



ASSOCIATION OF
BREAST SURGERY

Association of Breast Surgery: Return to Work Framework



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Introduction

This framework provides suggested guidance to support breast surgeons returning to work after either:

- 1. a short period of absence (up to 6 months) or
- 2. a more prolonged period of absence (over 6 months)

This is to ensure they have the confidence, skills and energy required to resume independent clinical practice.

This framework IS NOT intended be used for individuals who have had a period of absence due to performance-related or disciplinary issues.

Disclaimer: These guidelines are advisory and are intended to help to guide members and their managers when planning their return to work. They do not replace local Trust policies or protocols.

General requirements

All individuals should have a named supervisor (usually their departmental Clinical Lead, Line Manager or Clinical Director) to undertake their initial return-to-work meeting, manage any workplace-related adaptations, review their job plan in the context of the wider service requirements, and to then conduct regular meetings with the individual until they feel confident to resume independent clinical practice. This supervisory role should be job-planned for 0.5PA (2 hours) per week.

Individuals returning to work will require dedicated time for refamiliarisation with Trust policies, national guidelines and IT systems. All individuals should be job planned for appropriate levels of clinical activity with colleague support until they have regained their confidence and skills following their period of absence.

Occupational Health or Practitioner Health guidance must be taken into account when designing a return-to-work programme.

1. Short absence

These individuals may have had a shorter period of absence from the workplace due to, for example, illness, parental leave or carer responsibilities. They will not have had any issues with their clinical performance prior to their period of leave. The support required will simply be to manage and accommodate any ongoing health needs, reduced energy levels or ongoing carer responsibilities until the individual is able to resume full practice.

Areas which should be discussed and agreed between the individual and supervisor may include:

- Refamiliarisation with Trust IT systems and updated policies
- Clinic length and timings of slots
- Theatre list timings and colleague support
- Wellbeing resources
- Planned review points and projected full return to work date (subject to progress)

2. Prolonged absence

Individuals with a prolonged absence may require more structured support and a longer period of acclimatisation prior to their full return to work. A longer period of absence may impact many areas including workforce changes, new IT systems, new national and local policies, mandatory training requirements, loss of surgical skills, etc.

In addition to the named supervisor, it is advised to identify at least two other senior breast team members who can provide constructive feedback to inform the discussions between the individual and their supervisor.

At the first meeting, the supervisor and individual should discuss the full remit of the role based on the ISCP competencies (appendix) to facilitate reflection. Goal setting and timescales should be agreed with the individual at a follow up meeting (form in appendix).

Weekly/ fortnightly meetings should then be scheduled between the individual and their supervisor to assess their progress against the identified goals, and to identify any additional support required.

Following the phased return period, the lead supervisor and individual should undertake a final meeting, reflecting on feedback from the senior colleagues to inform the discussion. If any areas are still identified by the individual or their supervisor as requiring support, a plan can be made to amend the date for resuming full duties, address these areas, and a further meeting scheduled.

Sample return to work timescale for prolonged absence

The individual should meet with their supervisor every 2 weeks to assess whether they are confident to move to the next stage

Phase 1: This should be on a part-time basis (one session per day). Gentle reintroduction to work, including reconnecting with colleagues, managing emails and administration, attending meetings and training sessions, familiarisation with hospital IT systems, and observing clinical practice.

- catch-up with people and emails, reducing any anticipatory anxiety about return
- complete mandatory competencies and outstanding training
- observing clinical practice in the outpatient clinic plus attend multidisciplinary meetings and case-based discussions.

Phase 2: Full days but 4 days a week. Gradual re-engagement with clinical duties, starting with reduced clinics with an experienced clinic nurse in attendance for each consultation. It is envisaged that assisting in theatre will resume.

- Undertake reduced patient lists in the outpatient clinics, attend multidisciplinary meetings, joint operating in theatre with reduced case load.
- Progress to independent outpatient clinics with $\frac{3}{4}$ capacity, multidisciplinary meeting, joint operating in theatres with full case load.

Phase 3: During this period the working pattern will be full time. Restart surgical duties as the primary surgeon assisted by another experienced breast surgeon. This period will include continued provision of full breast surgical clinics and weekly attendance at the MDM. Any additional managerial or leadership roles can be gradually reintroduced.

Competency reassessment and sign off for prolonged absence

At the end of the phased return period, the lead supervisor should review the initial discussion and SMART objectives with the individual. If these have been achieved, the supervisor can sign the individual off in the relevant domain. If all domains are signed off, the individual can resume independent clinical practice.

If any of the domains are not achieved, either due to self-reflection or the supervisor's observations, a further SMART objective should be set with a revised time point.

Once the individual has resumed independent practice, there should be a follow up meeting arranged after approximately 3 months to check whether any further support is required by the individual.

Maternity/ paternity leave

The Royal College of Surgeons has produced separate guidance for individuals returning to work after parental leave; this can be accessed here: [Surgery, pregnancy and parenthood - Royal College of Surgeons](#). Further resources and information are available via this link: [Delivering Ambitious Change for Parents in Surgery | RCS England](#)

Appendix: Supporting documentation

ISCP Consultant-level required competencies

Generic Professional Capabilities:

Domain 1: Professional values and behaviours

Domain 2: Professional skills:

- Practical skills
- Communication and interpersonal skills
- Dealing with complexity and uncertainty
- Clinical skills

Domain 3: Professional knowledge:

- Professional requirements,
- National legislative requirements,
- The health service and healthcare system in the four countries

Domain 4: Capabilities in health promotion and illness prevention

Domain 5: Capabilities in leadership and team working

Domain 6: Capabilities in patient safety and quality improvement:

- Patient safety
- Quality improvement

Domain 7: Capabilities in safeguarding vulnerable groups

Domain 8: Capabilities in education and training

Domain 9: Capabilities in research and scholarship

Capabilities In Practice:

1. Manages an out-patient clinic
2. Manages the unselected emergency take
3. Manages ward rounds and the on-going care of in-patients
4. Manages an operating list
5. Manages multi-disciplinary working

Knowledge: ISCP Breast syllabus topics:

1. Breast and axillary assessment
2. Benign breast conditions
3. Breast cancer
4. Principles of oncoplastic surgery
5. Implant based/assisted reconstruction
6. Autologous reconstruction
7. Principles of breast aesthetics including symmetrising surgery

Tools available to support assessment and reflection on specific competencies

Self-Assessment on GPCs and CiPs (initial, midpoint and end of placement)

Objective report: Multiple Consultant Report (MCR): compares performance in each CiP and in the GPCs (initial and endpoint)

Clinical knowledge: Case based discussions (weekly)

Operative competencies: PBAs, logbook (endpoint)

Communication skills: CEX/ CEX Consent (midpoint and endpoint)

Team-working: MSF (initial, endpoint)

Initial and final meeting: review/ assessment of competencies

This document can be used to guide discussion and support in specific areas of independent clinical practice

Area	Comments
Professional values and behaviours	
Communication skills	
Clinical knowledge	
Clinical assessment	
Operative skills	
Team working	
Leadership skills	

Individual’s reflection:

Supervisor’s reflection:

SMART objectives agreed

Specific: what area (s) is identified for support	Measurable: how will this be undertaken and assessed	Achievable: what support will be given to the individual	Relevant: How will this support development in the specific area	Time: set a date to achieve this	Date achieved and reflection
<i>e.g. I need to update my oncology knowledge</i>	<i>I will attend the ABS Advanced Skills in Breast Disease Management Course</i>	<i>Study leave and funding to attend the course</i>	<i>The course will provide updated information on current oncology treatments relevant to my clinical practice</i>	<i>March 2026</i>	

Competency areas: suggested sources of support

Professional values and behaviours

- Non operative technical skills course e.g. RCS Ed NOTSS
- Reflective logbook
- Case based discussions

Communication skills

- ABS or other Advanced Communication skills course (including medicolegal content)
- Attending and contributing to MDT discussions
- Seek feedback from specialist nurses

Clinical knowledge

- Attending educational courses mapped to individual requirements e.g. ABS Advanced breast disease management course/ ABS annual conference
- Case based discussion of 3 cases after each MDT over 12 weeks

Clinical assessment

- Attending outpatient consultations including One stop, Results and Post op, initially as an observer over 4 - 6weeks, followed by undertaking independent consultations with a senior breast care nurse always in attendance. Seek feedback from patients and families.

Operative skills

- Operating theatre sessions: Initially observing / assisting over the weeks 5-8, then undertaking procedures as primary surgeon observed and assisted by consultant supervisors in weeks 9-12.
- The case mix as the operating surgeon during weeks 9-12 should be resectional surgery including benign and malignant (no oncoplastics).
- Maintain a reflective logbook of cases and outcomes (complications/ margins/ etc)

Leadership skills

- Undertake a leadership and management course, e.g. online ISC course
- Undertake lead role in MDT in weeks 10-12 and seek feedback from multidisciplinary team members
- Connect with line managers (Business Service Manager and Divisional Operations Manager) to review and understand current service outcomes and targets

Knowledge: suggested case-based discussion topics

Diagnostic pathway

Indications to request breast imaging for symptomatic breast problems including:

1. Ultrasound
2. Mammogram, tomosynthesis (and eventually contrast enhanced mammography)
3. MRI, Contrast enhanced mammography
4. CT, PET CT
5. Bone scan

Family history and genetics

- Family history
- Can risk assessment / Manchester score
- Genetics (such as BRCA 1and 2, PALB2 etc)
- Indication for mainstream genetic pathway testing
- Discussions of steps to reduce risk of breast cancer including:
 1. Lifestyle
 2. 'chemo' prevention
 3. Risk reducing surgery
- HRT. Knowledge of different types and effect on breast cancer incidence and / or recurrence risk.

Benign breast conditions

- Mastalgia
- Management nipple related problems including
- Rash/dermatitis/Paget's
- Nipple discharge
- Duct ectasia
- Inverted nipple

Male breast

- Male breast pathology
- Management breast lumps
- Aetiology gynaecomastia
- Management of gynaecomastia
- Investigations for gynaecomastia including when to request mammogram, ultrasound and blood tests

Breast infection

- Management of acute infection including mastitis and abscess formation.
- Management of periductal mastitis mammary and duct fistula
- Management lactational sepsis and abscess
- Indication for cabergoline

Indeterminate breast tissue pathology

- Management P3 lesions
- Management of B3 lesions and intraductal papilloma, radial scar, AIDEP (ADH) and LCIS

Breast cancer pathway

- The patient with proven breast cancer
- Breaking bad news
- Discussion of breast cancer management options including
- Primary endocrine therapy
- Neoadjuvant endocrine therapy
- Surgical options to breast and axilla
- A knowledge of the indications of when to consider oncoplastic breast conserving surgery
- Management of the axilla including knowledge of when to consider sentinel node biopsy, axillary node clearance, nodal radiotherapy, targeted node dissection.
- Discussion of surgical techniques, side effects, post op complications and risks, post operative recovery and aftercare
- Obtaining informed consent

Breast cancer pathology

- Discussion about the implications of different tumour subtypes and pathology including
- Invasive Ductal Carcinoma
- Invasive Lobular Carcinoma
- Less common subtypes including mucinous and tubular, inflammatory
- In situ disease DCIS, papillary carcinoma in situ and pleomorphic LCIS

Adjuvant non-surgical treatments

- Different types, indications for use, side effects and complications of anti-oestrogen therapy
- Indications and use and problems of bisphosphonates
- Indication for use of CDK 4/6 inhibitors
- Indication and rationale for use of a PARP inhibitor
- Tumour genetic testing, oncotype and recurrence score
- Indications for systemic cytotoxic chemotherapy
- Indication for radiotherapy to breast (whole breast and partial breast) and regional lymph nodes
- Management of bone health

Operative and non-technical skills: Suggested case-based discussion topics**Pre-op management**

- Informed consent and case selection
- Competence in Operating List planning
- Leading pre theatre discussion
- Thromboprophylaxis
- Reducing risk of post operative sepsis

Intra-op management

- Reducing risk of excessive bleeding and haematoma
- Appropriate peri operative and post op pain care management

Technical competence in:

- Sentinel node biopsy
- Axillary node clearance
- Wide local excision of breast tumour
- Seed/ Radioisotope guided or wire guided wide excision
- Assessment of surgical margins
- Simple or total mastectomy

- Wound closure
- Indications for use of negative pressure pressing
- Indication for and management of post op drains
- Suggest a minimum of 4 operating lists observed / assisting prior to undertaking cases with support from a consultant colleague. And a minimum of 4 of each of the index procedures before being signed off as competent via PBA at level 4.

Post op management

- Post op pain care management
- Lymphoedema management
- Physiotherapy and shoulder movement
- Post op complications: Haematoma, seroma, pain, sepsis, skin flap necrosis
- Consultation skills and dealing with unhappy patient
- Surveillance imaging



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