

Briefing on supporting staff who are shielding to return to work

This briefing is aimed at the government, arm's-length bodies, employers, commissioners, training bodies and others on how they can support doctors who are clinically extremely vulnerable (or those who are 'shielding by proxy') to return to the workplace or continue working remotely.

Shielding will soon be coming to an end across the UK, after which those who have been shielding will be able to return to work provided their place of work is 'COVID-19 safe.' Doctors who have been shielding are feeling concerned about returning to work,¹ particularly given that working in healthcare carries an increased infection risk. To ensure that workplaces are safe and doctors are supported, whether or not they are able to return to work, it is vital that the government, arms-length bodies, commissioners, training bodies, and employers provide the necessary funding, guidance, and assistance.

Guidance on shielding

In England and Northern Ireland the formal process of shielding will be paused from 1 August after which the Shielded Patient List will still be maintained in case of need for local or national re-activation. In Scotland, people are advised to keep shielding until at least 31 July. In Wales, shielding will continue until 16 August. Pausing shielding does not mean that the presumption of high risk disappears. People classed as clinically extremely vulnerable are still at risk of severe illness if they catch COVID-19 and should continue to take precautions, however, the government has deemed that the risk of catching the virus is now sufficiently low for the shielding guidance to be relaxed.

National guidance is limited and a number of issues remain on how healthcare staff who are extremely vulnerable or who are protecting others who are vulnerable will be able to safely return to their usual clinical duties. In addition, taking on board and implementing existing guidance on shielding from the government, employers, and national public health bodies, can cause confusion, particularly with regards to the use of PPE (personal protective equipment), and therefore a clear and consistent approach is needed.

The impact of shielding on the workforce

Those who have been shielding have faced enormous challenges and uncertainty, including disruption to training, career development, isolation from their peers, job insecurity, as well as practical challenges around remote working. Many have endured loss of access to the family unit as well as bereavements and funerals not attended. Some will have also faced additional financial pressures because of a lack of access to other sources of income (such as private practice or locum work) while still being financially responsible for school fees and childcare costs.

Shielding has impacted on doctors' emotional wellbeing with many feeling guilt, embarrassment, frustration, anxiety, and loneliness.² In addition, staff have had to open up about their health conditions to their employer and colleagues, which they may not have felt comfortable to do. Many have also not felt fully supported with 30% saying they felt unsupported or the support was not satisfactory.

¹ BMA COVID-19 tracker survey results (10 July 2020)

² Evidence from BMA members, BMA COVID-19 tracker survey results (1 June 2020) and 'Supporting the shielded – results from a national survey of shielding doctors', Association of Anaesthetists



Even as the possibility of returning to work presents itself, many doctors have concerns about safety at work and are hesitant about returning. According to the recent BMA COVID-19 tracker survey only 29% of doctors who are shielding (or protecting someone who is vulnerable) have agreed a return to work date. 30% said they would not feel confident to return even after safe working adaptations had been agreed with their place of work. The majority (84%) said that they would feel confident to return after a vaccine was available to them.

A recent survey of shielding doctors published by the Association of Anaesthetists found that more than half said they were feeling anxious about returning.³ In the survey, some reported feeling under-prepared to return to work as they have been out of clinical practice, concerned that they will not fit into their department, worried about the lack of strict adherence to social distancing among staff in their place of work and apprehension about their colleagues being aware of their health conditions. Although the prevalence of coronavirus is now lower, working in healthcare carries increased workplace infection risk. This is demonstrated by recent local outbreaks in healthcare settings, such as one at Hillingdon Hospital. A recent study in the UK and the US estimated that frontline healthcare workers had a 3.4 fold higher risk than people living in the general community for reporting a positive test (adjusting for the likelihood of receiving a test).⁴

What employers, arm's-length bodies, commissioners, and training bodies can do to support return to work

Making workplaces safe

The government and arms-length bodies should:

1. Provide clear guidance and protocols on how workplaces can be made safe for staff who have been shielding.

Commissioners should:

2. Provide support and funding to ensure that workplace settings are able to make the necessary adjustments ie. GP practices, hospitals, public health, universities, community and any qualified provider settings (these may require additional funding to the normal NHS tendered funding)

Employers should:

3. Provide evidence on the safety measures being put in place to make workplaces 'Covid-19 safe' to reassure staff.
4. Establish and follow strict health and safety protocols if there is a COVID-19 outbreak, which should include the immediate withdrawal of vulnerable staff.
5. Establish clear channels of communication through which staff and trade unions can raise concerns about the implementation of safety measures.

Undertaking individual risk assessments

Employers should:

6. Undertake timely, individual and bespoke COVID-19 [risk assessments](#) which cover the basis of shielding properly and a decision on return to work should be made on a case-by-case basis. The risk assessment should be undertaken with input from occupational health services and should be repeated if there is a change in the clinician's medical condition.
7. Ensure that mental health and wellbeing support is part of discussions around risk assessment and return to work.
8. Support staff to make informed personal decisions about returning to work, by providing honest and open information about risks and act on concerns that are raised.

Developing a plan for return

Employers and training bodies should:

9. Work with doctors to develop a plan for returning to work and make appropriate workplace adjustments, including access to adequate PPE. They should ensure that their organisation is taking an inclusive approach so that staff feel they are returning to a supportive, caring and safe environment.
10. Avoid putting pressure on staff to return to work or to take on too much too soon particularly if they have been out of clinical practice. Shadowing, observation or mentoring should be provided to help ensure a smooth return to work.

3 <https://anaesthetists.org/Home/Resources-publications/COVID-19-guidance/Supporting-the-shielded-results-from-a-national-survey-of-shielding-doctors>

4 <https://www.medrxiv.org/content/10.1101/2020.04.29.20084111v6>

11. Adjust their approach accordingly if new public health advice emerges.
12. Ensure trainees who are returning to work are adequately supported, for example, through the [SuppoRRT programme](#) (or equivalent programme) and Professional Support Units.
13. Plan for the scenario that shielding could be 're-activated' to minimise any possible disruption to the individual in terms of career progression and training.

Plan for the long-term

Arm's-length bodies, regulators, training bodies, and employers should:

14. Provide guidance on supporting those who may be shielding in the long-term, including clarity on training, standing down from on-call rotas, appraisals, career progression and pay protection.

It is clear that workplaces will need to undergo significant changes in order to ensure high risk staff will be able to return, for example, ensuring social distancing, one-way system of moving through spaces, segregating non-COVID/confirmed COVID cases, appropriate levels of adequate PPE, staggering start times and implementing flexible working patterns. Depending on the type of speciality the doctor works in and healthcare setting, some of these mitigating measures will not be possible to implement e.g. social distancing.

While there will always be residual risk after any mitigation process it is the employer's duty to take reasonable steps to protect employees' health and safety and to make the workplace as safe as possible. In order to be fit for purpose risk assessments should also take into account the circumstances of doctors 'shielding by proxy' (those protecting others who are vulnerable).

Please see the BMA's [guidance on individual risk assessments](#) to find out more about how the process should work and how the BMA can help.

What employers, regulators, and training bodies can do to support vulnerable staff who can't return to the workplace

It is likely that some staff may not be able to return to their workplace for the long-term and this needs to be incorporated into any workforce planning. Employers and colleagues need to recognise the invaluable contribution these doctors will continue to make the NHS, from helping to plan the restoration of NHS elective surgery and procedures to providing leadership on estates, workforce and protocols, and they should therefore take a proactive approach in ensuring that staff are well-supported to work remotely.

Employers need to support staff to continue to contribute to work

Working remotely has meant that staff have had to change the type of work they do and adapt to new ways of working. Given that staff will need to continue to work in this way for the long-term it is vital that employers review tasks and work arrangements on a regular basis to support staff wellbeing and ensure development. Employer should adopt a flexible approach when it comes to working patterns to take into account personal circumstances such as children or dependents. Remote working for those shielding can include a variety of tasks, for a list of examples see Appendix 1.

Employers should ensure staff are supported to work from home

Employers should ensure that staff have suitable equipment to work from home to support the creation of a work environment in their living space. How well doctors will be able to contribute to work will also depend on their access to good IT hardware/software as well as support and training. It is vital that commissioners provide the right IT infrastructure and support.

Staff who are shielding should not be disadvantaged in terms of pay

Those shielding with amended or altered duties should not suffer financially as a result of changes to their working patterns due to COVID-19. Those shielding should continue to receive full pay and this should not be classed as sick leave, especially if working from home.

GP practices should be funded to cover the full pay of the staff that can't return to work as well as cover for their replacement.

For junior doctors pay should include any enhancements/ banding and extend beyond rotation dates. As trainees switch to a new department they will need to have pay protection confirmed, especially as their ability to seek alternate sources of income may be significantly restricted and this isn't something income protection would necessarily cover as it is not a period of ill health.

Staff who are working from home should not be put under pressure to reduce their hours or change their job plans. Job plans can only be amended by consent.

Education bodies and deaneries should adopt a flexible approach to training

It is vital that steps are taken to ensure trainees who need to continue to shield do not lose out in terms of training and learning opportunities. National training bodies should adopt a flexible approach to training and development and make more opportunities available for remote learning. Rotation arrangements should be smooth to minimise disruption caused by repeated risk assessments and new working patterns and access to IT equipment. It is vital that the number of shielding trainees are identified by national bodies and guidance is provided with regards possible rotation options.

Improved wellbeing/psychological support should be provided

It is vital that line managers support the wellbeing of workers through regular check-ins and protected break times. In addition, doctors who are shielding may need additional support to support their mental health. Employers should promote the role of employee assistance programmes and OH services to ensure staff have access to wellbeing support. Buddying arrangements and mentoring can be helpful to reduce isolation. It is vital that staff are provided with a choice of providers when it comes to support. The BMA wellbeing support services offer confidential 24/7 counselling and peer support to all doctors and medical students (regardless of BMA membership), plus their partners and dependents.

Staff should be supported to keep their competency up to date

There needs to be clarity around what the process for appraisals and revalidation will look like in the long-term for those who cannot return to their usual roles. This is particularly vital for staff who are in procedural specialities (e.g. surgery) who can't do this work remotely.

Staff who are caring for someone who is vulnerable may need additional support

Even where the workplace can adapt, staff who are protecting others in the household may not be able to return. This could be related to issues around child-care or personal care for relatives. Consideration should be given to those with shielded children at home who cannot be expected to move into temporary accommodation.

Social distancing within a home has also been impossible where someone provides care for a very young child or an older relative. Staff who need separate accommodation in order to protect someone they live with should continue to be supported financially.

Appendix 1

For those working remotely in primary care tasks to consider are:

- Telephone triage
- VC/ telephone consultations
- Clinic letter coding such as Docman
- Medication reviews
- Chronic disease management
- Prescribing review (portfolio requirement now for GP trainees)
- E-learning such as safeguarding

For those working remotely in secondary care:

- VC/telephone clinics
- Audit and QIPs
- Research projects/studies
- Senior doctor letter validation/clinic administrative tasks
- E-referrals and referrals to other departments
- Review and filing of bloods and scans from ED for ED registrars
- Laparoscopic box training (e.g. general surgery trainees)
- E-learning e.g. GCP, online CPD courses
- Virtual ward rounds and board rounds
- Providing remote teaching/support for FYs and CTs and medicals students
- Requesting bloods and scans
- Home reporting
- Chasing scan results and bloods and phoning then through to the team
- Updating the electronic worklist
- Reviewing drug charts (e.g. on JAC)
- M&M preparation
- Rota coordinating
- Discharge summaries (if notes and meds are already electronic)
- Relative update phone-calls (as long as all notes electronic)
- Updating patient information
- Re-writing Standard Operating Procedures
- Updating induction materials for new staff
- Providing clinical input to outstanding audits