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Supporting occupational health and wellbeing professionals

A framework for managing the **sudden and unexpected death of a colleague** in a primary care setting

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Introduction

The sudden death of any work colleague, whether by illness, accident or, rarely, suicide, is shocking, distressing and destabilising. Emotional reactions can be very powerful and may have a major impact on the wellbeing and functioning of staff members. If a colleague has been ill for some time, the loss is still as important, but there will have been some opportunity for psychological and practical preparation.[1] This is not the case with a sudden unexpected death. A compassionate and supportive approach is needed, both within the practice and from external sources, to help the entire team stabilise and recover.

General practices and some other primary care organisations are staffed by small and stable teams, and employees will often have cultivated close working relationships or personal friendships. Even if a practice is part of a larger group, a relatively small team will typically be responsible for the day-to-day delivery of care. Moreover, patients may have forged a personal connection with the team member who has died, and this applies just as much to non-clinical staff as it does to clinicians.

Whatever the professional role of the person who has died, primary care practices will find it challenging to cope with the aftermath. Staff will need time and space to process what might be intense emotional reactions and provide mutual support, while also attending to the immediate needs of patients. It should be acknowledged, therefore, that the sudden death of a colleague can cause considerable disruption to the organisation, which can last for some time. Dealing with this may require the investment of significant time and resources.

Our original report, published in 2020, was based on interviews with those who have experienced the death by suicide of a team member, but many of the issues identified would apply to any sudden death.[2]

The **Royal College of General Practitioners Sudden Bereavement Support** (RCGP SBS) group, which was established following the publication of the original report, offers practices immediate practical advice and signposting following the death of a key team member.[3] The team has highlighted the value of having guidance available which applies to any sudden death of a colleague. This revision is designed to meet this need.

It is useful to consider the response to the death of a co-worker in three phases: immediate, short term and longer term. These guidelines, therefore, identify the likely effects and the actions and support needed

a. on the **first day**

b. in the **first week**

c. during the **first month**, and

d. over the **longer term**.

1. Intensive Care Society. Unexpected death of a colleague first aid kit. September 2022. https://ics.ac.uk/resource/unexpected-death-of-a-colleague.html
2. Kinman, G. & Torry, R. (2020). Responding to the death by suicide of a colleague in Primary Care: a postvention framework. https://www.som.org.uk/sites/som.org.uk/files/LTF_SOM_Responding_to_the_death_by_suicide_of_a_colleague_in_Primary_Care.pdf
3. Royal College of General Practitioners Sudden Bereavement Support. https://www.rcgp.org.uk/learning-resources/primary-care-development/sudden-bereavement-support-resources

The first day: disclosure, shock, communication and support

1. Hearing the news

The team may learn of the death of a colleague in various ways, whether during the working day or over the weekend. There may be a phone call from a family member or a friend, or they may learn about it through social media or a newspaper report. The most immediate need is to acknowledge that the sudden death of a colleague will have a major impact on the psychological wellbeing of people within the organisation and their ability to function. The immediate aftermath is a time of shock, confusion and intense emotion, so it is crucial to ensure that accurate information is provided, and there is a plan for coordinated support.

2. Breaking the news to staff

The person who first hears the news is likely to be responsible for informing their colleagues. Someone in the practice – ideally not a person who is profoundly emotionally affected by the news – must decide when and how to share the information. This will usually be one or more of the practice partners, or the practice manager. It can be difficult in the first moments of shock to make appropriate decisions, and sharing this responsibility is helpful. It is best to break the news as quickly as possible, before rumours and misinformation start circulating, but decisions about how much information to share and with whom will depend on the circumstances and will usually be taken after consulting the family. It may be necessary to tell staff that the family do not wish to discuss the cause of death. There are additional considerations following a possible death by suicide, and these are dealt with in the original report.[2]

It may be possible to gather the staff at the end of the surgery to break the news, but making some people aware of the circumstances before a larger meeting would be helpful. If possible, there should be no external interruptions during this meeting. The news should also be communicated to staff who are not at work that day to prepare them before they are next on duty. If the news breaks at the weekend, it may be necessary to telephone staff at home. In larger practices, a small team might be able to divide the phone calls to avoid overloading a single person.

3. Managing the distress of staff members

Supporting those affected is one of the main priorities in the immediate aftermath of a colleague's sudden death. Early support is key to recovery. Although people will react to the death in different ways, it should be recognised that in a small practice every team member is likely to be emotionally affected. Grief reactions are influenced by several factors such as life experiences, coping skills and cultural beliefs about death, as well as their personal relationship with the colleague who has died and the circumstances of their death. This may be more intense following a death by suicide.[4]

Box 1 (following page) highlights feelings and behaviours people commonly experience. Some are likely to occur soon after the event, whereas others may be experienced later. In addition to the shock, disbelief and sadness that follows the news of any sudden death, members of the team (especially those who knew the person well) might also feel guilty about not paying sufficient attention to health symptoms or other signs of distress and acting accordingly. Opportunities to talk over what has happened and vent feelings of sadness or guilt with a trusted person who can listen without judgement can assist with the recovery process.

4. Gerada, C. (2019). The Aftermath of a Colleague's Suicide. British Medical Journal; 365: l2290. https://doi.org/10.1136/bmj.l2290

BOX 1: *Common feelings and behaviours following the death of a colleague*

- Feeling unprepared for the situation
- Feeling overwhelmed by everyday tasks
- Automatic behaviours, or feelings of dissociation from reality
- Poor concentration, due to intrusive emotional reactions and memories
- Changes in sociability, such as wanting to withdraw from others, or an increased need to talk
- An inability to 'switch off' from thinking about their colleague at home during evenings and weekends
- Physical symptoms, such as shortness of breath, nausea, rapid heartbeat, or aches and pains
- Altered eating and sleeping habits
- A strong need to tell other people about the event; to be with people who knew the person who had died; a drive to reach out to the family

Staff, especially clinical staff, may feel impatient with themselves for having intense feelings which can interfere with their perceived need to 'be professional' in the work environment. They might feel a conflict between their role as a healthcare professional – responsible for the wellbeing of others – and their personal response to the death as a human being.

During the first day and the next week or so, it is crucial to identify any member of staff who is too distressed to continue to work safely. The cognitive deficits associated with extreme shock and grief, such as poor concentration and memory, means that performance can be compromised. This may be hard to establish, as people experiencing emotional shock can appear to carry on as normal (even to those who know them well) despite being profoundly distressed.

The emotional effort of trying to behave 'professionally' after experiencing trauma can be exhausting and compound grief reactions. Moreover, healthcare professionals frequently struggle to be self-compassionate and often find it easier to comfort others than attend to their own emotional needs. Staff members may, therefore, need to be given 'permission' to take care of themselves. Time away from patient-facing work, or even time away from work altogether, may allow staff to process and come to terms with events. Ways to facilitate this, where appropriate, must be found even if that individual is resisting help. Cover may be needed at short notice, so it may be helpful to have people on standby.

At this stage, it may be worth considering what types of workplace accommodation could be offered in the first few days and weeks to support a team that is struggling. These concessions could provide the staff with the space to regroup and move forward. The RCGP SBS has observed that practices often find it helpful to seek permission to close their doors and switch off the phones for a short period, such as half an hour at lunchtime.

Obtaining support from the Integrated Care Board (ICB) and the Primary Care Network (PCN) at an early stage is recommended.

4. The burden on the leadership of maintaining 'business as usual'

It is both a strength and a weakness of the general practice setting that people in leadership roles have considerable autonomy. They do not have to consult others when making decisions but carry a heavy responsibility for ensuring the decisions are the 'right' ones. Leaders play a critical role in the immediate response to a colleague's death, but the demands they face can be extreme; they might feel the impact of the death as profoundly as others but be obliged to provide support. There might be concerns about maintaining continuity of service, particularly if the death has been of a key member, and it may take some time to find a suitable replacement. The people we interviewed for the initial study emphasised the importance of obtaining cover from appropriately trained staff who can work autonomously and share the load.

Ideally, managers should prioritise their own physical and emotional needs before attempting to care for their colleagues, but this can be very challenging. In traumatic situations, people often want someone to 'take charge' because they feel helpless and overwhelmed; they typically look to leaders to set the tone. Although leaders can be powerful role models for 'healthy' grieving by openly acknowledging their own feelings about the loss of a colleague and advising on effective coping strategies, this responsibility can be an additional burden for them to carry. Concerns about the psychological effects of the death on team members and feeling responsible for their wellbeing can be stressful; it was of major concern that many of those we interviewed struggled to get support from their professional networks, although such support, when available, was helpful.

5. Royal College of General Practitioners Sudden Bereavement Support (RCGP SBS)[5]

To be effective, support must be timely and appropriate to the needs of the practice and the people working in it. The RCGP has trained a small team of advisers from the Primary Care Development programme to provide immediate practical advice and signposting following the sudden death of a key practice member. The team aims to respond within 24 hours during the working week. Previously funded by NHS England, this initiative is now funded by the RCGP at no cost to the practice. The RCGP is not able to provide direct funding to practices but can signpost to potential resources and support.

5. Royal College of General Practitioners Sudden Bereavement Support (RCGP SBS). https://www.rcgp.org.uk/learning-resources/primary-care-development/sudden-bereavement-support-resources

The first **day:** key actions

- ☐ Arranging a coordinated discussion on the information that should be provided to staff, liaising with the family if appropriate.
- ☐ Breaking the news to all members of staff in a quiet environment and ensuring people who are not on duty are also aware.
- ☐ Dealing with the distress of staff members.
- ☐ Ensuring there is time and space to debrief and for staff to support one another.
- ☐ Identifying any member of staff who is too distressed to continue working and encouraging them to take time out if they need it. This may require probing questions and/or asking other staff members for their opinions on colleagues' wellbeing.
- ☐ Contacting the ICB and the PCN to share the information and seek urgent support.
- ☐ Contacting RCGP Sudden Bereavement Support.
- ☐ Assessing the staffing situation: reallocating work or finding cover to ensure service is not disrupted.
- ☐ Identifying the concessions that could be made available in the first few days and weeks if staff members are struggling.
- ☐ Identifying potential sources of support for the future.

The first week: communication, coordination and continuing support

1. Informing external bodies

Several external bodies will need to be informed, depending in part on the role of the person who has died. These may include the medical director, the Integrated Care Board (ICB), the Local Medical Committee (LMC), the Primary Care Network (PCN) clinical director and, for a doctor, the responsible officer. Our interviews highlighted the difficulties that practice leaders sometimes experience when determining who to inform of the death and how to contact them.

2. Breaking the news to patients

After colleagues have been informed, patients will need to be told, as is usual following the death of a staff member. Sometimes the cause of death may be unclear, or unusually sensitive, as in a suspected death by suicide. Whether the family wishes the 'true' cause of death to be communicated widely may be unknown. It may then be appropriate to avoid specifying the cause of death and instead refer to the staff member as having 'died suddenly' or, if they were on sick leave, 'died following a short illness'. Patients might ask staff members about the cause but can reasonably be informed that this is not yet known.

As the reception team will bear the brunt of patients' responses, they should be involved in discussions about when and how the news is communicated to patients and other stakeholders. If the death is not already in the public domain, it may be advisable to wait for 24 or 48 hours to allow staff time to process the news. It is important that the information provided by members of staff is consistent to avoid confusion and further queries. The practice may know of patients who have a particularly close relationship with the colleague who has died. Some may be emotionally unstable or experiencing longstanding illness and had been receiving support from them. It may be helpful if somebody from the practice could break the news to such people personally and offer support if required, rather than leaving them to hear the news indirectly or via rumours.

3. Providing a memorial opportunity

At this stage, it can be comforting for staff and patients to prepare posters and place flowers in reception. A poster could include a photograph of the colleague, with their date of death, and highlight the contribution they had made to the practice. Practices often also provide a memorial book in reception and online for patients to write their tributes. This book can be a tremendous source of comfort for staff and eventually be given to the family. If a book is placed in reception, creating a separate queue to write in the book has the added value of enabling patients to talk to one another about the death, while allowing others to reach the reception desk. Practices may also wish to communicate the loss of a valued member of staff on their website.

4. Dealing with the continuing distress of staff members

Patients are likely to be understanding if staff become upset when discussing the death of a close colleague. Nonetheless, everyone in the practice should be ready to support someone who becomes emotionally overwhelmed. It should be emphasised that taking a break from the reception desk or stepping out of

the office is entirely understandable and acceptable. Arranging front desk cover for such situations in the first week or two might help. Staff should also be vigilant for colleagues who attempt to 'carry on as usual' without seemingly processing the news; they are also at risk and may benefit from a gentle conversation to help them connect with their feelings in a safe and healthy way. A 'buddy' system can be useful in the early days and weeks following the death of a colleague, where two people look out for each other and provide mutual support.

Box 2 offers some examples of how leaders can support staff members. This guidance is relevant not only at the early stages following a colleague's death, but during the weeks and months following.

BOX 2: ***How leaders can support staff after the sudden death of a colleague***

- Maintain open communication with all colleagues.
- Promote shared decision-making and mutual support.
- Be sensitive to staff needs; don't make assumptions about their relationship with the colleague who has died.
- Ensure staff know who they can talk to in the workplace.
- Designate a quiet place where people can go if they need time out and, if necessary, someone who can go with them.
- Provide opportunities for staff to meet over coffee or lunch to discuss their feelings and offer mutual support.
- Determine when staff need breaks, time off, or help from relief staff to cover their work.
- Check in with each staff member regularly and offer help at an early stage if their performance is suffering.
- Watch out for signs such as a lack of concentration or outbursts of anger and offer support and help.
- Ensure there is a list of professionals trained to deal with grief freely available, so staff don't have to request this information.
- Share the burden with others and receive support themselves.

5. Providing opportunities for mutual support

Staff, particularly those who were close to the person who has died, may experience physical reactions to grief, such as fatigue, insomnia and nausea. Such symptoms are likely to recede in time, but grief reactions which are handled improperly or are ignored can be destructive and disruptive. At this stage, staff will still need opportunities to give and receive support to help them come to terms with the loss, while also managing the day-to-day running of the practice and the impact on patients. It can be particularly helpful for staff to meet informally, perhaps over lunch, to share memories and feelings. A more structured approach, where people are invited to share their most important memories, can also be effective.[6] A meeting held after the practice has closed may be more appropriate, as it prevents staff who are upset having to return to work.

6. Gerada, C. (2019). The Aftermath of a Colleague's Suicide. British Medical Journal; 365: l2290. https://doi.org/10.1136/bmj.l2290

6. Communicating with the family

Establishing communication with the family is crucial for expressing condolences, understanding their preferences for how the death is announced, and obtaining information about the funeral. Colleagues might be reluctant to make initial contact with the family, for fear of intruding during such a difficult time. The team could nominate a key person to maintain contact with them over the first few weeks and develop mutual trust. Some families may choose to be in close contact with the practice and may be very willing to talk to members of the team. Others may prefer to avoid contact with the workplace and colleagues or may have negative feelings about the practice. At some stage, the family might also want to see their loved one's room or workstation and remove their personal items themselves.

7. The funeral

A sudden death intensifies the emotional reactions to a bereavement, so being able to attend the funeral or a memorial event is particularly important. It allows colleagues to offer their condolences and express their grief to the family and friends of the person who has died, share memories and start the process of recovery. Some families may welcome all members of staff at the funeral or memorial event, whereas others may prefer only one or two from the practice attend. A colleague may be asked to speak because it can be meaningful for people to learn how much their family member was appreciated and valued both as a colleague and a friend. The family might also be happy to invite patients to the funeral and may ask the practice to pass on the details. The best way to find out their wishes is to have an open and honest conversation.

Although the family may welcome colleagues to the funeral, not everyone may be able to attend. A key consideration is how close the funeral is to the practice. Assuming the funeral is local and all colleagues are invited, the practice will need to seek the agreement of the Integrated Care Board (IBC) to close their doors for the duration of the funeral. As practices are permitted to close for a half-day for protected learning, it seems appropriate that they should also be able to do so for the funeral of a current staff member. It is no longer contrary to NHS England policy to permit a closure in these circumstances. Our initial interviews indicated that there can be significant costs for those who 'volunteer' to remain at work to provide cover. Feeling obliged to do so can lead to long-lasting distress.[7] However, practices need to provide cover, as they do for training sessions, and this can be costly.

Whether all members of the team are able to attend the funeral, a memorial event could be held at the practice later. This should be done in an inclusive and sensitive manner, paying tribute to the person who has died. Staff and patients may also wish to contribute to an appropriate charitable cause in the name of their colleague, which could be agreed with the family, or be a separate arrangement coordinated by the practice.

8. Dealing with personal belongings

The workplace will have many subtle reminders of the person who has died. Their name might be on their office door, or their personal belongings may be on their desk or workspace. If possible, the workstation should be left as it is for a few days. If personal belongings are cleared away too quickly, colleagues might feel angry or resentful. But it might not be possible to leave the workspace untouched for long. The family should be consulted to ensure they are involved in this process as much or as little as they want. Removing the personal possessions of a colleague who has died might be a job that is best shared, sometimes with a family member, so people are supported during what can be a distressing task. It might be helpful to offer to deliver the colleague's personal belongings to their family if that is their wish.

7. Seren Boyd. Fallen friend – dealing with the loss of a colleague. BMA News, November 2020. https://www.bma.org.uk/news-and-opinion/fallen-friend-dealing-with-the-loss-of-a-colleague (Accessed 4.9.24)

9. IT management

Attention needs to be paid to practical issues. The colleague's NHS email address needs to be disabled and removed from both internal and external mailing lists. It is also crucial to make sure automated recalls are not sent to patients in their name.

The first **week:** key actions

- ☐ Identifying relevant external bodies to inform of the person's death and making contact.
- ☐ Involving all relevant staff in deciding how to break the news to patients.
- ☐ Breaking the news to patients, dealing with their distress and determining who might need additional support.
- ☐ Dealing with the continued distress of staff and identifying anybody who is struggling.
- ☐ Ensuring there are continuing opportunities and a physical space for staff to get mutual support.
- ☐ Placing a memorial in reception, e.g. flowers, a poster or a memorial book for patients to write their tributes. Deciding whether to provide a memorial on the practice website.
- ☐ Nominating someone to liaise with the family about the funeral arrangements and deciding who should attend.
- ☐ Liaising with the Integrated Care Board (ICB) if the practice is to close for a half-day for the funeral or, if this is not possible, providing cover so colleagues can attend.
- ☐ Organising a memorial event for all staff if required.
- ☐ Dealing with personal belongings and returning them to the family in accordance with their wishes.
- ☐ Managing IT issues.

The first month: getting the 'right' kind of support, and working towards recovery

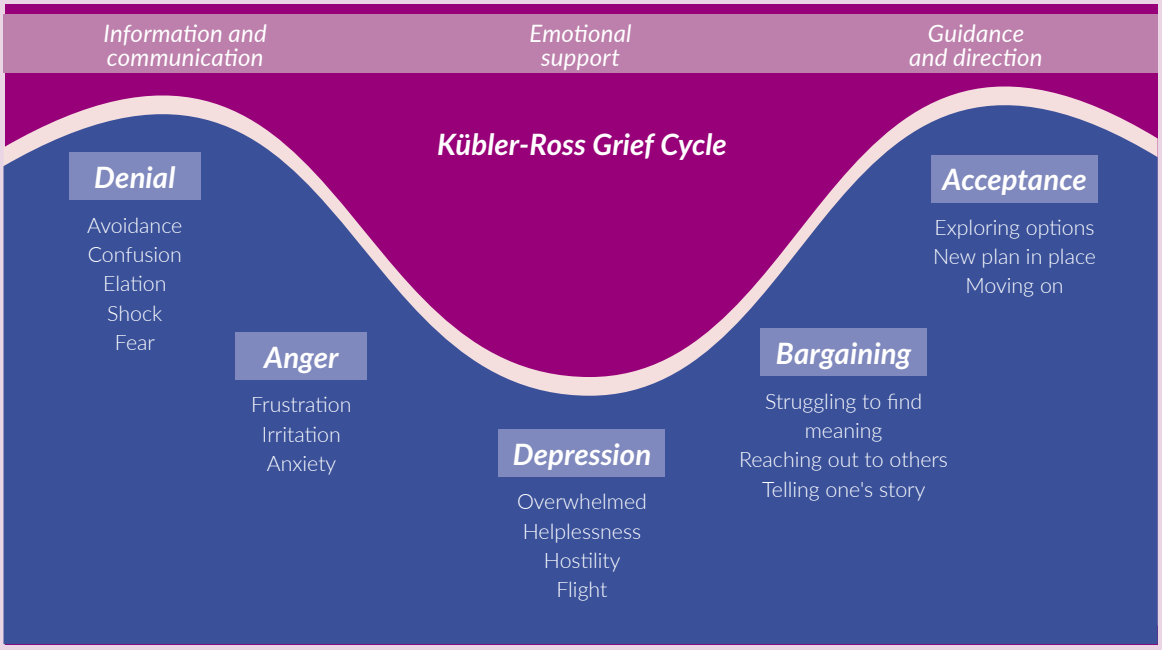
1. Dealing with continuing distress and emotional responses in the team

Team members may continue to be distressed for some time and experience complex emotional reactions over the longer term. Staff will continue to need an outlet to express their sadness about the death of a close colleague and their continuing sense of loss. Everyone in the practice should remain alert to the needs of all team members, and time and space should be available for people to share their feelings if they wish. Staff should also be encouraged to identify and share information on what can nourish and replenish them (e.g. rest, relaxation, exercise, or other diversions). An understanding of the Kübler-Ross Grief Cycle[8] may be helpful – its key principles are shown in **Box 3**. It is a useful framework to identify people's likely emotional reactions and support needs at different stages following a bereavement or any significant personal loss.

BOX 3: *The Kübler-Ross Grief Cycle*

This is a useful framework to identify people's likely emotional reactions and support needs at different stages following a bereavement or any significant personal loss. Nonetheless, since the grief process is highly personal, a flexible approach to support and recovery is needed.

The initial reactions to hearing the news are likely to be shock, denial and emotional numbness; at this stage, communication is key, particularly the need to reiterate the situation to allow it to 'sink in'. People may subsequently experience anger and depression when they accept that the death has really occurred. As these emotions can be difficult to express, it's helpful to reassure them that such feelings are shared and understandable. At the stage of bargaining and acceptance, people often feel the need to reach out to others and find meaning as a way of coming to terms with their loss.



8. Kübler-Ross, E. & Kessler, D. (2014). On Grief and Grieving: Finding the Meaning of Grief Through the Five Stages of Loss. Simon & Schuster.

It may become apparent at this stage – or earlier – that members of the team were closer to the person who has died than their colleagues had realised. People might find that the death invokes memories of past bereavements, or other distressing experiences. It is not unusual to feel guilty in the aftermath of a sudden death, especially a death by suicide; people may regret not noticing their colleague's distress, or wish they had phoned or visited them, or asked how they were feeling. It is natural for people to feel that doing something differently might have helped avoid the death, but excessive self-blame can be damaging.

Sudden death, especially a death by suicide, can be a potent cause of anger. While such feelings are understandable, they can be destructive and disruptive. Staff may become angry with one another and with those who hold responsibility in the practice. Partners may become angry with one another, with the IBC, or with the medical practitioners who were caring for their colleague. The wider medical community may express anger about a 'failure' of the practice or secondary care colleagues to appropriately support and care for the person who has died, especially if they were well known locally. Those involved may find themselves displacing their frustration and anger onto their families or the patients.

Although anger is a common emotional response to grief, angry feelings can be difficult to disclose. People expect to feel sadness after the death of someone close to them, but anger can cause confusion, anxiety and shame because it can be considered an inappropriate response. It is important to find a way to express angry feelings in a safe, trusted space, otherwise they can intensify. There are techniques that can help people lessen their feelings of anger after a bereavement, such as writing a letter to the person who has died or releasing angry emotions through exercise.[9]

2. Talking about a team member's death with patients

The reception team is often the first point of contact for enquiries, so it can be helpful for the practice to decide in advance what should be communicated. The family will often, but not always, be happy for the cause of death to be widely known once it has been established, and it may be openly talked about at the funeral. They may prefer to avoid discussing the cause of death, especially if it involves sensitive issues such as alcohol overuse, HIV infection or, occasionally, cancer. Their wishes should be established and respected. The discussion of a death by suicide is especially complex and is addressed in the original report.[10] Any discomfort should be spoken about openly and honestly within the team to avoid ambiguity and confusion.

3. Practical risks to running the practice

As with any death in a practice, steps must be taken to maintain the day-to-day care of patients. The risks and the actions needed will, to some extent, depend on the role played by the person who died, and the size of the practice. For larger organisations, maintaining the level of service to patients is likely to be more manageable. Locums may be needed, but partnership and managerial responsibilities can usually be covered. It is important, however, to assess the risk of placing additional pressure on staff members during a time that will be unusually emotionally demanding and stressful.

If a single-handed practitioner dies, the Integrated Care Board takes on the responsibility of running the practice and making decisions about its future. Small practices are at significant risk. If one partner in a two-partner practice dies, or if a single-handed doctor loses a manager they depend on, it can be close to impossible to continue to maintain the necessary service. The remaining partner may have little knowledge about managing the financial situation. They may not feel able to take time off when they need to. They may be overwhelmed by anxiety for themselves, their patients, and the staff they employ. The risks of burnout are very high for people in this position, especially for those who lack practical or emotional support.

9. Murray, J. (2019). Why we need to talk about anger in grief. Marie Curie Talkabout. https://www.mariecurie.org.uk/blog/anger-in-grief/253186

10. Kinman, G. & Torry, R. (2021). Responding to the death by suicide of a colleague in Primary Care: a postvention framework. p8–9.

4. Getting external support

Teams who have suddenly lost a valued member may struggle to meet their support needs over what can be a protracted period. While seeking support is not obligatory and teams may manage effectively with their internal resources, it is important to identify those who are experiencing intense or ongoing difficulties and offer additional help. People in a leadership role might be particularly vulnerable to long-term adverse effects; they may only be able to support others by dissociating from their own feelings, and find it difficult to find the necessary time and space to grieve themselves. Doctors who are struggling can refer themselves to NHS Practitioner Health (PH)[11] and should be encouraged to do so. PH is a free, confidential NHS service for doctors and dentists across England. It can help with issues relating to mental health, including stress or depression, with a particular focus on issues that might affect work. In Wales, Canopi offers a free and confidential mental support service for any social care and NHS staff.[12]

For non-medical members of the team, the local NHS Talking Therapies, for anxiety and depression team[13] can be helpful. As well as offering individual support, they may be willing to hold a group session for members of the practice. There may also be a minister of religion who knows the family and the practice and who can offer individual support if required. It is important to bear in mind, however, that members of staff are likely to have diverse religious and spiritual beliefs.

The external bodies mentioned earlier (the Integrated Care Board, the Local Medical Committee, the clinical director and commissioners of the Primary Care Network and, in the case of a doctor, the Responsible Officer) will have to be informed of the death. Experience indicates that the level of support and advice provided varies. The ICB may be able to provide financial assistance through their crisis fund.

The first **month:** key actions

- ☐ Assessing the risks to the short-term and longer-term functioning of the practice.
- ☐ Ensuring opportunities for the team to meet and offer mutual support.
- ☐ Dealing with any continuing distress and emotional responses such as guilt and anger.
- ☐ Recognising that staff will have different emotional experiences at different stages, so an individual rather than a collective approach to support is required.
- ☐ Signposting people who may be experiencing protracted, more serious emotional distress to external support.
- ☐ Agreeing on a consistent approach to ongoing communications with patients.

11. NHS Practitioner Health https://www.practitionerhealth.nhs.uk/
12. Canopi. Confidential mental support service for any social care and NHS staff in Wales. https://canopi.nhs.wales/
13. NHS Talking Therapies, for anxiety and depression. https://www.england.nhs.uk/mental-health/adults/nhs-talking-therapies/

Longer-term effects and actions: vigilance, continued support, and remembrance

1. Continuing support among the team and meeting the needs of individuals

During the initial acute phase after the death of a colleague, staff may find it difficult to maintain focus and be productive. Most people will recover their ability to function in a fairly short time, provided they receive support and are compassionate towards themselves. After the first few weeks, it is common for people to want to start getting 'back to normal', and they will try to find a way to continue grieving while meeting their responsibilities.

Over the longer term, team members may not need to meet up regularly to discuss their loss, but this could be arranged on an ad hoc basis if required. Nonetheless, unrealistic expectations of oneself and others to 'move on' should be avoided. People may be reluctant to disclose that they are not coping well. Some colleagues may continue to feel the loss intensely or experience more complex emotional reactions. Existing vulnerability factors may be stress related – to the job, their personal life, health problems, a limited social support network, or a previous complex bereavement.

Some team members may express their reactions behaviourally, through absenteeism or problem drinking, or through psychological reactions such as negativity and cynicism. Others may work excessively long hours to distract themselves from feelings of loss and negative emotions. In a small organisation, such as a primary care practice, such reactions can place additional pressure on the remaining team members. Therefore, discussions and additional support, both emotional and in terms of cover for absence, may be necessary. Managers may continue to experience challenges as they balance the need to care for and support staff with providing essential services to patients. They must also practice self-compassion and prioritise their own recovery.

2. Remembering the colleague who has died

Decisions about memorials are best made collectively, with the input of all team members. Some months after the death, a memorial event involving patients as well as staff can be a source of comfort for all involved.

Marking the first anniversary of the colleague's death and sometimes other key milestones may be appropriate. Planning memorial activities can be a great source of comfort and help people derive a sense of meaning from the loss. Examples include planting a tree or placing a memorial bench in the grounds of the practice or in a local place special to the person who has died.

Hanging a photograph or creating a memory board, with photographs and other meaningful items to mark the person's life can be simple and effective. Continuing to mark their contribution to initiatives and projects can also be comforting and help keep their memory alive. It is also useful to plan for 'grief triggers' such as birthdays, or activities and traditions the person particularly enjoyed.

Longer term: key actions

- ☐ Ensuring there are opportunities for continuing support among the team that meet individual needs.
- ☐ Being aware of how distress might manifest itself over the longer term and remaining vigilant for signs of difficulty.
- ☐ Balancing the loss with the need to resume 'business as usual', while ensuring expectations of the team are realistic.
- ☐ Highlighting the need for self-compassion and self-care for all team members, including leaders.
- ☐ Deciding how to remember the colleague who has died over the longer term.

Conclusion

The sudden death of a colleague is a stressful and disruptive event that can have a long-lasting impact on many aspects of life and work. If the members of a practice can 'pull together' and provide mutual support, it will help the recovery process. Larger practices are generally able to find resources internally, but our original interviews indicated that small practices are more likely to struggle at every stage. A single individual may be left to manage major practical tasks, as well as cope with the emotional impact of losing a close colleague. This can place both the individual and the practice at high risk.

Our hope is that this revised framework will be helpful to all practices experiencing the sudden death of a team member.

Recommendations

- Practices should develop a crisis protocol for the sudden death of a team member, as they do for other major incidents.
- The framework we are offering should be widely disseminated so it is available when needed.
- Practices are recommended to contact the RCGP Sudden Bereavement Support team, who will be able to talk through the processes to follow and give practical advice.

Summary table: actions and timescales

Action	First day	First week	First month	Ongoing	Undertaken by whom
Contacting external coordinator/task force to receive guidance on who to inform and to receive ongoing support					External support needed
Access to a helpline to talk through key issues					External support needed
Deciding what to say to staff/liaising with family if appropriate; breaking news to team					Internal
Ensuring there is time and space to de-brief and offer initial support; dealing with distress of staff					Internal
Arranging immediate locums/cover for staff, possibly on an ad hoc basis in future					External support helpful
Access to the crisis fund to meet the costs					External support needed
Identifying anybody who is unable to continue working and ensuring they take time out; reallocating work or finding cover if required					Internal; External support helpful
Deciding what to say to patients, breaking the news and dealing with their distress; managing ongoing conversations consistently					Internal
Providing a memorial e.g. flowers and a book of remembrance in reception					Internal
Liaising with the family about the funeral/memorial and finding out their wishes					Internal
Arranging to close the practice for the funeral or getting cover if this is not possible					External support needed
Organising an informal and inclusive memorial, if required					Internal
Identifying practical risks to running the practice (short-term and longer-term) and how they can be managed					Internal
Dealing with personal belongings					Internal
Dealing with ongoing distress among staff and being aware of how it can manifest itself; deciding if external support is needed and where it can be found					Internal; External support helpful
Access to an experienced counsellor for personal support, if required					External support needed
Ensuring opportunities for the team to continue to meet and offer mutual support					Internal
Remaining vigilant for signs of difficulty and referring on if required					Internal; External support helpful
Deciding how to remember the colleague who has died over the longer-term					Internal
Ongoing external support: a national mentorship scheme and support group for people to share similar experiences					External support needed

Resources

National Health Service Practitioner Health (NHS PH)
https://www.practitionerhealth.nhs.uk/

NHS PH is a free, confidential NHS service for doctors and dentists across England. The service is accessed by self-referral. It can help with issues relating to a mental health concern, including stress or depression or an addiction problem, with a focus on issues that might affect work. The service can also offer support to a doctor leading the response to a death by suicide in their practice, which may not be well known. They also host a regular bereavement group for families of health professionals who have been lost to suicide.

British Medical Association (BMA)
https://www.bma.org.uk/advice-and-support/your-wellbeing

The BMA offers confidential 24/7 counselling and peer support available to all doctors and medical students, as well as their partners and dependants, on 0330 123 1245.

Canopi
https://canopi.nhs.wales/

Canopi offers a free and confidential mental support service for any social care and NHS staff in Wales.

Doctors in Distress
https://doctors-in-distress.org.uk/

A charity committed to reducing the prevalence of burnout and suicide among doctors in the UK. Their primary goal is to reduce stigma, change behaviours and cultures, and promote the value of good leadership.

NHS Talking Therapies, for anxiety and depression
https://www.england.nhs.uk/mental-health/adults/nhs-talking-therapies/

This replaces Improving Access to Psychological Therapies (IAPT). These services are offered by all clinical commissioning groups across England, so are locally responsive. The service offers a range of talking therapies, delivered by fully trained and accredited practitioners, matched to the mental health problem and its intensity and duration, and is designed to optimise outcomes. The practitioners may be willing to go into a practice and work with a group of staff.

Royal College of General Practitioners (RCGP) Sudden Bereavement Support
The RCGP has trained a small team of advisers to provide practical advice and signposting following the sudden death of a key practice member. The team aim to respond within 24 hours during the working week. There is no cost to the practice.

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