CRITICAL STAFFING #3

A best practice framework for RETURNING TO WORK

September 2022

What is the Critical Staffing series and who are they for?

The Critical Staffing series brings together recognised and practical 'Best Practice Frameworks' on staffing. These frameworks have been produced to guide commissioners, hospital management and critical care teams. They provide a resource for individuals from across the multi-disciplinary workforce as to what they might expect from their directorate and employer.

Critical Staffing is a three-part series. The first and second in the series are:

1. A best practice framework for safe and effective Critical Care Staffing
2. A best practice framework for wellbeing and sustainable working in Critical Care

What is Critical Staffing #3 covering?

This framework explores the many reasons why time away from work is taken. It uses vignettes to demonstrate some of the difficulties that individuals have experienced during the return-to-work process and highlights examples of good practice that could support a successful return and improve the overall experience.

Returning to work following a physical illness may require different adjustments to one following mental illness.

Changes in the working environment whilst someone is off work will add to the burden of their return and is frequently under appreciated.

The framework will prove useful for managers and their staff, ensuring that the return-to-work experience is positive.

CONTENTS

What is the Critical Staffing series and who are they for? **2**

What is Critical Staffing #3 covering? **2**

FOREWORD **4**

EXECUTIVE SUMMARY **5**

1.1 Why this is essential for every unit 6

2. EXECUTIVE PROTOCOLS **7**

2.1 What is an executive protocol? 7

3. EXISTING STANDARDS AND BEST PRACTICE RECOMMENDATIONS **8**

4. THE ROLE OF OCCUPATIONAL HEALTH **10**

4.1 Occupational Health Assessment 10
4.2 Occupational Health Report 10
4.3 Reasonable adjustments 10
4.4 Phased return to work 11
4.5 Other issues in Occupational Health 11

5. PERSONAL EXPERIENCES OF RETURN TO PRACTICE **12**

5.1 Maternity Leave 12
5.2 Burnout 12
5.3 Bereavement 15
5.4 Physical illness 15
5.5 GMC referral 16
5.6 Carer Responsibility 17
5.7 Return after working abroad 18
5.8 Reflections from a senior NHS manager 19

6. PRIMARY AND SECONDARY PREVENTION **20**

6.1 Consultant and Specialty Doctors and Associate Specialists (SAS) job planning post return 20
6.2 Consideration of Flexible Training for Trainees 20
6.3 Support for staff with caring responsibilities 21
6.4 Support for staff returning after maternity, paternity or adoption leave 21
6.5 Financial considerations 21
6.6 Dealing with Complaints and Concerns 22
6.7 Other primary prevention resources 24

7. SECONDARY INTERVENTIONS: Additional support for staff in need **25**

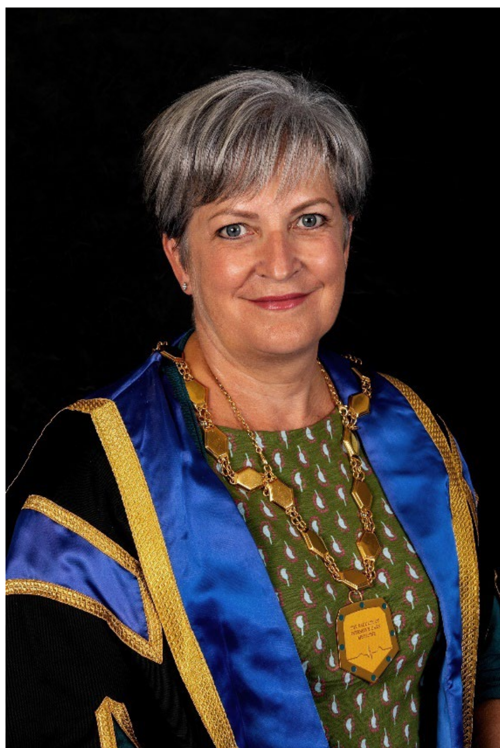
7.1 Other Resources 25

8. CONCLUSIONS **26**

ATTRIBUTIONS **27**

USEFUL RESOURCES **27**

FOREWORD



Staff are our most valuable resource, making it vital to recruit and retain the best people to care for the critically ill. There may be situations that necessitate time off work for reasons other than annual or professional/study leave. Providing appropriate support for the return-to-work process is essential to avoid having a negative impact on the individual, resulting in them feeling that the only solution is to leave. Compassionate leadership will make the organisation a more attractive place to work and helps protect individuals and the wider workforce.

We started the pandemic on a background of staff vacancies and, although people have been attracted to work in the NHS, many trained critical care staff have left due to their experiences during the pandemic. Some staff may have been considering a change in career before COVID. Others may have required time off work and struggled to return to work successfully. Whatever the reason, it is now more important than ever to personalise the approach in supporting a return to the working environment. No two experiences will be identical. The speed at which a return will be successful will vary and whilst recruitment to critical care remains challenging, retaining the staff we have and embracing a flexible approach will benefit everyone.

This is the third document in a suite of 'Critical Staffing' publications aimed at providing practical best practice frameworks to help support safe, effective, and sustainable staffing in critical care. The pandemic response necessitated a dramatic change to ways of working and, whilst some staff have already left, there is an opportunity to utilise this framework to help successfully reintegrate staff back into the working environment now, and in the future.

Dr Alison Pittard
Dean of the Faculty of Intensive Care Medicine

EXECUTIVE SUMMARY

The response of critical care services and staff to the public health threat of COVID necessitated unprecedented changes to staff working. The effect on staff members' mental and physical health, as well as their emotional wellbeing are increasingly recognised. "Moral distress" has entered the lexicon for good reasons. Critical care services need to be engaged in mitigating the longer-term impact of necessary emergency responses but also to plan for a future beyond this pandemic, whilst also being better prepared for others.

The Faculty's report after the COVID pandemic's first wave, *Voices from the Frontline* identifies what stressors were present, and how some people and departments went on to meet them. However, it is also clear that many of those stresses of working in critical care services existed pre-pandemic and will continue to exist in a future post-pandemic critical care environment. Some of these stresses are related to the core essence of critical care. That is not to say that we can't reduce them and help make the positives of working in critical care outweigh the negatives. We need to increase those positives and this needs to include a framework for those returning to work; to support those who, for whatever reason have had a period of time away. This is likely to be even more important as we exit this pandemic especially considering increased numbers of staff trying to return to the critical care workplace.

There are a wide variety of reasons why people may be returning to work. We have used vignettes, written by those with personal experience to illustrate good and bad practice. We hope that these help guide departments and individuals on how to best support those returning to work in critical care units.

Maintaining and increasing necessary staffing numbers requires both recruitment and retention. Supporting those returning to work is an essential component of this. Good visible supportive structures are crucial to staff returning to work and may possibly stop some needing to step away in the first place; avoiding the need to return to work by better supporting people in work. Retention of clinical staff in critical care is absolutely essential to our modern workforce.

1. INTRODUCTION

1.1 Why this is essential for every unit

> *"Designated bodies and their Responsible Officers, doctors, employers, contractors and regulators all have a responsibility to ensure that an appropriate process is in place and is followed for a doctor's return to practice to safe guard patient safety."*

Return to Practice, Academy of Medical Royal Colleges, 2017

Many of us working and training in critical care medicine have worked in departments where we feel appreciated and if it was ever necessary, feel we would be well looked after by the department. This feeling is often difficult to put a finger on; it may be one or two colleagues, the staff room atmosphere, or regular social events. These are key indicators of functioning, supportive departments.

This third in the series of 'Critical Staffing' however is on 'Returning to Work' after an absence. It outlines the responsibilities of the employer to you, if for whatever reason you have a period of time off work. Although parental leave is common, and referral to the General Medical Council is not, there are common themes in returning to work. Directorates and hospital managerial structures have a duty of care to you. These structures should be visible and signposted within departments such that people are aware that their needs would be catered for and can point others in the right direction if necessary. Knowing about these structures is important to enable a well-managed return to work.

The amount of time taken off is important. The longer someone is off, especially any period over two years, the harder it becomes to return successfully, and more support structures will need to be put in place to successfully manage their return.

To return to the same place of work can, in some instances be very difficult. For some people, it may be better to completely change the place of work to a new Trust or Health Board, but still remain working in critical care. Recognising this is important. People trained in critical care medicine are of great value and returning to work for many of us gives additional meaning to our lives. We should not be taken for granted, and when necessary, changing where we work may be the best way to keep us in the workplace through to our retirement.

We hope this document helps critical care directorates put structures in place with the necessary involvement of higher hospital management, including clinical leads, educational supervisors, workforce leads and medical directors to successfully manage the return to work.

These structures do not replace those human touches that colleagues can bring to people who are off work and looking to or have returned to work after an absence. Human kindness, compassion can be seen in many of the "Experiences of Returning to Practice" which movingly describe how tough it can be, how brave these colleagues are, and how crucial their colleagues can be to a successful return. The importance however of visible structures and processes in managing a return-to-work also need to be clearly in place.

2. EXECUTIVE PROTOCOLS

2.1 What is an executive protocol?

An executive protocol frames the standards, recommendations, prevention techniques and interventions into a succinct checklist so you can check that you are managing the risks with due diligence. Protocols can be used by line managers (for example by Clinical Directors, Clinical Leads, Educational Supervisors, Directorate managers etc.) and also for individual employees in the critical care team to identify their own risks. These protocols are only a framework to ensure good practice and do not negate the importance of kindness, understanding and good human relationships.

PROTOCOL FOR DIRECTORS, MANAGERS AND COMMISSIONERS OF CRITICAL CARE	
Consideration	**Management/Mitigation**
Directorates should increase awareness of the Terms and Conditions of Employment in relation to maternity/paternity/ adoption/and shared parental leave	**Yes/No**
Directorates should ensure that those returning from maternity/paternity leave have a designated consultant available to support and advise during the first three months of their return to work	**Yes/No**
Clinical line managers should ensure availability to those retuning to work of any significant changes and developments to guidelines, procedures or equipment made during their absence. These should be made available electronically.	**Yes/No**
Depending on the reason for being off work it is recommended employers offer 'shadowing' to employees returning to work. Keeping in Touch (KIT) days	**Yes/No**
Directorates need to prepare for returns, identify issues, agree the processes, and help put appropriate, targeted, and proportionate support and training in place. Directorates should facilitate the return to work of employees.	**Yes/No**
As part of clinical governance, Responsible Officers (RO) need to ensure there is proper evaluation and support of doctors who return to practice to ensure their safe return to the workplace.	**Yes/No**
Appraisers may help identify and resolve issues affecting the returning doctor and ensure correct processes are being followed.	**Yes/No**

3. EXISTING STANDARDS AND BEST PRACTICE RECOMMENDATIONS

Pre-Return to Working in Critical Care Checklist

(adapted - Academy of Medical Royal Colleges, 2017)

To be undertaken at least 4 weeks prior to returning to clinical duties.

STANDARDS
How long has the staff member been away from ICM?
Has the absence extended beyond that which was originally expected? If so, what impact has this had? (If it was an unplanned absence, the reasons may be important)
How long had the person been practicing in ICM and the expected role they are returning to prior to their absence?
What responsibilities does the doctor have in the post to which they are returning? In particular, are there any new responsibilities?
How does the person feel about their confidence and skills levels? Would a period of shadowing or mentoring be beneficial? Do they have a mentor?
What is the doctor s full scope of practice to be (on their return)? What is their on-call commitments? Is there a nominated consultant they can speak to?
If the doctor is returning to practice but in a new role, what induction support will they need and will they require any specific support due to the fact that they have been out of practice? What can the doctor reasonably do to prepare themselves?
What support would the doctor find most useful in returning to practice?
Has the doctor been able (felt able) to have relevant contact with work and/or practice during their absence e.g. Keep In Touch' (KIT) days?
Have there been any changes since the person was last in post? These changes need to be outlined by the person managing the return to work: The need for training such as for new equipment, medication, changes to infection control, health and safety, quality assurance, other new procedures, NICE guidance, or any mandatory training missed etc. Changes to common conditions or current patient population information? Significant developments or new practices within ICM? Service reconfiguration in the department? Changes to procedures as a result of learning from significant events? Changes in management or role expectations? Are there any teaching, research, management, or leadership roles required? These may well need to be deferred until the person is back into their mutually agreed job plan and are settled.

Has the absence had any impact on the person's licence to practice and revalidation? What help might they need to fulfil the requirements for revalidation? Is their responsible officer (RO) aware?

Have any new issues (negative or positive) arisen for the doctor since the doctor was last in practice which may affect the doctor's confidence or abilities?

Has CPD been possible in preparation for a return to work. This can be useful in assessing concentration and helping to improve confidence. The expectation that someone has been able to keep fully up to date with CPD while absent may be stressful or unrealistic, depending on type of leave needed.

If the doctor is a trainee, what are the plans for a return to learning? Are there special considerations related to their training? Is their educational supervisor aware and what clinical supervision is in place?

Is the person having a staged return to work on the advice of Occupational Health?
Has anyone else been involved in their return to work e.g. clinical psychology, General Practitioner, or Practitioner Health programme (PHP)?

Are there any issues regarding the person s next appraisal which need to be considered? Is the revalidation date affected? (If either applies, the Responsible Officer/ appraiser should be informed)

Are there other factors affecting the return to practice or does the doctor have issues to raise?

Is a period of observation of other people's practice required and/or does the doctor need to be observed before beginning to practice independently again? e.g., joint ward rounds, practical procedures, talking with families

Will the doctor need training, special support or mentoring on return to practice? If so, are there any funding issues related to this which need to be considered?

Signatures

Doctor .... *Date* ....

On behalf of the organisation .... *Date* ....

4. THE ROLE OF OCCUPATIONAL HEALTH

Most healthcare organisations have a policy to be followed when someone is off work with health-related issues and when they are ready to return to work after an absence. This policy will frequently include a routine referral to Occupational Health (OH) to evaluate fitness to return to work and any recommendations to facilitate a sustainable return. In many cases, early referral to OH can promote a positive outcome by ensuring the staff member receives a holistic assessment and timely advice regarding available support. In addition, absence may be prevented or shortened in duration or frequency by considering OH recommendations on adjustments and restrictions.

4.1 Occupational Health Assessment

OH is a clinical specialist service for supporting staff and advising employers. It uses evidence-based assessments and adjustments to promote efficient participation and attendance at work and provides advice on balancing workplace demands with the functional capacity of individuals affected by health conditions. OH can help organisations understand how to support workers in returning to work and undertaking work activities effectively and safely. An OH assessment can usually be arranged through a Management Referral or self-referral. The clinician will take a history and examine the worker, focusing on functional capacity, and impact of health on work, or work on health. All types of health conditions can be assessed by OH. Where further information via a medical report and liaison with the GP or Specialist would be appropriate and helpful, the OH clinician will arrange to do so with the individual's consent. Signposting to in-house support if available, such as counselling, physiotherapy, or referral to external relevant services such as the drug and alcohol team is often part of the OH process.

4.2 Occupational Health Report

OH doctors, nurses and therapists are bound by the same duty of confidentiality as other healthcare professionals. Reports produced by OH focus on fitness for work and will contain minimal medical detail in order to preserve confidentiality. With the staff member's consent, they will share a report with the referring manager and/or HR, outlining their functional assessment and fitness for work, what work tasks they can and cannot undertake and recommendations on adjustments, on a temporary or permanent basis. Reports may also include a statement on the likelihood of the applicability of the Equality Act 2010 which legally requires employers to make reasonable adjustments for employees with disabilities or health conditions.

Further information about reasonable adjustment for workers with disabilities or health conditions within the provisions of the Equality Act can be accessed here.

4.3 Reasonable adjustments

Depending on the nature of the absence and the objective functional capacity of the worker, OH reports will typically recommend workplace adjustments, to help overcome any obstacles to returning to work, and supporting the worker to remain at work. These may include changing the worker's working hours, duties or tasks, place of work and equipment. OH has an advisory role and it is ultimately for the employer to determine whether the recommendations are practicable, managers should ensure they understand their obligations well and therefore give careful consideration to each individual case. You may want to view the Equality and Human Rights Commission on workplace adjustments here.

4.4 Phased return to work

Returning to work after any prolonged time away is almost invariably surprisingly physically, mentally, and emotionally exhausting. Because of this a phased return to work may be recommended if considered beneficial to the worker, considering both hours and tasks. The aim is to gradually increase duration and complexity over a defined time, typically four weeks, with regular review, working towards full duties.

4.5 Other issues in Occupational Health

There will be an absence management policy (or policies) which staff and directorate management should be familiar with. It is important for those that have had time-off work to try and understand that meetings, referrals to Occupational Health etc. are routine. This can be difficult, but the idea is that such policy is designed to be helpful to both worker and manager, and should not be seen, or imagined as 'punishment'.

OH can be a helpful partner for the development of People and Organisation, right from the stage of policy development to wider engagement of the workforce. OH coordinates health surveillance programmes, like skin surveillance and health promotion initiatives such as smoking cessation. OH can provide valuable insight into areas of concern in the organisation from a health and wellbeing perspective and help offset or manage any associated evolving risks.

5. PERSONAL EXPERIENCES OF RETURN TO PRACTICE

5.1 Maternity Leave

"During my training in ICM and anaesthetics I have taken three periods of maternity leave. Each of my return-to-work experiences have been quite different and they have given me the opportunity to reflect on the positives and negatives that I experienced during these times.

The return from my first maternity leave was undoubtedly the most positive. The key difference between this and subsequent returns was that I returned to the same department in which I had been working prior to going off. It was a very sympathetic, friendly department and I had been part of it for some time. They had already expressed support for my desire of returning less than full time (LTFT). I was given time to re-adjust on my return, I was doubled up for theatre lists and I did not have any on call commitments for the first two weeks. Consequently, I felt well supported and secure whilst I regained confidence in my abilities and adapted to the 'new normal' routine.

Unfortunately, I do not feel able to view my two subsequent return-to-work periods after maternity leave in the same positive light. On both occasions I was moved to a new hospital whilst I was on maternity leave and every time, I moved to a different hospital I was expected to re-apply for LTFT training. On one occasion I was informed by the new department that whilst I could work LTFT in anaesthesia, I would be required to work full time for blocks in ICU or maternity. The prospect of intermittently having to find additional, short-term childcare for multiple children gave me sleepless nights and was the source of great stress during the latter part of my maternity leave. After many discussions and with some assistance, I was able eventually to feel secure in the knowledge that LTFT really meant LTFT and not intermittent FT/LTFT. These discussions did not leave me feeling particularly welcome within my new department. In addition to dealing with all the usual stresses associated with a return I was trying to find my way around a new hospital, learning new faces and feeling under pressure to appear capable at a time when my confidence in my abilities was at an all-time low.

During my third maternity leave I wanted to speak up and say that I was unhappy with changing hospitals again at this stage however I felt under pressure to not appear to be "difficult" and so once again I found myself returning to a new department. I view myself as being reasonably resilient and I was determined to put a happy, smiling face on it all, knowing that it does get easier with time. It was, however, immensely challenging, and my façade slipped when a consultant found me in tears in the changing rooms one day. I wish I had spoken up and not allowed myself to be put in that position. To date I still count it as one of the most stressful times of my working life and not one that I would want to repeat."

5.2 Burnout

"I did not see it coming. The stationary driver pulled out onto the roundabout at the exact moment I cycled past. It was true – everything slowed down and I clearly remember the back of my head smacking into the road. I thought I had had a lucky escape until a few months later when my right arm became unbearably painful.

In hindsight, after the several months off work and the time taken for the neuropathic pain to settle, my return-to-work plan was naively vague, unstructured, unsupported, and too short. I struggled. Everybody was so busy, and some colleagues seemed resentful at how much time I had been away. I struggled mentally as never before with the level and speed of decision making required and the sheer cognitive load of a ward round. In my mid-50s, I struggled physically, particularly with nights on-call; I would still be recovering from the previous night by the time the next one came along.

I did not see it coming. Several months after my initial return to work, I put the telephone down and found myself falling. A throwaway comment by a colleague, a bad joke and I found myself falling into a darkness I had never experienced before. As the day progressed everything began to unravel, and I found myself entertaining thoughts that I look back on with horror and disbelief. Burnout, breakdown, crisis, mental distress, or whatever name you want to give it. Ultimately it is an unravelling.

Mountains have been one of the great constants of my life and I was due to go away the following day with old friends from the world of mountain medicine, but what I had been looking forward to with excitement was now the last thing that I wanted to do. I talked honestly with my wife, and we agreed that I should still go but on the condition that I tell my closest friends in the group what had happened and the thoughts that I had experienced. My friends' response was overwhelmingly supportive, but they laid down a challenge. No job or career should destroy you.

The mountains brought clarity and perspective. I had wanted to be an intensivist from my first weeks as a house officer some 30 years previously, but no job was worth the cost that ICM was now exacting. After discussion with my wife, we agreed that I had to step away from ICU. I was dually accredited and had spoken previously with management about taking up anaesthetics again. Their previous unsympathetic response to my suggestion that I should step back from night-on-calls should have alerted me to what was to come. As doctors we are trained to diagnose and implement effective treatment and yet despite the cause of my problems being clear and the solution obvious, the unwillingness of management to explore a safe way of me stepping back from ICU remains profoundly shocking. Despite all the lip service given to wellbeing, service provision, perhaps understandably, will always be middle management's priority but at what cost to a highly trained and dedicated workforce?

An unpleasant battle ensued lasting several months. My GP signed me off work with the very clear reasoning that if work had precipitated the problem, it would be dangerous to return to an unchanged environment. I referred myself to our Occupational Health Consultant shortly before he retired who in turn referred me on to the last remaining NHS Occupational Health Consultant in Wales. Their support proved crucial. I also sought out a private clinical psychologist, specialising in the care of doctors and she acted as a vital, objective sounding board. Her professionalism enabled me to keep perspective at a time when management's refusal to countenance a solution that was clearly needed felt increasingly like gaslighting. The opportunity to explore the strong feelings, including a sense of personal failure, at the prospect of giving up ICM was exceptionally helpful.

The next few months were a pointless and vicious circle of frustration with management unable to coherently explain how I was to continue in ICM and yet follow the unequivocal advice of my GP, two Consultants in Occupational Health and a Consultant Clinical Psychologist. The head of Human Resources wanted to refer me to see the Occupational Health nurse, presumably in the belief that they would give a different opinion that would suit their agenda. I refused and in frustration asked to see the Medical Director who told me that it was his duty to abide by whatever opinion an Occupational Health Consultant gave him. He saw no barrier to returning to anaesthetics and told how he himself had had to step back from on-call work a few years previously.

My return to work as an anaesthetist was a model of good practice – an identified and sympathetic consultant to supervise my return and working with only a few other, designated consultants to begin with; a clear and slow buildup of my working week and regular meetings to assess progress. My anaesthetic colleagues were unfailingly welcoming and supportive. I continued to see my clinical psychologist throughout this process and the opportunity to reflect on a variety of strong emotions - going back to learning with its consequent loss of autonomy; the perceived loss of professional prestige as an ICU consultant; stepping away from the specialty that I loved – was immensely useful.

Did it work? The biggest confirmation came from my daughter, then 10, who said that she liked the fact that I had given up ICU because I was so much less tired compared with how I used to be and did not get irritable anymore. Of course, COVID changed all that as it did for all of us, but that's another story…"

So what have I learned from these experiences?

1. When you do begin to step back and look at your work and its place in your life objectively, be prepared for some uncomfortable but ultimately liberating surprises. As the Franciscan Richard Rohr points out, *Life is made up of many failings and fallings, amidst all of our hopeful growing and achieving."* This truth has been recognised in the wisdom literature from multiple cultures, yet it sits very uncomfortably within our Western philosophy of unrelenting progress and personal success which modern medicine embraces, affirms, and encourages. Times of crisis and unravelling can become the source of our greatest growth if approached with courage and appropriate support.

2. Many of us work while chronically sleep deprived and subsequently exhausted without realising it. Chronic tiredness robs of us our perspective and makes us dangerously vulnerable to deteriorations in our health. There is a reason that sleep-deprivation is a recognised method of torture. The restoration of a healthy sleep pattern through giving up night working was profoundly restorative for me.

3. It is important to look for physical pathology and the best person to do this is your GP. We are psychosomatic beings, and our physical and mental health are intrinsically linked.

4. Swiss cheese holes can line up when you least expect them. We can run on empty for a long time and get away with it, only to be suddenly caught un-prepared. The last thing I was expecting on the day before a long-anticipated ski trip was for things to fall apart as catastrophically as they did. A sudden unravelling can be precipitated by the most seemingly insignificant trigger.

5. Despite all of the talk about wellbeing in the NHS, in many situations it remains just that: talk, and a target given for managers with no real understanding of the subject. If it comes to a choice between your wellbeing and maintaining a rota, do not expect management to put your wellbeing first.

6. We can be remarkably inflexible in medicine. In industry and business somebody with the seniority of a consultant may reinvent themselves several times during their career and yet the idea that I could move back into a specialty that I had trained in, passed professional exams in and held a CCT in was greeted with incomprehension by a number of people.

7. There are good ways and bad ways of facilitating a return to work. I have experienced both. For a return after any prolonged period of absence to be successful I believe it should be deliberately conservative, clearly structured and there should be identifiable people who have been mutually agreed to support the return. There should be safety nets in place which provide permission for things to go wrong and a creative approach to assessing progress, particularly in the early days of a return to work, which will facilitate the process.

8. The support of family and friends is obvious, and the support of my wife was central to coming out the other side of this process stronger and healthier; nevertheless it is frequently our partners who suffer the most when things fall apart. Because of this, a professional who is external and can be objective about the situation and your emotional response is crucial.

9. Interests outside of work and regular exercise are very important. For me, getting out into the mountains and photography were two key factors that enabled me to retain perspective and to nurture gratitude for life. This is pivotal in any healthy recovery.

10. It is a sad reality that the NHS is grossly under-resourced for what it is expected to deliver and the expectations of some of the patients using it grow increasingly unrealistic. There comes a point when you have to accept that it is very difficult to provide the standard of care for your patients and the quality of education for your trainees that you would like and have always aspired to. Without acceptance of this inconvenient truth, you risk being perpetually unhappy working in the 21st century NHS.

5.3 Bereavement

"There is no 'top trumps' of bereavement and how it affects people. My first husband died on the ICU where I worked: I had been a consultant for just over a year and hadn't trained in the region so was without an immediate support network. It was traumatic for everyone involved – both family and the clinical team, it's just that I was the one most obviously bearing the burden of coming to terms with it. All the 'usual' bereavement processes kicked in after his death and I was spared much of the administrative burden of that first few months.

I thought I was ready to return 6 weeks after his burial and that my colleagues shouldn't be continuing to carry me: I was an unreliable witness. I hadn't been forced to consider how I would feel about being in work as an ICM doctor, which might have helped me recognise how damaged I was. Doing a ward round and unable to make decisions for a patient in 'his room' made it painfully clear to me in that first week back that I wasn't anywhere near ready. A long period off work was needed dealing with post-traumatic stress disorder and a complicated bereavement reaction before I could face trying again.

During this second period, my colleagues (medical and nursing) kept a link. Lots of them just 'touching base'. It was the random acts of kindness and normality that stay with me. The nights eating take away pizza with a colleague's family watching TV, the walks in the park, and the coffee shop conversations or invitations to supper with no obvious greater purpose than just to see me. In a time of upheaval, it was the normality, the quiet, unsaid demonstrations that there can still be another Act, at a time when I felt my future had come to a full stop.

It takes time to adjust (years not months). My colleagues had incredible patience and tolerance. They were supportive, interested in the things I was doing whilst off work and never directly asked me about the future or if I was coming back. They kept me up to date with work gossip and developments, all of us assuming I would be back 'at some point'.

When I came back to work, I was not myself. But there is a difference between my clinical capability which returned more reliably on this occasion and my healing which took much longer. My colleagues understood that. My return to clinical duties was supported by always working with a colleague and another 3-6 months before I was put on-call. Work patterns were adjusted so that I contributed as a recognised consultant member of the team, but not put in a position where I was potentially exposed to something that might be a trigger event. It took somewhere between 18 months and 2 years before I was back on unsupported on call and a year after that before I felt ready to actually lead on anything for the unit. That coincided with being signed off the books by the psychiatrist who had been working with me for 3 years. Revalidation had not been introduced then, but I remember having no problems with collecting information I needed for appraisal in this time.

I would not be where I am now without my colleagues. It's their decency and quiet support at a time when they must have wondered if I'd ever come back that I remember."

5.4 Physical illness

"I am a consultant in intensive care and anaesthesia. I also have pathological myopia, and because of this, I've had two retinal detachments in my left eye, and a cataract in my right. In October 2017, I developed a retinal haemorrhage in my right eye (my 'good 'eye) which rendered me visually impaired – unable to drive, to read anything further than 5cm from my left eye, and certainly unable to work.

I had previous experience of returning to work after maternity leave. The process of returning to work this time felt very different. Unlike with maternity leave my employers and I had no opportunity to plan being off work, and it wasn't clear for some time whether I would ever be able to return to my previous clinical role.

I was diagnosed with myopic choroidal neovascularisation and received a course of three intra-vitreal injections of anti-VEGF treatment. Three months after my bleed, my vision had improved sufficiently that I was able to come back to supernumerary clinical work. I was referred to our Health Board's occupational health service who told me vision issues fell under the Equalities Act, which meant my employer was obliged to make 'reasonable adjustments 'to accommodate me.

My clinical directors in ICU and anaesthesia were more than willing to do whatever was needed to allow me to return to practice. I was told I could be doubled up in theatres with another consultant for as long as I felt it was necessary. In the end I had 4 days doubled-up in theatre before returning to solo practice. At that time in our ICU we had 2 consultants on during the day, so I was able to spend several months building up my clinical confidence doing daytime work, with a colleague on hand to help if needed. Six months after the bleed, I was able to return to on call without needing any adjustments to my working pattern or nature of work.

If I were to pick out examples of excellence in the way my return to work was handled, I would highlight:

- My line manager's communication with me was frequent enough to make it clear they were keen to support me in whatever way they could – but I never felt I was being hassled back to work.
- Early referral to the occupational health service gave me an opportunity to learn about possible modifications my employer could make to support a return to work and allowed me to imagine what this might involve.
- My phased return to work was treated as a flexible plan, with an expectation that it would need to be modified as needed. In the event no such modification was required but knowing that it was possible was incredibly reassuring."

5.5 GMC referral

"In 2016 I was handed over the out-of-hours care of a deteriorating critically ill patient. Conflict existed both within the patient's family about what was in the patient's best interest, but also conflict between some members of the family and the day consultant colleague. The day consultant had contacted the Health Board's Complaints and Legal team and made a plan to move to end-of-life care. In good faith I followed this advice.

The patient's spouse put in a complaint. Over the next few months, I took part in correspondence with the Health Board's Legal team. They confirmed they would defend their legal position. However, later that year they performed a U-turn, and I was referred to the GMC by the medical director citing issues with my communication.

When the GMC released their pack of information to me in 2017, I discovered that the information provided by the Health Board's legal team to my colleague had been a shambles, and the legal advice did not follow GMC guidance on dealing with conflict. The GMC investigation took two years, and the case was closed without action against me; given that I had demonstrated learning.

The experience undermined my whole expectation of how leadership in an organisation dealt with adverse events, choosing to place blame on the team member at the sharp end, rather than the root cause.

I largely managed to keep working through the whole GMC referral, but felt under severe distress, suffered sleep disturbance and confusion about the Health Board's mixed messages and lack of transparency. Following the GMC outcome, I raised a grievance with the Health Board to clarify what went wrong and how things could be improved. As this dragged on, lasting 11 months I lost confidence in my employer,

resulting in sick leave for 2 months and a subsequent phased return to work. Shortly after my return I decided to leave the Health Board and took up a consultant post at the tertiary hospital in a near-by Health Board, where I work now and am very happy.

During this experience there were a number of things which I found helpful. Not all were as I returned to work, but overall they kept me going and eventually back to work.

Health for Health Professionals (HHP) in Wales offers a free, confidential service that provides NHS staff, students and volunteers with access to various levels of mental health support https://hhpwales.nhs.wales.. Through them I met with a cognitive behavioural therapist who was able to talk through what I was experiencing and ways to cope.

Seeing my GP was useful to allow them to assess me (rather than relying on my own opinion) that I wasn't suffering with depression, and able to provide some short courses of medication to help me improve my sleep pattern.

Later seeing a psychologist through the Health Board who was able to contextualise what I was experiencing and help me understand that we have a relationship with our employer. We discussed the benefit of getting back to work, given that long absence could lead to higher chance of never returning, and also the need to feel safe within an organisation.

Finally, the decision to leave the Health Board. This hadn't been something I wanted to do, as I had a great working relationship with many colleagues, and I'd always wanted to work in that unit. In many ways, I left this decision too long because I hadn't even considered it. Ultimately moving on meant I could leave behind the struggle to engage with the Health Board and start a new relationship with a different employer."

5.6 Carer Responsibility

"In 2013, while on a night shift in ICU, my wife called me in tears. She was hearing voices telling her to harm herself, and in her precise words "I have a knife in my hand, and I don't know what to do". At the time I was an ST6, dual training in ICM and anaesthetics. I called my consultant and said "I'm going home to my wife. She's suicidal. I don't know when I'll be back"

He said "Go. Don't come back until she's okay". I did what he said and did not return fully until 2017.

Being a carer for someone with significant mental illness is quite challenging, and something I had never envisaged doing before. There were pulls in multiple directions - work expected me to return (as I wasn't the sick one); family expected me to work and couldn't understand why every time I tried to return to work my wife deteriorated and became more unwell; family struggled to understand her illness, and really struggled with being respite carers; and I struggled with the loss of my purpose and identity.

The time away involved a lot of therapy and trips to psychiatrists. Medications were started, stopped, and adjusted. Multiple side effects were managed.

And one day – one day – she felt safe enough for me – for us really, to return to work. Reflecting on it now, I didn't find the return daunting in a "traditional" way. During my time as a carer I had found an outlet through the Free Open Access Medical Education (FOAMed) movement – I was writing for some major outlets (Life in The Fast Lane, The Bottom Line), and as a result had kept remarkably up to date with the literature.

My main concerns were about the technical aspects (could I remember how to intubate!); but more importantly, I was most worried about getting "that phone call" again.

So my wife, our psychologist, and I made a safety plan. I would always have my phone on, and my wife would have multiple coping strategies. I also had to pick the right job, that would allow flexibility for me to leave anytime I needed.

I found the right job in Basingstoke ICU, where they employed me as a clinical fellow. I had a built-in graded return with no on calls. Over three months I gradually built up to full time working, and my wife and I were able to cope. Before I knew it, I was in full time work, and a year after successfully re-applied to return to training.

My biggest lesson in all of this? A return to work can't be rushed. Before my successful return I had tried on 3 other occasions to return, all of which ended in abject failure as my wife's depression and suicidal ideation aggressively worsened.

As a late-stage trainee, I could appreciate the efforts and focus of many of my mentors, trainers, and colleagues to get me to return soon - I do wonder if that haste and focus on "me" and my career was detrimental: rather than focusing on my wife and me as an 'us' and thinking about how we could cope together.

Interestingly, everyone (including me) focused on the procedural worries about getting back to work. On my first day I placed an ultrasound guided subclavian line successfully despite not having done one for 4 years. I guess it really is like "riding a bike".

I did do some courses – an ALS course, a resuscitative ultrasound course, and a national ICU meeting (ICS State of the Art) a month before I started again. I think they were helpful. A lot of the procedural stuff was muscle memory, and required a little bit of fine tuning – nothing more.

One of my biggest challenges coming back was actually cultural. In my time away, I had grown, and learned about the sometimes toxic culture of hospital work. I had gained new insights and how I often contributed to that culture. Returning meant looking deep into myself and not tolerating some things I would have before- like misogyny or racial micro-aggressions. Stepping up to challenge these behaviours is something I still find very difficult.

I am no longer a carer. My wife has made significant improvements in life and has made amazing strides through her pain. We talk a lot more and are more cognisant of our mental health. I do worry still about working in the NHS. I worry that I will return to the person I was: a highly focused doctor but unfortunately neglectful husband who ignored his wife's mental distress, and only noticed when it threatened his career. I still worry about getting "the phone call". Sometimes I dream about it.

If the phone call ever came, I would do exactly the same thing as last time. I would go to her. As wonderful as medicine is, sometimes it really is just a job- and needs to be put in its place."

5.7 Return after working abroad

"I have returned to work a number of times for a few different reasons. The time I surprisingly found most difficult was when I returned from six months in Australia, working as a neonatal and paediatric ICU retrieval registrar. I went at the end of my ST5 year and had really enjoyed my time 'out of programme' despite being away from friends and family, as well living on the other side of the world doing a very stressful and demanding job.

I returned to the UK in February and was placed in a hospital which involved a 100 mile commute each day. The initial few weeks were really hard, and took a lot of settling in. With retrospect I think there were signs that I was struggling, and I probably should have been aware of this and sought out help - I found it really hard to get to work on time, I was tearful at home and very tired indeed.

Once I had adjusted to life back in the UK and the NHS I enjoyed my placement, but I did find the adjustment harder than expected.

The other times I have returned to work (twice after maternity leave, once as a trainee and once as a consultant and after a break for elective surgery) felt much easier as I realised that I did need a little extra support and guidance. I took part in the 'return to work' course after my first maternity leave (it had just been set up), so I was very lucky to have that resource. Also, I planned my future returns better by thinking about things like supervisory needs and goals and potential problems I might encounter which made me better prepared for a safe and happy return."

5.8 Reflections from a senior NHS manager

"I have managed staff at various grades for over 10 years and have supported staff coming back to work for a variety of reasons. Over recent years some of the most common reasons for longer periods of sickness are stress and anxiety, often with work related elements. Throughout episodes of sickness it is important to keep in touch with the member of staff regularly, this is particularly relevant for staff dealing with stress so that they don't feel isolated from the workplace, friends, and colleagues. Depending on the circumstances, I may also discuss with the individual whether they want updates on work. I have often found people ask "How is work?" but don't actually want to know the answer. Many feel guilty for being off and adding to colleagues' workloads, whilst others worry more about what is going on in their absence so these people may value a brief update.

It is also helpful to help to identify what is causing them to feel this way and this can often be facilitated through wellbeing services. As a return date comes closer, I start to talk to the staff member about how the return to work feels to them and identify any situations that may increase stress levels or suggestions to help the transition back to work. This can be supported with Occupational Heath to develop a phased return or to modify roles for a period of time. This may be for example, only doing a percentage of a shift pattern for a while, only working day shifts when there is more likely to be more senior support available or working in a non-clinical role for a period of time. If there are specific aspects of work that the individual finds challenging, I often find sharing some simple ideas may to help manage this. For some staff it is about feeling overwhelmed with workload, so I can offer support to manage email activity, create tasks or prioritise workloads and colleague requests for example. For any of these phases or modifications it is important to agree with the staff member, how long they are needed for and schedule regular review periods to keep track of progress or modify the return if the staff member needs longer to return.

On the actual day of return I try and sit with the staff member and provide reassurance and welcome them back. It is also an opportunity to complete return to work documents, including reasons for sickness, amount of time off and the return plan is agreed. This should also be added to the personal file so that the sickness can be monitored for frequency and themes so I can discuss this with the staff member and see if there are further actions that are needed to help the staff member to also seek help or support themselves.

This should allow staff to return to their substantive role in a planned way, so they feel supported and valued within the team."

6. PRIMARY AND SECONDARY PREVENTION

6.1 Consultant and Specialty Doctors and Associate Specialists (SAS) job planning post return

Job planning and appraisal should be addressed annually but following a return to work, job planning should be considered more frequently. This should include the cultivation of an individual's talent and opening up of new opportunities, as well as a regular check-in to make sure everything is going to plan.

Individual job plans need to be flexible and take into account an individual's changing needs over their career including with reference to on-call and night-work as an individual ages, or experiences other limiting factors. Following a return to work, elements of their previous work plan need to be considered such as when to reintroduce on-call commitments or working alone.

Resources

- *An Overview of Job Planning*, BMA, 2021. https://www.bma.org.uk/pay-and-contracts/job-planning/job-planning-process/an-overview-of-job-planning
- *E-job planning the clinical workforce*. NHSE/I, 2020). https://www.england.nhs.uk/wp-content/uploads/2020/09/e-job-planning-guidance.pdf.

6.2 Consideration of Flexible Training for Trainees

It is common for doctors-in-training to take approved time out of their training programme. Doctors-in - training returning to work after a period of time away may want to consider whether they want to return to the same intensity of work with regards to the number of hours undertaking long days, nightshifts and weekends on-call.

In the first instance doctors-in-training should get in contact with their Training Programme Director to discuss what will suit them best. The options could include less than full time training at between 50% and 90% of full-time training. Through the Health Education England SuppoRTT programme doctors-in -training are offered a variety of options for supported return to training, including a period of enhanced supervision, funding for a period of supernumerary time, courses, mentoring and/or coaching. Scotland (NHS Education for Scotland) and Wales (Health Education Improvement Wales) NHS offer similar options.

Resources

- *Delivering greater flexibility*. HEE, 2021. https://www.hee.nhs.uk/our-work/doctors-training/delivering-greater-flexibility
- *Flexible Training*. BMA, 2021. https://www.bma.org.uk/advice-and-support/career-progression/training/flexible-training
- *Less Than Full-Time Training*. FICM, 2022. https://www.ficm.ac.uk/trainingexamstrainees/less-than-fulltime-training
- *Supported return to training*. HEE, 2021. https://www.hee.nhs.uk/our-work/supporting-doctors-returning-training-after-time-out
- *How do I apply for LTFT training?* HEIW. https://heiw.nhs.wales/support/ltft/how-do-i-apply-for-ltft-training/
- *Less Than Full-Time Training*. Scotland Deanery, 2022. https://www.scotlanddeanery.nhs.scot/trainee-information/less-than-full-time-training-ltft/

6.3 Support for staff with caring responsibilities

An increasing number of NHS staff have caring responsibilities, making it difficult for these staff members to achieve adequate respite between work responsibilities and caring at home. Support for and policies related to individuals with caring responsibilities should be clearly signposted by Clinical Leads and Educational Supervisors.

Resources

- *Supporting staff with caring responsibilities.* NHS Employers, 2021. https://www.nhsemployers.org/articles/supporting-staff-caring-responsibilities
- *Supporting our working carers*. NHSE/I, 2021. https://www.england.nhs.uk/supporting-our-nhs-people/how-to-guides/supporting-our-working-carers/
- *SuppoRRTive Culture*. HEE, 2021. https://www.hee.nhs.uk/our-work/doctors-training/supporting-doctors-returning-training-after-time-out/supporttive-culture

6.4 Support for staff returning after maternity, paternity or adoption leave

Leave for Maternity, Paternity or Adoption often differs from many other periods away from work in that it can be planned, although timelines and circumstances sometimes unexpectedly change.

During maternity and adoption leave staff are entitled to up to 10 Keeping in Touch (KiT) days. These are optional and do not need to be used consecutively. They can be used for supervised clinical work, attendance at courses, meetings or teaching days and can be taken any time after the first two weeks of compulsory maternity leave but before the staff member is back on payroll (for example on accrued annual leave). KiT days should be prospectively approved by the service lead. In instances where shared parental leave is taken there is also the option for Shared Parental Leave in Touch (SPLiT) days; 20 days can be taken by each parent and the use of these days are similar to KiT days.

Other specific requirements may involve access to a room and time allowed for expressing for those that are still breastfeeding. Health safety guidance relevant to pregnancy continues to be relevant for those who are less than 26 weeks post-partum or are still breastfeeding.

Tragically not all pregnancies result in a happy outcome and for those situations where a baby has been stillborn further advice and support links can be found through Sands (link provided below).

Resources

- https://anaesthetists.org/Home/Wellbeing-support/Career-support/Keeping-in-touch-KIT-days
- https://www.bma.org.uk/pay-and-contracts/maternity-paternity-and-adoption/return-to-work/returning-to-work-and-your-rights-as-a-working-parent
- https://maternityaction.org.uk/advice/continuing-to-breastfeed-when-you-return-to-work/
- https://www.sands.org.uk/sites/default/files/SANDS-RETURN-TO-WORK-BOOK.pdf

6.5 Financial considerations

Individuals and their family finances may play a significant role in the decision of when to return to work. This needs to be taken into consideration when discussions around returning to work take place. Individuals who have worked for less time in the NHS, in particular International Medical Graduate's (IMGs) length of NHS service may significantly impact on their pay and therefore affect their finances much

quicker than those who have trained and always worked in the NHS. IMGs may also have other significant pressures on their financial situation particularly if they have a family and are the only earner.

Similar pressures to return may also apply to doctors-in-training especially early on in their careers. This may impact on mental health and well-being which may be the reason why they are unable to work.

Length of service	Full Pay	Half Pay
Up to 12 months	One month	Two months - if completed 4 months' work
Up to 2 years	Two months	Four months
Up to 4 years	Five Months	Five months
After 5 years	6 months	6 months

Resources

- https://www.juniordoctorfinance.co.uk/sick-pay-for-nhs-junior-doctors/

6.6 Dealing with Complaints and Concerns

An active policy of dealing with concerns and complaints within the critical care directorate may help prevent time off work and provide better support for individuals involved in a complaint. Complaints can be a trigger for staff members to stop working and trigger anxiety, and mental illness including suicide. How complaints are handled and how staff are supported is therefore very important. In ICM, considering the often-traumatic nature of critical care and our patients' outcomes, the number of serious complaints is relatively few. However, those that we do get can be very complex and traumatic for patients, relatives, and staff. Staff should be made aware how complaints are handled within the directorate and hospital. This should be done at induction.

Recommendations

- If any member of medical staff is named in a complaint or concern, then they should be spoken to directly to make them aware at the earliest possible moment. That person may or may not, then wish to be directly involved in the handling of the concern/complaint. It is important that staff involved in a complaint or concern are actively supported by the department.
- Doctors referred to the General Medical Council (GMC) sadly have a high rate of taking their own lives. There is support offered by the GMC, but individuals may not feel they are in a position to seek help themselves and are better offered it.
- Staff named in a concern/complaint should see the final draft response before submission. Hospital Trusts or Health Boards "Concerns Department" however usually reserve the right to make changes in order to fall line with their statutory NHS regulations on how to deal with complaints and concerns.
- The final response from Concerns however should be made available to the Directorate and to any named individuals who wish to see it. The individual (s) should be kept updated about the progress of a complaint through to its' resolution.
- The Executive member responsible for Complaints is often the Director of Nursing. The Medical Director, or an Associate Medical Director may be involved where medical staff are directly involved.

The following may be of use if your directorate does not have a policy for complaints/concerns.

Structure

The Critical Care Concerns team consists of e.g. nursing and medical lead. The nursing lead allocates an Investigative Officer (IO); either a senior/ lead nurse for nursing concerns, a consultant for medical concerns or a member of Directorate Management Team (DMT).

The Intensive Care consultant lead is appointed by the Clinical Directorate with time allocated in their job plan to address concerns/complaints.

Concerns and complaints should be raised as a standing agenda item in the monthly consultant meeting, as well and the monthly Quality and Safety (Q&S) meeting.

Process

Once received, a concern/complaint is assigned an Investigative Officer (IO) who coordinates the response. The response is drafted, approved, and returned through the concerns/complaints department within a set timeframe.

Due to the nature of critical illness some concerns/complaints can be re-directed to those best placed to respond where the issues arose either before, or after a patient's critical care stay.

Some responses are better directed to either Bereavement or Follow Up rather than a formal concern/complaint response. This will usually be best done in conjunction with nursing colleagues.

If legal advice is required, this is usually determined by the Concerns/Complaints department.

If a consultant, or doctor-in-training is named in a complaint they are strongly advised to keep their own notes of the case and inform their own defence organisation – Medical Defence Union (MDU), Medical Protection Society (MPS), or Medical and Dental Defence Union of Scotland (MDDUS). Doctors-in-training should speak with their educational or clinical supervisor. Consultants should consider reflecting on the complaint or concern within their appraisal. More immediate discussion with colleagues, Clinical director or Lead Clinician is highly recommended.

Outcomes

The outcomes of concerns/complaints may necessitate changes in how care is delivered. Changes in care will usually be delivered through a combination of Q&S, Directorate Management Team (DMT), consultant communication, Morbidity and Mortality, or teaching/education/simulation etc.

Some cases, following receipt of the initial response require further clarification to the complainant. These will come back through from the Concerns/Complaints department.

In some cases, their complaint/concern is not upheld but the complainant does not feel the issues have been dealt with. These may then be referred to the ombudsman. How to make contact with the ombudsman is explained to them.

Some cases do require a legal response and meetings with the Health Board's legal team. Redress may need to be agreed.

It is important to note that Emails relating to a case, minutes from meetings related to a case (e.g., M&M, Quality and Safety), as well as the medical and nursing notes can be requested by a patient's or relative's legal team.

If you are ever concerned that a case is going to result in concerns or complaints this should be highlighted as early as possible to the Directorate Management Team (DMT).

Patient and relatives are often just seeking answers to questions they are finding or have found difficult to obtain. These questions may arise at the time, or subsequent to a patient's death or discharge from critical care.

Some concerns/complaints are vexatious with some seeking financial recompense; the majority are not. Most serious complaints are the consequence of acute grief and problems relating to communication between clinical staff, patients, and families.

Directorates can learn a lot from addressing Concerns and Complaints well; they allow people to reflect on the care given and make necessary changes, or corrections to specific processes of care, how we best communicate with patients and their family/friends, and sometimes wider healthcare issues within the Trust/Health Board.

Supporting Staff

The handling of a concern can take time, and during this process and potentially for some time afterwards, those staff involved can feel anxious, bothered, or upset by the nature of the concern.

If you are finding it difficult following a concern/complaint please make contact with whoever you feel most able to make contact with – friends, colleagues, clinical psychology, Occupational Health, Directorate Management Team, Health for Health Professionals etc. The potential help depends on where you work but should be identified and signposted clearly.

If you find a complaint difficult and it is impacting on your mental health, your home and family life, or your ability to work please let the Directorate Management Team know or directly contact our clinical psychology colleagues.

Contact

You can also speak with Occupational Health, or your own GP. Help is only a conversation, email, text, phone call, or WhatsApp message away.

6.7 Other primary prevention resources

- FICM Wellbeing Centre. https://www.ficm.ac.uk/careersworkforcecareershub/wellbeing-centre.
- *Caring for Doctors, Caring for Patients*. GMC, 2018. https://www.gmc-uk.org/-/media/documents/caring-for-doctors-caring-for-patients_pdf-80706341.pdf.

7. SECONDARY INTERVENTIONS: Additional support for staff in need

The availability and awareness of Support Systems should be made clear to everyone within the department. Most NHS Trusts/Health Boards have access to Occupational Health for well-being and workforce issues. Addressing well-being should not be tokenistic and is best done at directorate level. See Critical Staffing #2.

Leaders should stay aware and keep up to date with their local resources. Where and when necessary, members of staff can then self-refer or be referred for support.

Access to psychological therapies is important and can be accessed from a number of different sources. The directorate management team should clearly understand what is available in their Trust/Hospital/Health Board:

- Primary and secondary NHS mental health services are available via the GP
- Some NHS Trusts have access to counselling, or psychological therapies via their Occupational Health service
- Some critical care departments have chosen to directly access a Clinical Psychologist to offer more rapid access to individual interventions, but also to support the department in providing primary interventions, organisational health monitoring, awareness training, and team building
- Deaneries provide access to psychological therapies via the Professional Support Unit.

7.1 Other Resources

- **DocHealth**
  Provides confidential face-to-face and virtual consultations delivered by Consultant Medical Psychotherapists based at BMA House in London. Available at: https://www.dochealth.org.uk.
- **Doctors Support Network**
  Offer peer support for doctors and medical students with mental health concerns. Contact through online CONTACT form. Available at: https://www.dsn.org.uk/
- **Samaritans**
  Samaritans offer free, confidential support lines for health workers based in England and Wales. Available 24 hours a day, 365 days a year. Call 116 123.
- **Health for Health Professionals – Wales**
  Health for Health Professionals Wales (HHP Wales) offers a free, confidential service that provides NHS staff, students and volunteers in Wales with access to various levels of mental health support. Available at: https://hhpwales.nhs.wales/about-us/
- **General Medical Council**
  Available at: https://www.gmc-uk.org/concerns/information-for-doctors-under-investigation/support-for-doctors
- **Practitioner Health Programme (PHP)**, where available, is a free confidential NHS primary care mental health and addiction service with expertise in treating health professionals. The service is a multi-disciplinary, integrated team, with clinicians across England providing a mix of face-to-face and virtual consultations. Scotland and Wales have similar services. Available at: https://www.practitionerhealth.nhs.uk/

8. CONCLUSIONS

A 'Return to Work' policy is a requirement for NHS organisations but sadly, as can be seen in some vignettes that does not mean such policies necessarily work well. Even within the same organisation there is not always consistency. Policies that don't hold individuals at their centre in their attempt to 'Return to Work' will most likely fail that individual. It is very important to realise that any one of us may, at some point in our career require some time-off work. Investment in primary prevention will help some individuals in not needing to take time-off. However, there will always be a need for some to have time away from work and a well versed and practiced 'Return to Work' policy, which is kind, considerate and individualistic will be of all-round benefit.

The vignettes are very informative, and we are very grateful to the authors for putting pen to paper, whilst also being full of admiration of the bravery that comes through in many of these personal stories and experiences. It is not easy to re-visit such traumatic events so a big thank you.

Whilst addressing most Return-to-Work situations these vignettes do not cover all. Many of the experiences are very individual but there are also key common themes which are applicable more widely:

1. Don't rush the return. A rushed return is likely to fail and ultimately result in a longer delay in returning to the workplace and may be destructive.
2. A structured approach is beneficial for both sides but within that structure there must be the ability to call 'time out' and a need for flexibility. Again, rushing or pushing the return is likely to ultimately result in a delayed return.
3. Departments need to be aware of the resources available to help individuals in their department. Occupational health, clinical psychology, deanery support etc.
4. Attempts to maintain regular formal contact from the department are important.
5. Individuals in departments can, independent of the formal return provide much needed human warmth, kindness, and support.
6. For individuals off-work, maintaining physical health and interests outside of work provide necessary balance especially if and where expectations need to be readjusted due to circumstance.
7. Individuals off-work and returning may find professional help from GPs, psychologists, or organisations of enormous objective support to them and also relieve the burden, real or imagined on their partners, friends and family.

This third in the series of the Faculty's 'Critical Staffing' documents is a call to all critical care departments to ensure that their 'Return to Work' policy is in place, is widely understood and is implementable rather than window dressing. We hope that this document provides good grounds for this, with supporting evidence and links to resources that will help critical care departments, and most importantly the staff that work in them. The COVID pandemic has proven exceptionally hard on many members of staff and the need to support critical care staff members 'Return to Work' where and when necessary is more important than ever.

Attributions

Editors

Julia Wendon, Cat Felderhof, Zoe Brummell, Jack Parry-Jones and Natalie Bell

Vignettes

Nick Mason, Danny Bryden, Rosie Baruah, James Williams, Segun Olusanya, Liz Thomas, Claire Main

A special thank you to all those providing vignettes.

Acknowledgements

During the process of writing this document we have consulted with and are very grateful for the advice, and subsequent endorsement from the Society of Occupational Medicine (SOM):

Nick Pahl Chief Executive Officer of the Society of Occupational Medicine

Dr Masood Aga, Clinical Director for Occupational Medicine, Specialty Lead for Health and Wellbeing, Sandwell & West Birmingham Hospitals NHS Trust

Dr Finola Ryan, Occupational Medicine Specialist Registrar

Dr Sarah Porter, Occupational Physician and Chair of Society of Occupational Medicine Northern Ireland Group

Reviewed by FICM's Careers, Recruitment & Workforce Committee

Design and layout by the Faculty of Intensive Care Medicine

©2022 Faculty of Intensive Care Medicine

Useful Resources

Academy of Medical Royal Colleges:

Support for doctors' resource: http://www.aomrc.org.uk/supportfordoctors/

Return to Practice: https://www.aomrc.org.uk/wp-content/uploads/2017/06/Return_to_Practice_guidance_2017_Revison_0617-2.pdf

FICM Wellbeing Centre: https://www.ficm.ac.uk/careers-recruitment-workforce/wellbeing-centre

GMC guidance:

Caring for doctors, caring for patients: https://www.gmc-uk.org/-/media/documents/caring-for-doctors-caring-for-patients_pdf-80706341.pdf

Return to Work: https://www.gmc-uk.org/education/standards-guidance-and-curricula/guidance/welcomed-and-valued/how-can-postgraduate-training-organisations-apply-their-duties/return-to-work

Intensive Care Society:

Wellbeing Hub: https://www.ics.ac.uk/Society/Wellbeing_hub/Wellbeing_Hub

Unexpected Death of a Colleague First Aid Kit: https://www.ics.ac.uk/Society/Wellbeing_hub/Unexpected_Death_First_Aid_Kit

www.ficm.ac.uk

@FICMNews

Churchill House | 35 Red Lion Square | London WC1R 4SG
tel 020 7092 1688 | *email* contact@ficm.ac.uk