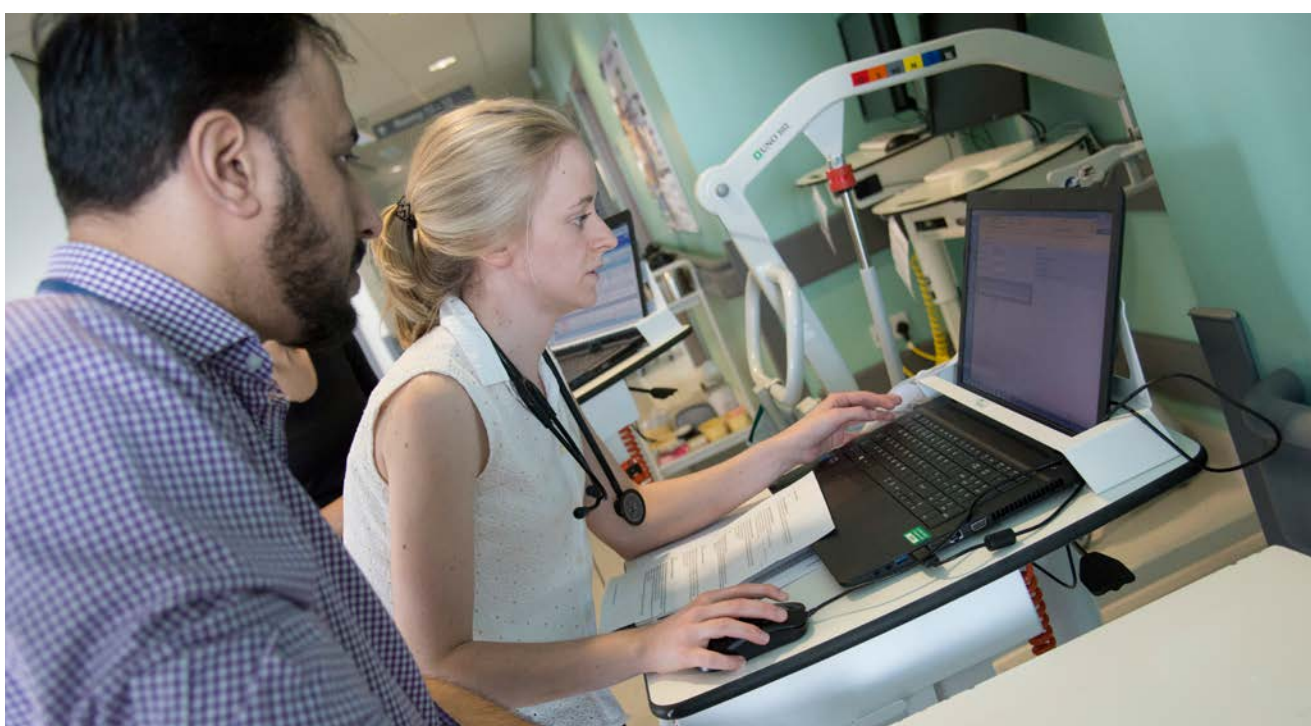
‘offered a training job on the other side of the country but took a job to be near my wife and wider family.’ [W]

There was additional external influence that served to increase confidence in taking the natural break (section 3.2.2). This came from the perceived implicit approval of the regulator:

‘the GMC say you have three and a half years before your proof that you’re F2 level expires.’ [S]

As well as the volume of roles advertised on the NHS’s central employment system:

‘There are so many jobs available, you just go on NHS jobs and look at ‘fellow’. There’s hundreds of them...so it made me confident I could find one somewhere in something I enjoy.’ [S]



3.4 Reflections on F3

'It broke the trainee Stockholm syndrome' [W]

Interview participants were asked whether the year had provided them what they hoped, as well as what their response would be to a current F2 asking whether they should take an F3 (Chapter 6). Although survey respondents were not overtly asked these questions, the depth in which many wrote about their experience has provided reflection on action that has allowed a breadth of insight into their experience and subsequent influence on others.

The overriding finding was of positivity and strength of feeling toward the benefit of the year.

'I enjoyed myself thoroughly. My love for, and enjoyment of, clinical medicine was restored, and I was healed as a clinician.' [W]

There were only two reflections in the data suggestive of negative implications of the F3, highlighted as:

'that little bit of anxiety about how it will be perceived... whether they will think poorly of someone who isn't so dedicated.' [S]

In addition to a sense of dissociation from the wider systems of training and employment, particularly with respect to the individual onus on appraisal and portfolio development.

'you can sometimes feel like a little bit of an outsider' [S]

There was a clear picture that, whatever combination of factors had precipitated the decision, personal and professional objectives had been met through taking an F3 year. In terms of the subthemes within section 3.2.1, there was a sense that the break from the stressors of training and service provision had been achieved. For example, when working clinically in F3 the removal of compulsory educational burdens resulted in increased enjoyment in the clinical role. One respondent shared that they:

'really enjoyed being able to go to work without the pressure of having to complete a prescriptive portfolio' [W]

The year had a beneficial impact on work-based wellbeing, with a number of responses reporting readiness, enthusiasm, and positivity in relation to the return to a training post. For example, one respondent shared

'Once I did start training I felt more motivated and keen to learn' [W]



This work-based wellbeing was also evident in the shift from negativity and cynicism in the tone of written and spoken data, to positivity and enthusiasm when discussing current (F3) or future clinical work. This positive impact on broader professional outlook was described succinctly and enthusiastically by one respondent who said:

'I've gone from being a doctor that was like "great, I'm a doctor, it's hard work" to someone who's like "Oh my God, medicine is the most amazing opportunity, the whole world is your oyster when you're a doctor" [S]

As described in section 3.3, the influence of colleagues and friends in the decision to take an F3 is substantial. The sentiment shared by all respondents in the context of their experience and advice to others was heavily positive. A number of these are shared below:

'I would say absolutely 100% do an FY3 year even if you're 100% sure you know exactly what you want to do. There are still so many advantages you can get by taking an F3.' [S]

'10/10 would recommend' [W]

'Best decision I ever made' [W]

'Wouldn't change a minute of it for the world and would definitely recommend 'a break' to anyone I can!' [W]

Furthermore, the reflections of the participant who took an F3 year because of no training post offer (section 3.2.2.4) revealed a wholly positive experience and subsequent ongoing recommendation to junior colleagues to take an F3. They specifically reflect on the benefit of additional specialty experience and absence of portfolio pressure, both of which subsequently resulted in them taking a further break between core medical training and specialty training. Reflecting on their experience, they 'strongly recommend it' to foundation doctors, expanding that:

'You now can be also as late as you want to be in looking for an alternative because, as I know, there are plenty of gaps and vacancies' [S]

When reflecting on the options within training that may have ameliorated one interviewee's desire for flexibility, they explained:

'They are trying their best (training leads) to encourage out of program experiences and research when you're in a training program. But even then, it's not very successful, because of all the hoops you have to jump through and all the forms and the procedures you have to go through when you do it' [S]

Whilst some reflected on the clear shift to preparedness and motivation for specialty training after F3, such as being.

'refreshed and excited to start CMT' [W].



Other study participants found that commitment to an ongoing path outside specialty training crystallised. This signified a new direction rather than a break between training programmes. These participants highlighted the ongoing impact of the factors described in section 3.2 (above) in their decision, such as the factors in the sample of quotations below: finance, flexibility, control, personal and professional opportunities, autonomy and avoiding burnout. The quotations also illustrate how organisational and system-wide influences also support this active choice to develop clinical careers outside the mechanism of traditional specialty training pathways, for example naming 'the alternative certificate',²⁶ SAS (specialty and associate specialist) careers, and CESR (Certificate of Eligibility for Specialist Registration).²⁷

'it feels like a massive step backwards to go back into a training pathway where I'm getting paid less, less flexibility.' [S]

'I intend to create my own IMT Job using the alternative certificate.....to choose which specialties I train in, follow my girlfriend... and do some of my learning abroad. I do not have to ask permission before doing any of it, I am in control of my SHO training.' [W]

'My F3 achieved all the above (a break from pressure, flexibility, travel) and more, so much so that I took an F4 and have subsequently taken more time out after core training.' [W]

'I suspect I will continue in this vein, with my eventual specialty being decided by which ones allow SAS and CESR. Taking time off when I want to, having that control, is incredibly important.' [W]

'I would rather stay in my current role and progress through experience rather than a training pathway.' [W]

In this context, the terminology around F3 was raised in the data, with the universal sentiment that one is no longer a foundation doctor following completion of the foundation programme. As such there was a request:

'please don't call it F3/4/5 - these doctors have completed the foundation programme and are not foundation doctors! A better term is needed.' [W]

²⁶ Alternative certification of attaining curriculum competences. in lieu of completing the traditional training programme.

²⁷ Certificate of Eligibility for Specialist Registration or Certificate of Eligibility for GP Registration application

<https://www.gmc-uk.org/registration-and-licensing/join-the-register/registration-applications/specialist-application-guides/specialist-registration-cesr-or-cegpr>

3.5 Talking about treadmills

The word treadmill appeared frequently in study participants' written and spoken data, often within the phrase:

'stepping off the treadmill' [W]

In this section we will develop the treadmill metaphor as an analytic device that provides insight. Even though the participants in this study used the term treadmill negatively, associated with exhaustion and constraint, we know there are people who like running on treadmills to increase and maintain their fitness. In the narrative below 'treadmill' is only negative if the doctor training on that treadmill finds it so. And training on the same treadmill may feel positive to one doctor and negative to another.

Imagine a large gym, with the usual array of gym machinery and equipment on a vast ground floor, which is zoned to provide different types of fitness development through training programmes or individual use. There are regular opportunities for self-assessment of fitness aided by feedback, and regular opportunities for fitness reviews and assessments by people who supervise in the fitness development gym and, intermittently, external assessors. There is also a first-floor mezzanine reserved for elite members who have completed all the training requirements and demonstrated fitness for elevation from the ground floor to the mezzanine. The key card for the mezzanine is normally granted after securing eligibility for entry to the GMC's Specialist Register, usually demonstrated through completion of an approved specialty training programme but there are alternative routes which have been used by increasing numbers of doctors in recent years. Retaining one's key card for the mezzanine requires continuing professional development and periodic external assessment.



The focus of our study is the zoned ground floor and transitions between zones. Doctors enter the ground floor gym for postgraduate clinical experience, training, and assessment. They come from a network of other gyms called medical schools. The first zone in the gym is called the Foundation Programme and the study participants have described the equipment there as a treadmill. Let's imagine a treadmill for each trainee and each trainee must reach the Foundation Programme fitness goals on their treadmill. This is normally completed in two calendar years called F1 and F2, although some variation in duration occurs to accommodate matters such as working less than full time, blocks of time out for various reasons and reasonable adjustments under the Equality Act.

Foundation trainees are a diverse group and react differently to training on the foundation treadmills, some enjoy running on treadmills and look ahead eagerly to a large range of more impressive and powerful treadmills in the zone of the gym straight ahead, which is called specialty training. They know that most people who move to the specialty training zone gain a mezzanine key card. It is likely to be the quickest route to the mezzanine. While they complete their time and fitness requirements on their foundation treadmill these doctors will be thinking about the specialty training treadmill which attracts them most, aware that they will be competing with others from the foundation zone, and from other ground floor zones for their treadmill of choice. They will be trying to shine on their current treadmill, maximising their strength whilst completing the necessary distance to remain competitive. They know that they may be offered a treadmill with settings they do not want, and may decide not to accept it, instead moving to an alternative zone.

Nowadays, most doctors do not move directly into the specialty training zone, secure in the knowledge that their achievements on the completed foundation treadmill programme will remain redeemable for entry to the specialty training zone for a number of years, and that alternative routes to the mezzanine exist. Some of the doctors running on their foundation treadmill want to jump onto a specialty training treadmill soon but are too tired by the foundation treadmill and seek a bit of time out first. For others, a unique combination of the factors described in Sections 3.2-3.4 will influence the decision not to step straight onto a specialty training treadmill. They, and others on the foundation treadmills, look around the gym and see alternative equipment for developing fitness – rowing machines, different types of bicycles, cross-trainers, free weights and so on, and life going on outside the glass walls of the gym. They are also privy to conversations between other gym goers, both in the various ground floor zones and on the mezzanine and may engage in these conversations themselves. Much of the discussion is around the benefit of moving to alternative fitness equipment or to the rest areas inside and beyond the walls of the gym, instead of directly into the specialty training zone. These conversations assure the foundation doctor that the specialty training zone will remain open.

Doctors have to be kept moving through the gym's zones so that new doctors can enter from medical schools. Therefore, doctors must leave their foundation treadmills when they have completed the training requirements there and move to another zone in the ground floor gym, or a rest area, or perhaps to a different training gym. Quite recently, most used to step straight across to the specialty training zone, but this is no longer the case. The barriers to stepping straight across include needing a break to avoid or mitigate burnout, or to explore options, uncertainty about which pathway in the specialty training zone to join, and the highly competitive entry gates for many training pathways. Factors which used to inhibit the choice of an F3 year between training programme treadmills have simultaneously diminished. For example, alternative zones within the ground floor gym are now more numerous and visible and contain a growing array of options. More experienced gym goers are now much more likely to encourage exploration of other options and taking a break by taking an F3 year. F2s running on their treadmills have increasing visibility of the enjoyment and benefits of alternative zones experienced by others during F3 years. Cultural change has made it more acceptable to prioritise aspects of life outside the gym walls and one's own wellbeing. Thus, whilst each doctor has to step off the foundation training treadmill, the push and pull factors related to the specialty training zone have changed profoundly and contain feedback cycles which have embedded the new norm of an F3 year before moving into the specialty training zone; or as an opportunity to develop a personal career plan that does not include the mezzanine or reaches the mezzanine via an alternative route.



The current postgraduate training system and NHS need to keep the ground floor gym equipment in use because this provides patient care and ensures that doctors leaving the mezzanine will be replaced. This includes the treadmills in the training programme zones and the other fitness equipment in the alternative ground floor zones. Arguably, the more content the doctors are with their chosen zone, or series of zones, the more likely they are to remain within the ground floor gym and become increasingly experienced, fit and strong, doctors who can meet population health needs, while overseeing, encouraging and inspiring successive generations of newly qualified doctors on their foundation programme treadmills. The challenge lies in balancing the individual preferences of those in the ground floor zones with the system-level requirements to continue to fill the mezzanine and to ensure that the workforce develops the right kinds of fitness in the right kinds of proportions for the breadth of health service needs. The challenges of running a training gym in these circumstances need no additional emphasis from us.

This study has demonstrated the complexity and uniqueness of individual decisions about whether to step straight onto a specialty training treadmill after the foundation training treadmill. We have seen that cultural and organisational inhibitors to deviating from this immediate transition have diminished significantly in recent years, to the extent that those who make an immediate transition are in the minority. It is no longer the 'normal' training pattern. Analysis of the rich data set that this study generated suggested that the feedback loops in this 'new norm' act in ways that reinforce it. We found no data suggesting that study participants perceived limits or disadvantage in the 'new norm' and it is important to note this silence in the data. We will discuss these possibilities in the next chapter.



4 Discussion

'When we try to pick out anything by itself, we find it hitched to everything else in the universe' John Muir

In the next section we will set this study and its findings in the context of wider work to understand and respond to the new norm of taking an F3 year. In section 4.2 we will delve more deeply into the extent of interconnectedness between factors that lead towards the choice of an F3 year, and we emphasise that interconnectedness militates against the effectiveness of factor-by-factor interventions, unless these are also joined up. In section 4.3, focused on workforce retention, training, and progression we view these issues through the lens of the findings in this study, we begin to broaden the current dichotomy of 'in training' or 'out of programme/ training'. In section 4.4 we will summarise the areas of discussion within the template of 'recognition, recovery and re-alignment, retention, return or re-route', providing context to our subsequent recommendations and a framework within which to continue the discourse.

4.1 Seeking to understand and respond to the new norm

As outlined in the introduction (Chapter 1), the progressive increase in the proportion of doctors taking an F3 year has reached a point where the majority of completing F2 doctors move to F3. The increase does not appear set for imminent reversal. It has become a new norm, which is embedding. Attitudes, expectations, outcomes, workforce planning, and the clinical training pathways are adapting. As the situation evolves, we need to respond, even before we have the depth and breadth of understanding that will be available to those looking back a decade from now. This study is one response. It was commissioned to deepen understanding of junior doctors' perspectives on taking an F3 year. This was a jigsaw piece which needed to be examined more closely before setting it alongside other types of knowledge about the new norm to help create a more holistic understanding of the contemporary, and dynamic, situation.

Many of the subthemes within our findings in Chapter 3 (section 3.2) mirror those found in the recent scoping review from Church and Agius²⁸ and have been highlighted as wider issues amongst trainees in recent surveys²⁹. As a result, several factors have already been considered and prioritised for the development of responses, which are now underway. For example, the detrimental demands of excessive training elements within the foundation programme have been acknowledged in curriculum changes for 2021³⁰, with a decrease in the assessment burden. The pressures of service provision, particularly through the pandemic, and the subsequent increase in burnout have been widely recognised. The accelerated introduction of 'less than full time training' via category 3³¹ for foundation doctors offers one avenue for reduction of full-time service pressure, and potential to prevent or reduce burnout experienced through foundation training. The specialty application process itself is highlighted in the most recent 'enhancing junior doctors working lives' report³², with the development of dynamic recruitment to provide greater flexibility.



²⁸ Church HR, Agius SJ. The F3 phenomenon: Early-career training breaks in medical training. A scoping review. *Med Educ*. 2021 May 4. doi: 10.1111/medu.14543. Epub ahead of print. PMID: 33945168.

²⁹ GMC National Training Survey Results 2021 [national-training-survey-results-2021---summary-report_pdf-87050829.pdf \(gmc-uk.org\)](https://www.gmc-uk.org/national-training-survey-results-2021---summary-report_pdf-87050829.pdf)

³⁰ UK Foundation Programme Curriculum 2021 [New UK Foundation Programme Curriculum 2021 - UK Foundation Programme](https://www.ukfpo.org.uk/curriculum-2021)

³¹ Less Than Full Time (LTFT) Training Category 3 allows trainees to request the opportunity to undertake a period of less than full time training for personal choice

³² Enhancing Junior Doctors Working Lives Progress Report 2021, Health Education England, [Enhancing Junior Doctors' Working Lives | Health Education England \(hee.nhs.uk\)](https://www.hee.nhs.uk/enhancing-junior-doctors-working-lives)

Specialty uncertainty has been recognised in the most recent foundation review with respect to both career support through foundation training, and the acknowledgement of ongoing support needs for those taking time out after foundation training. One response to the call for increased flexibility in roles and specialty training is evident in the flexible portfolio training²⁹ being offered at specialty level. This is pertinent to our findings given the numbers choosing to develop research, QI, teaching and leadership skills during F3. Offering this portfolio development through specialty training may negate the need for some to take time away from training for this purpose. This process of understanding and responding to the new norm of taking an F3 year will continue and evolve with the embedding norm.

The findings of this study have highlighted the importance of each factor behind the decision to take an F3 year, but more importantly, the interconnectedness of factors and unique personal combinations of factors which create the multifaceted decision to take the F3 route. We will return to discussion of this interconnectedness shortly, but first a brief word on some factors which cumulatively serve to embed the norm. The findings in Chapter 3 also highlighted participants' strong perceptions of the beneficial experience of the F3 year and their subsequent encouraging advice to others (section 3.4). F3 doctors are now part of the majority in their peer group, empowerment is gained from peer support and alignment of group goals to share this once alternative route. The reactions of seniors and organisational signals are also important (section 3.3). Encouraging advice given by those more senior, (for whom this trajectory was not in existence at a comparable stage) demonstrates the level to which the F3 has been integrated as an accepted and positively regarded option in the postgraduate trajectory, by doctors at every stage. This fuelled individual confidence and organisational responses deepened the sense of legitimisation. For example, participants had reassurance that GMC recognition of F2 level competence remained valid for some time, irrespective of the content of their F3 year. This provided a safety net in taking the break. Ever-increasing job opportunities, labelled as F3 posts or suitable for F3 doctors, signal that organisations welcome F3s and provide a wealth of choice, thus encouraging the embedding of the norm.

More equivocally, highly competitive specialty training selection also contributes to embedding the F3 norm (sections 3.2.3.4 and 3.3). Trainees feel they need the F3 year to enhance their professional portfolio and CV to enable a competitive application. This finding may generate some ambivalence if it is seen as being equivalent to embedding 'grade inflation' and lengthening training by a year. Furthermore, the perceived, and in some cases potentially proven, need for F3 necessitates consideration of equality, diversity, and inclusion issues. Cleland and colleagues³³ reported that.

'those entering medicine after high school and doing a 5-year (standard) programme, males, of white ethnicity and whose parents were educated to degree level were more likely to take time out of the training pathway than their counterparts.'

³³ Cleland J, Prescott G, Walker K, Johnston P, Kumwenda B. Are there differences between those doctors who apply for a training post in Foundation Year 2 and those who take time out of the training pathway? A UK multicohort study. *BMJ Open*. 2019; 9(11):e032021

For some, the risks that time out of formal training may pose in terms of long-term employment certainty and career progression may outweigh the benefits of F3. These outcomes and their adverse consequences warrant monitoring and attention to mitigation. However, the findings of this study suggest that the F3 year delivers important outcomes, such as retention in the clinical workforce, mitigation of burnout, and increased certainty about a preferred career pathway. On balance, the embedding of the norm appears positive for most.

4.2 Interconnectedness

Factors leading to the F3 decision are presented in a necessarily linear manner in the findings of this report. Discrete factors align well with current and future reforms (see section 4.1 above). However, the specificity and interconnectedness of these factors for individuals, in combination with other influences, was the pronounced finding in this study. The richness of participants' contributions demonstrates the individuality and nuance within influences on the decision to take an F3. The dynamic is a more complex model than merely cause and effect. There is multidimensionality in individual factors, and external influences from people and organisations, together with progressive legitimisation and normalisation of once 'alternative' career pathways.

There are many interconnections between factors and broader influences on the F3 decision presented in section 3.2. Not all of these can be discussed in this report, a small number of carefully selected examples must suffice. One example begins with uncertainty about what specialty to apply for. This was seen to be compounded by a desire for both autonomy and certainty in relation to geographical (or sometimes organisational) location and training post. This was often related to the external influence of family requirements. When combined with a knowledge that the GMC allow for 'a break from' the training programme, these factors precipitate a subsequent interest in F3 opportunities, as highlighted by peers or seniors, that can provide the desired autonomy and certainty, whilst offering potential to confirm specialty choice, without any risk to future applications for specialty training or other career pathways.



A second example centres on feeling unready to make a specialty training application and concern over the calibre, or comparative standard, of one's application. Following one route backwards from this factor, there are connections to the sense of burnout from the foundation programme: service pressure, particularly through COVID-19, resulting in both reduction in workplace wellbeing and a lack of capacity for portfolio building and application preparation. Continuing forwards from this unreadiness, there are opportunities presented via NHS Jobs that could offer adequate capacity for recovery from burnout through reduced service provision, in conjunction with roles to advance and improve application calibre. The F3 decision becomes obvious. Quickly, this decision is fuelled and accelerated by F3 becoming the new norm. The cycle of concern around application calibre is further perpetuated by awareness that a number of those competing for the same training posts will have additional experience and higher scores due to the opportunities taken during their F3 years.

If considered as standalone factors, specialty uncertainty and unreadiness for specialty application could both be remedied through 3-year, broad-based training stems following completion of F1 (as proposed in the Tooke report³⁴). This would allow for rotation through more specialties, with additional opportunity for portfolio improvement. However, recognition of the interconnectedness of other factors in the examples above, and in every individual experience, makes it easy to see the extension of broad-based rotations, focused just on specialty uncertainty and unreadiness for application, as a response is too blunt and rigid. Something more individually supportive and tailored to need is required. In addition, and as described in section 3.2.1, there is a palpable desire by this cohort for a complete break from the training programme pathway which may be difficult to overcome irrespective of programme reform. Returning to our gym metaphor (section 3.5), could doctors have confidence in being offered the same opportunities for flexibility and certainty that the 'alternative' fitness development zones present via F3 and other 'non-training' roles, if doctors remain within the treadmills of the formal training programmes zone?

4.3 Workforce retention, training, and progression

As discussed above, this phenomenon seems set to continue, and potentially grow. This is recognised in the most recent foundation review, acknowledging that

'it is likely that a significant number of trainees will continue to take time out of training after FY2.'³⁵

Leading us to consider what the potential impacts of this may be.

The NHS Interim People Plan³⁶ called for

'improved retention of doctors at all stages of their medical training and career, through improved working lives, flexible training options and rewarding careers and conditions.'

³⁴ Tooke J. Aspiring to excellence: findings and recommendations of the independent inquiry into Modernising Medical Careers. London: MMC Inquiry, 2007. www.mmcinquiry.org.uk

³⁵ Supported from the start; ready for the future; The Postgraduate Medical Foundation Programme Review. 2020, Health Education England. [FoundationReview FINAL for web.pdf \(hee.nhs.uk\)](https://www.hee.nhs.uk/sites/default/files/2020-06/FoundationReview_FINAL_for_web.pdf)

³⁶ Interim people plan. 2019. NHS. [Interim-NHS-People-Plan_June2019.pdf \(longtermplan.nhs.uk\)](https://www.nhs.uk/longtermplan/interim-plan/)



In our study the majority of doctors undertaking an F3 year worked clinically within the NHS through 'the break'. They were not retained within the training programme pathway during this time but were retained in the clinical workforce. The GMC data of 2017³⁷ revealed a return to specialty training for 93% of post foundation doctors who stepped out of the training programme within 5 years of completing the foundation programme, suggesting that there was no longer term retention in training issue. However, in subsequent years the F3 has been increasingly integrated into the postgraduate journey. The reflections of our study participants' around continuation of 'out of programme' training (section 3.4), alongside work to acknowledge and support the SAS workforce³⁸, and the potential impact of COVID-19, lead us to advocate caution in the assumption that such a return to training programme pathways will continue at a similar level going forward. It is unlikely that the proportion remaining 'out of programme' long term will be as high as the proportion of doctors taking an F3 year. However, the cultural shift toward F3 'breaks' from training programmes, alongside increasing legitimisation and acceptance of once unusual 'alternative' pathways, are likely to represent drivers of an increase in the number of doctors continuing to develop their expertise within the workforce but 'out of programme' following F3.

Retention in training has been the norm and major focus of attention for several years. This was presented in the gym metaphor (section 3.5) as direct continuation from the foundation training

³⁷ GMC National Training Survey Portal <https://webcache.gmc-uk.org/ntspportal/Account/GuestLogin.mvc>

³⁸ Maximising the potential: Essential work to support SAS doctors. 2020. Health Education England and NHS Improvement. [SAS Report Web.pdf \(hee.nhs.uk\)](#)

zone to the specialty training zone on a fairly predictable timeline. At the macro system level, this pathway allows for relatively predictable movement of junior doctors through the ground floor gym, appropriate numbers in each specialty pathway and reliable senior numbers on the mezzanine to provide service, leadership and ongoing assessment of those in the specialty training zone. In this model (workforce retention in training), service provision and training progression align through overarching management of the training programme. There is relative predictability of workforce numbers and progression to senior positions. Even attrition at each stage can be modelled and factored into the 'input' numbers.

In the current dynamic situation of increased participation in an F3 year and much lower, but still increased, participation in alternative routes to standard training programmes, we know too little about the impact of F3. On balance, does completing an F3 retain doctors in the workforce? Thereafter, does it retain them in the workforce and in traditional training pathways? This study is cross-sectional and centred on junior doctors' perceptions: it was not designed to ask these questions. However, workforce and training processes routinely collect data which could be adapted to address these questions.

The F3, and any subsequent years out of programme, represent a time in which service provision most commonly continues. With increased procedural and clinical exposure and informal supervision from seniors, workplace-based learning whilst delivering this continuing service is occurring. In addition, parallel experience in teaching, research, QI and leadership is often taking place. There is an option to maintain a portfolio whilst undertaking an F3 year, and it is likely that many seeking to improve their portfolio will continue to accrue selected workplace-based assessments and other training progression markers in this formalised fashion. It can be deduced that training is therefore also happening for a large proportion of these F3 doctors. Within the gym metaphor this is represented as those exploring alternative ground floor zones after foundation training, continuing to exercise, gain strength and often undertake fitness reviews. This model represents workforce retention and training, beginning during the distinct break of F3 and potentially continuing through subsequent years. The historic data would suggest that most will then return to the specialty training zone and ultimately enter the mezzanine via this route, we have urged caution in assuming this will continue.

With retention and progression as the goals, the most pressing questions raised by this model include: how can the system adapt to recognise such training reliably and efficiently without removing the rowing machines, cross-trainers, exercise bicycles and free weights that motivate people to stay in the gym and improve their fitness, and replacing the motivating diversity of this gym equipment with alternative training pathway treadmills? How do we codify and assure enough without stultifying and suffocating?

For training to occur, via either model, there must be an adequate number of seniors to educate, support and assess competence in order to assure progression of doctors and safety of patients. It could be assumed that prolonged working lives of those in the metaphorical

mezzanine, in line with longer working lives in the population as a whole, could mitigate mezzanine depopulation caused by slowing of the journey through the ground floor zones by widespread pursuit of F3 years and exploration of alternative training routes. Extending the period of mezzanine occupancy would ensure assessors and senior service providers. However, the trend among senior practitioners is turning away from extended mezzanine careers. Current data from the most recent GMC national training survey³⁹ reports a quarter of trainers to be burnt out. Will the impact of COVID-19 on the capacity of those in the mezzanine to continue in service provision and/or training roles for the maximum length of time result in a problematic mismatch between ground floor and mezzanine?

Whilst the likely retention of a significant number of post foundation doctors within the NHS workforce is positive, there are challenges for managing this growing cohort retained and training, rather than in training. How do we deliver supervision and assessment of training whilst acknowledging the desire for separation from an official training programme? How do we ensure rapidity of progression to senior clinician, assuring service delivery at all levels, whilst meeting the interconnected and individual needs of the doctors?

4.4 Recognition | Recovery and Re-alignment | Retention | Return or Re-route

Recognition of this new norm, the interconnectedness of factors leading to it, and the depth of integration into the postgraduate pathway provides a basis for future monitoring, planning, and reform. Our findings have demonstrated the positive experiences of recovery from burnout and re-alignment of personal and professional goals as a result of the F3 year. However, there must also be recognition of the impact of this new norm on the wider predictability of workforce planning, and on specific groups to whom it may be less accessible. The continuation of clinical service during F3 warrants optimism with respect to retention, but highlights challenges around managing training, assessment, and progression in this context. Whilst the subsequent trajectory of those who are currently choosing F3 remains uncertain, historic data and reflections within this study suggest return to specialty training or re-routing on an alternative pathway will continue to be the predominant destinations.



³⁹ GMC National Training Survey Results 2021 [national-training-survey-results-2021---summary-report_pdf-87050829.pdf](https://www.gmc-uk.org/media/1242/national-training-survey-results-2021---summary-report_pdf-87050829.pdf) (gmc-uk.org)

5 Recommendations

The 'new norm' of an F3 years is embedding. Feedback loops in and surrounding the F3 process and experiences will tend to reinforce this. Therefore, we recommend:

- System-wide planning for the norm of a gap of (at least) one year between the foundation programme and either specialty training or the forging of a different career pathway which develops clinical experience and expertise outside the support and constraints of formal specialty training pathways. This should be coupled with surveillance of the trends in this branching process to enable adequate adjustment as proportions change and perhaps then stabilise.
- New nomenclature to recognise and represent this group, F3 doctors are no longer foundation doctors.
- Equality, diversity and inclusion monitoring of those who do not take up F3 opportunities (however named in the future) because there may be systemic issues in society and the healthcare system which make it difficult for some doctors to pursue the norm of the F3 route.
- Monitoring of key potential impacts of the F3 year, such as retention in clinical practice, reduced attrition from specialty training, and continuation of out of programme training.
- Engaging with and learning from the teams recruiting and supporting F3 doctors at the local level (hospital management, workforce and medical education teams) to understand what is offered, how it is provided, and which aspects result in the positive experience of F3.
- Developing acceptable approaches to recognise the training and progression gained during F3.
- Simple, inexpensive interventions to keep in touch with doctors undertaking F3 years and provide easy access to information and support their next steps of return to a training programme or an alternative career pathway.

Influences on the F3 decision are uniquely individual, highly interconnected, nuanced, and dynamic. Attempts to identify problems and solve them individually will not be sufficient and are unlikely to keep up with the dynamic situation. Therefore, we recommend:

- Focusing on the broad patterns in the findings of this study without inferring that any individual experience fully matches any particular constellation of influences on the F3 decision.
- Pragmatically prioritising interventions which have potential for broad (and preferably multi-layered) impact and then monitoring for multiple impacts, particularly unintended consequences.

6 Appendix: data collection instruments

Semi-structured interviews

Expression of interest for the interview was via SurveyMonkey. This was accessed via a link on the study landing page. Following completion of the expression of interest form (below) a mutually convenient time was organised and a consent form was emailed to the study participant for completion and return to RS prior to the interview.

Expression of Interest
Name
Email Address
What is your current role?
Which foundation region do you currently work in?
Please list the most convenient dates for you to take part in an online interview



Prior to interview, each study participant completed the consent form below.

Consent to take part in research study:
A qualitative study exploring the motivators for taking, and the provisions gained from, the ever increasing FY3 post

I..... voluntarily agree to participate in this research study.

	Participant Initials
I have read the study information sheet and any questions have been satisfactorily answered.	
I understand that even if I agree to participate now, I can withdraw at any time prior to the interview without any consequences of any kind.	
I understand that participation involves an online interview between myself and the clinical project lead.	
I agree to my interview being recorded for the purposes of transcription.	
I understand that original recordings will be retained on the secure Royal College of Physicians network until transcription is completed and checked, and will then be deleted.	
I understand that a transcript of my interview in which all identifying information has been removed will be retained until the study is completed, and thereafter destroyed.	
I understand that I will not benefit directly from participating in this research.	
I understand that all information I provide for this study will be treated confidentially.	
I understand that in any report on the results of this research every effort will be made to maintain my anonymity.	
I understand that short, anonymised extracts from my interview may be quoted in publications and presentations based on the study.	
I understand that I am free to contact the study lead (Dr Ruth Silverton) with any queries and concerns and that I may also contact Professor Della Freeth to highlight any concerns or complaints.	

Date:

Agreement to participate will be confirmed by exchange of this email.

Contacts: ruth.silverton@rcplondon.ac.uk della.freeth@rcplondon.ac.uk

The semi-structured interviews were conversational and guided by the question prompts below. Additional open prompts were used as necessary, such as 'can you tell me a bit more about that?' or short questions for clarification.

Current F2	Current/Past F3
What are the factors that led to your decision to take an F3: Is there anything else? Were there any individuals that impacted your decision?	What were the factors that led to your decision to take an F3: Is there anything else? Were there any individuals that impacted your decision?
What do you plan to do during this year?	What did you do during this year? Anything else? – clinical or non-clinical
What do you hope it will provide you with?	Is it / did it provide you with what you hoped?
Is there anything you feel it won't provide you with?	Is there anything it isn't / didn't provide you with?
	If an F2 were to ask you now 'should I take an F3?', what would your response be?
Is there anything else on this topic you'd like to share?	Is there anything else on this topic you'd like to share?

Online surveys

The written survey data was collected via SurveyMonkey using three questionnaire forms with a mixture of drop-down menus [DD] for closed questions and expanding boxes for free text responses [FT], as indicated in the table below.

The questionnaire for current F2 doctors explored the factors playing into their decisions to take an F3 year, and their plans and hopes for their F3 (see questions in first column of the table below). There were two questionnaires which shared the questions in the second column below. First, a link to a questionnaire for current F3 doctors, which explored their reasons for undertaking the F3, what they were doing and the extent to which their experience was matching up with their hopes for the F3. Finally, a questionnaire link was provided for doctors who had previously completed an F3 year. The same questions were posed but using the past tense.

For current F2 doctors: Exploring the factors involved in making the decision to take an F3 year after foundation training	For current or former F3 doctors: Exploring the factors involved in choosing to take an F3 year, and reflecting on what their F3 experiences provided in relation to hopes/ expectations
Age group [DD]	Age group [DD]
Chosen gender [DD]	Chosen gender [DD]
Foundation School [DD]	Foundation School location of F3 post [DD]
Which option best describes the plan for your F3 year? [DD + FT] ⁴⁰	Which option best describes how you are spending/spent your F3 year? [DD + FT] ⁴⁰
Please describe why you have chosen to take an F3 year following completion of the foundation programme, and what you hope this year will provide [FT]	Please describe why you chose to take an F3 year and whether you feel it is/did provide you with what you hoped [FT]

⁴⁰ Respondents were given multiple options ranging from full time clinical NHS work, part time clinical NHS work in conjunction with teaching, further study, research, QI or leadership, non-clinical roles in teaching, research, further study, QI or leadership. There was also a free text box if the correct option was not presented in the drop down.

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