Compassionate leadership during COVID-19: an ABC approach to the introduction of new medical graduates as Foundation interim Year 1s (FiY1s)

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ABSTRACT
Background Increasingly challenging workplaces detrimentally affect doctors’ well-being and patient care. The General Medical Council’s ‘ABC’ compassionate leadership model aims to improve doctor well-being. When COVID-19 emerged, a 4 Nation agreement facilitated early graduation and provisional registration of final year medical students and deployment of new graduates into Foundation interim Year 1 (FiY1) positions. We report how the Northern Ireland Medical and Dental Training Agency (NIMDTA) applied compassionate leadership to the induction of FiY1s.

Methods Employing ‘What matters to you’, we identified FiY1s’ educational objectives and reviewed information dissemination options within distancing restrictions. A dedicated FiY1 webpage summarised requirements and resources. A regional digital induction with a well-being emphasis facilitated flexible completion. Welcome packs promoted belonging while a ‘buddy system’ delivered support. Collaboration with other stakeholders created staggered follow-up video conferences providing practical and psychological support, removing communication barriers.

Findings Feedback showed high FiY1 satisfaction with the global introduction to practice (83%) and 82% felt valued by NIMDTA and by Trusts after process completion.

Conclusion Applying compassionate leadership to induction creates positive effects on doctors’ feeling of value and aligns with organisational strategic aims to support, develop and retain doctors in training programmes. We envision this model being applied to future postgraduate induction programmes.

INTRODUCTION
Increasingly challenging National Health Service workplaces have contributed to decreased recruitment of doctors into training programmes.1–3 While the reasons may be multifactorial, the General Medical Council (GMC) highlight that increased workplace stress affects doctors’ morale and well-being.4 Healthcare staff report increased workplace stress compared with the general working population.5 Stress can result in burnout, absenteeism and workforce shortages which further intensify stress on remaining staff.6–8 Doctors in training report higher work-related stress, increased levels of burnout and lower engagement than consultants.9 Challenging workplace environments and impaired doctor well-being are associated with reduced quality of patient care, lower patient satisfaction and higher mortality.10,11

The Northern Ireland picture
In Northern Ireland (NI), reduced competition for and increased attrition during training programmes have emerged as concerns in the last 10 years.1 In response, the Northern Ireland Medical and Dental Training Agency (NIMDTA) transformed their approach to postgraduate education, instituting the VALUED strategy in 2016. This multipronged strategy aims to attract, support, develop and retain doctors in training focusing on six areas to increase workforce engagement, lower attrition rates and improve patient outcomes.6,10–11 (figure 1).

Focusing on the ‘up-to-date training’ component of the strategy and responding to increasing attrition from training after completion of Foundation Programme, the Placement Quality work-stream reviewed Foundation training in 2019.12 This analysis revealed NI Health Trusts as having lower rankings in the GMC National Training Survey for induction and shadowing.13 There was also low morale related to excessive workload, limited clinical experience, insufficient performance feedback, feelings of isolation from their clinical team and lack of inclusion. Recommendations for improvement were shared with Trusts.12 With the emergence of the COVID-19 pandemic, a 4 Nation agreement in March 2020 facilitated early graduation and provisional registration of final year medical students and deployment of new graduates into Foundation interim Year 1 (FiY1) positions to support frontline colleagues.14 NIMDTA seized this opportunity to apply the GMC’s ‘ABC’ compassionate leadership model to develop a new approach to introduce these doctors to the health system. In doing this we aimed to provide support, improve well-being and value these new doctors in training.

METHODS
Planning for action
Annually, all Foundation year 1 doctors (FY1) in NI collectively participate in a 1-day regional induction event. They then disperse to five healthcare Trusts each with 2–3 training hospital sites with on-site Trust induction.

We engaged with leaders in the Department of Health, NIMDTA ‘VALUED’ and Foundation teams, Trust Education and Human Resources (HR) departments. Collectively it was agreed to deliver FiY1 allocation across NI and regional and local
Trust induction programmes within a restricted timeframe of 5 weeks. Planning stages employed the Institute of Healthcare Improvement’s ‘What matters to you’ approach to understand trainees’ educational objectives. We sought input from all 20 FY1 representatives who were contacted by email with 17 responses detailing suggested content and offers of participation. Priorities identified were reducing onerous online learning requirements that varied across Trusts, development of task-specific induction content, a tone of inclusiveness and team integration. This FY1 collaborative alliance proved very beneficial. We also reviewed how information could be disseminated effectively to FY1s while adhering to social distancing restrictions.

**Intervention**

NIMDTA established a six-point campaign: simplified mandatory online learning requirements; effective information sharing; compassionate allocation; regional induction; Trust induction and follow-up support sessions.

**Table 1** FY1 introduction to practice initiative: global-specific and Trust-specific results

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<td><strong>Mandatory online learning</strong></td>
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<td>Accessibility</td>
<td>73</td>
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<td><strong>Website</strong></td>
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<td>Useful</td>
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<td><strong>Regional induction</strong></td>
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<td>Content</td>
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<td><strong>Trust Induction</strong></td>
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<td>Content</td>
<td>83</td>
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<td><strong>Follow-up support sessions</strong></td>
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<td>Accessibility</td>
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<td>Useful</td>
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<tr>
<td><strong>Global ‘introduction to practice’ score</strong></td>
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<tr>
<td>After my introduction to practice, I feel valued by NIMDTA</td>
<td>82</td>
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<tr>
<td>After my introduction to practice, I feel valued by my Trust</td>
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**Autonomy/control**

Described as a central core need, this comprises voice, working conditions and rotas. After listening to the voice of current foundation doctors, we advocated on behalf of FiY1s to streamline and regionalise mandatory online learning by negotiation with Trust HR teams. Working in partnership with colleagues in the Department of Health and existing technology-based learning platforms, we created a digital regional induction programme. This focused on roles and tasks with presentations delivered by current FY1s. The strong well-being focus entitled ‘Keeping you safe: Physically, Mentally and Professionally’ spoke to the anxieties voiced by doctors during the COVID-19 pandemic, detailing guidance for equipment use and emphasising professional support available to doctors regionally. This online induction allowed a flexible timeframe for FY1 doctors to complete. Regionally agreed Trust induction content had similar themes and focused on practical donning and doffing sessions, highlighted available on-call and canteen facilities and hospital-specific support facilities. NIMDTA recognised the difficult provision of adequate scrub supplies during COVID-19, specifically for these doctors entering the workforce several weeks after the start of the pandemic. This prompted NIMDTA to purchase branded scrubs for every FY1 doctor ensuring adequate uniform provision but also creating a sense of belonging and value. These were distributed as part of a ‘welcome pack’ including other practical equipment.

**Belonging**

Creating a healthcare community can help buffer significant workplace stressors that doctors face. Pandemic social distancing restrictions created obstacles to achieving this. A dedicated NIMDTA FY1 webpage was created detailing all requirements and resources. This included task-specific ‘Quick Guides’ written by current FY1 doctors creating a sense of collegial belonging and team integration. Recognising that multiple placement rotations undermine team coherence and belonging, NIMDTA approached FY1 Trust allocation compassionately, aligning these to either their most recent medical school placement or their future FY1 position. As UK medical schools graduated their students and GMC registration was obtained, the UK Foundation Programme released details of FY1s assigned to NIMDTA on a weekly basis. This created challenges with Trust allocation due to the unpredictability of workforce numbers, doctors’ personal requirements and a definitive job commencement date. We undertook mass allocation and job commencement aligning with Queen’s University Belfast graduation timeline as most FY1s attended here. Students attending universities graduating...
later were added to the FY1 cohort as able. This required sensitive negotiation, acknowledging their generous offer to support the response to COVID-19 and allocating where Trust capacity allowed.

Lastly in cooperation with NIMDTA’s Professional Support Unit and Queen’s University Belfast’s Student Wellbeing Team, staggered follow-up meetings addressed both practical and psychological support. Early Trust-specific FY1 support meetings coordinated by NIMDTA via video conferencing included NIMDTA educational teams, Foundation Programme Directors, Trust HR and FY1 representatives. FY1s opened the session discussing practical tips and challenges allowing open discussion of issues encountered with submission of anonymous questions by typed chat function. The session aimed to clarify roles and responsibilities, and create a sense of belonging and support with clear communication and visible leadership. Later psychological support meetings provided a space to discuss challenges or frustrations and to focus on well-being.

**Competence**

Doctors strive to deliver high-quality care which requires manageable workloads and appropriate supervision. Visible supervisors available at Trust induction and follow-up support sessions aimed to support doctors’ well-being at the start of their careers when the learning curve is steepest. The FY1 role was envisioned to reduce workloads for current FY1 doctors while the job role, including specific reference to a buddy system with current Foundation doctors and allocation to clinical teams, maintained consistent support for FY1s.

Initially tensions surfaced in the FY1 cohort who felt increased burden to ‘supervise’ FY1s but with further clarification of clinical roles, this was alleviated. Although FY1 COVID-19 shift patterns in NI required no enhancement of on-call shifts, some workforce isolation meant FY1 trainees were, at times, stretched across additional clinical areas. In the majority of Trusts, the FY1s followed their FY1 buddies’ shift pattern. Informal verbal feedback at Trust support meetings suggested this was viewed positively by FY1s, promoting development of prioritisation skills, while FY1 representatives described welcome assistance during busy shifts. In one Trust, FY1s (n=42) allocated to ‘in-hours’ work and not following their buddy’s out-of-hours shift pattern was highlighted as a grievance by both FY1s and FY1s, with FY1 representatives reporting out-of-hours as the most useful time to have extra staffing. This was then rectified.

**Assessment of intervention**

NIMDTA invited FY1s to complete feedback evaluating individual aspects and overall global scoring of the project including qualitative themes and quantitative data. The FY1 doctors’ feeling of ‘value’ was then compared with previous FY1 group responses. All stakeholders involved in delivering aspects of induction were invited to complete a survey of their opinions on the process with white space questions. No ethical considerations were identified in implementing or evaluating this mandated induction process.

**RESULTS**

Of 213 FY1s 180 responded to the survey. Thirty-six incomplete responses (25 survey opened with no responses, 11 <50% completed) were excluded leaving 144 for analysis (68% completion rate).

Individual process measures showed the most successful aspect was the regional induction, with 83% of FY1s satisfied/very satisfied with the global induction to practice on a 5-point Likert scale. White-space comments on individual aspects of the initiative were collated and returned to the organising teams. 82% of FY1s agreed/strongly agreed that they ‘felt valued by NIMDTA’ and 82% indicated that they ‘felt valued by their Trust.’ We compared this to the same question in an annual deanery-wide trainee survey where 4.8% of foundation doctors felt valued by NIMDTA, asked 4 months into their role in December 2019. This notable improvement may be affected by longer survey lag and low response rate to the annual optional survey (n=49 representing 9.6% of foundation doctors). Neither survey ascertained assigned clinical specialty.

We recognise that other workplace factors, ranging from paperwork requirements, reception by clinical teams and workload pressures, could all affect the ‘global introduction to practice’ rating and feeling of value. We filtered results by Trust and noted that the lowest feelings of value by Trust also had low satisfaction with Trust induction. Support sessions identified clarity of clinical roles as an issue in this Trust. Those feeling least valued by NIMDTA occurred in the Trust with a contracted hour grievance which may have impacted this result.

Fourteen of 39 stakeholders identified positive aspects of the initiative and suggested improvements. A similar format in future years was requested although removal of all face-to-face components was considered a negative. Recorded presentations allowed flexibility for presenters’ schedules. Support sessions with submission of anonymous questions allowed reporting of concerns. One notable positive outcome was the level of FY1 engagement. They contributed significantly to the initiative, gave valuable insight, and reported afterwards that they felt included, appreciated that their voice was listened to and their knowledge respected.

**DISCUSSION**

The complex challenges posed by the COVID-19 pandemic have made all organisations change their processes with some advantageous effects. We saw increased cohesiveness of teams willing to work tirelessly at a fast pace to deliver a project within a very tight timeframe. We saw collaboration across organisational silos to create improvements that had been slow to advance previously such as the streamlining and regionalisation of mandatory online learning required of Foundation doctors.

**Lessons learnt**

The ‘new COVID-19 way’ may not be the optimal way to integrate doctors into healthcare but results have highlighted that a compassionate leadership approach can create a welcoming introduction to the workplace and positive well-being outcomes.

One particularly successful aspect of the process was the ‘What matters to you’ appreciative inquiry with the FY1 doctors. Cultivating collaboration and promoting an improvement ethos encouraged FY1s to engage with the project, creating ‘Quick Guides’, presenting at regional induction and taking lead roles in follow-up support meetings. This near peer support was a tangible reflection of collegial community while visible senior leaders contributed to a feeling of appreciation of the FY1 role. Continuing with the VALUED ethos, we applauded the FY1 contribution afterwards. FY1 feedback on the project showed they felt heard, respected, appreciated and enjoyed the leadership opportunity.

The COVID-19 pandemic has highlighted that by working collaboratively we can tackle complex challenges with compassion that reaps rewards for the doctors in training, as well as for
the organisations which committed to improvement during these uniquely challenging times. This project highlights the positive outcomes of such an approach, and we hope that this ethos can be established in future initiatives. Although survey results were obtained too late to enable change in this year’s FY1 regional induction, lessons learnt have been discussed with the team to inform future induction programmes. E-learning requirements did not require repetition for FY1. Further analysis of the FY1 initiative is being undertaken nationally by Newcastle University.

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REFERENCES


