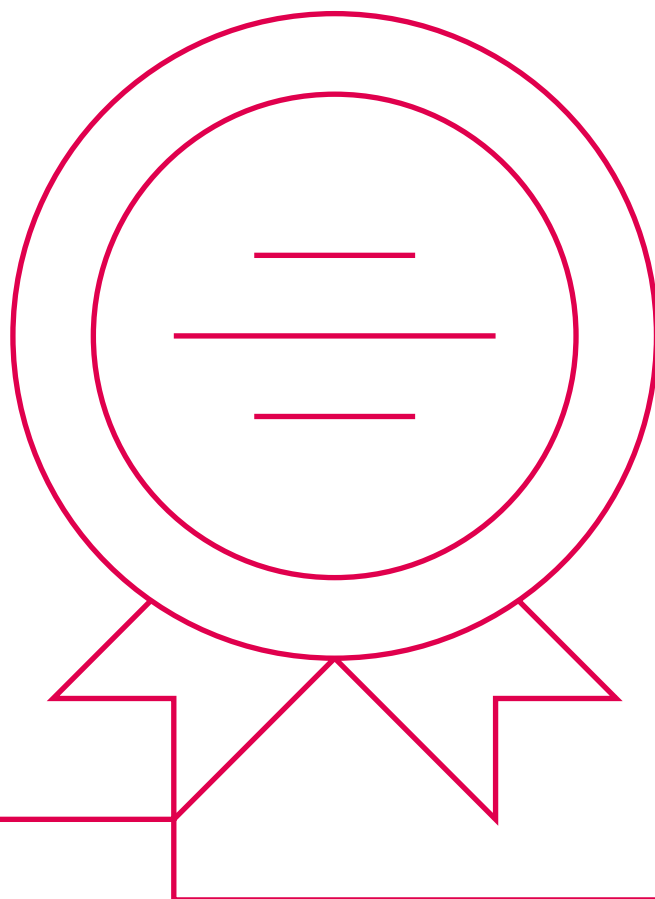


June 2017

Return to Practice Guidance 2017 Revision



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Preface

During the development of revalidation for doctors, the Academy of Medical Royal Colleges (the Academy) had considerable concern regarding the lack of guidance doctors' returning to practice after a period of absence.

In light of this a working group was established in 2010 to produce a report, both in order to highlight the importance of a good procedure for doctors returning to practice and to provide practical advice. The recommended guidance is based on the considerable experience of the working group involved and a review of the limited evidence available.

This revised return to practice guidance replaces that which was published in 2012, providing updated information on return to practice in line with new thinking.

Patient safety is the guiding principle of this report and must be put first, above all other considerations.

Who is the guidance for?

- All doctors returning to the same clinical area as previously practiced following an absence for any reason (including those returning to their usual practice after working in a different area of clinical practice). It is the duty of all doctors to ensure that they are safe to return to practice.
- All doctors who have been absent for three months or longer and including in all cases where the licence to practise has been surrendered and is then restored by the GMC.

This guidance can be used in all circumstances as part of the process of return to practice. In cases where there are unresolved issues that need to be addressed separately, these should be dealt with via the normal processes. However, this guidance can still be used in addition to those processes, if helpful. Examples of unresolved issues can include:

- Health issues (which should be addressed through occupational health processes). Where health is a major reason for absence, an occupational health opinion should be obtained to receive advice on adjustments to the doctor's role
- Conduct issues (which should be addressed through HR management processes)
- Capability issues (which should be addressed through remediation processes).

This guidance focuses on re-entry of doctors to practice. It is not designed as a guide to obtaining re-employment.

Who should use this guidance?

Doctors

It is the professional duty of the doctor to ensure that they are up to date, competent and safe to return to practice. Doctors must seek to identify and address issues arising from absence and help set in place the necessary processes to support them to update their skills and knowledge.

Designated bodies/those who employ or contract doctors (including GP partners)

Organisations need to prepare for absences and returns, identify issues, agree the processes and help put appropriate, targeted and proportionate support and training in place. Employers should facilitate the return to work of employees. This might often be within the remit of the Clinical Manager.

Regulators including the General Medical Council (GMC) and Responsible Officers

As part of clinical governance, Regulators and 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.

Doctors' appraisers

Appraisers need to identify issues affecting the returning doctor and ensure that the correct process is being followed.

Locums, their employers and contracting agencies

Employers and contracting agencies should clarify locums' employment records – these recommendations apply to doctors returning after an absence of three months or more from regular practice (or potentially less than three months if they have not been in regular practice). Where appropriate there should be a dialogue with the locum agency RO.

Those holding performers' lists. In England this is currently NHS England and in Scotland, Wales and Northern Ireland, this will be local Health Boards

These organisations may need to consider a mechanism to ensure that doctors absent from practice for three months or more can return to practice safely.

Health Education England (HEE) local teams and/or those delivering/designing training for doctors, and trainee doctors

Health Education England local teams should plan and ensure a safe and effective return to learning, and also to practice. Key individuals for trainee doctors will be the Postgraduate Dean and Training Director.

Organisations offering continuing professional development (CPD) and support to doctors, including Medical Royal Colleges

These organisations may offer updates to clinical skills.

How should this guidance be used?

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. The use of this guidance will help to facilitate this.

This guidance covers doctors who have been absent for three months or more. The checklists [Sections 5 & 6] should be used pre [where possible] and post absence to conduct an individual evaluation of the doctor returning to practice. The guidance also gives recommendations for a return to practice action plan and suggests an organisational policy to ensure an effective return to practice in the interests of patient safety. The checklists and action plan give an opportunity to identify issues, support and potential training required by the returning doctor. They do not assume that the returning doctor is not fit to practise. The doctor may need advice and guidance from colleagues and managers before answering the questions in the checklists.

Each doctor will have different needs when returning to practice reflecting their experiences and circumstances and not simply their length of time out of practice. Designated bodies and their Responsible Officers should use the checklists as part of the appraisal process when doctors are to return to practice. They will need to take account of the doctor's revalidation dates and their need to gather supporting information, including any participation in continuing professional development (CPD) while out of practice and any appropriate future CPD required.

The evidence gathered by the Academy's Return to Practice Working Group in 2011-2012 identified a key factor affecting a doctor's successful return to practice was the length of time out of practice. Taking this information into account, the longer the period out of practice, the more robust the process of return to practice should be. However, all return to practice reviews should be robust, appropriate and commensurate with the period of absence as well as other factors identified through the checklists.

- **Shorter absences:** An absence of less than three months appears less likely to cause significant problems, but may still affect confidence and skills levels. The majority of doctors in these cases should be able to return to work safely and successfully although they may sometimes require support. Should further research evidence on length of absence emerge at a later date, this suggested 'cut off' of three months may need to be reviewed
- **Longer absences:** An absence of three months or more appears more likely to significantly affect skills and knowledge. Therefore a review is recommended and support may be needed (although for shorter absences this will often not need to be a formal re-training programme and it will depend on individual needs). The approach should be commensurately more robust the longer the period of absence to ensure patient safety.¹

In practice, an absence of two years or more seems generally accepted as a rule of thumb for when formal re-training will more often be required. Therefore the closer the absence grows to two years, the more likely it is that formal re-training will be helpful. Individual needs will vary, and therefore reviews on a case-by-case basis will be the only way to identify what support an individual will require to return to practice safely.

It is important that doctors and employers prepare for any predictable absences from practice, such as maternity/paternity leave or periods of working abroad. Early notification of absence to the employer will be beneficial to both the doctor and employer, enabling better planning of any support needed on returning to practice. The notification of absence is the doctor's responsibility, but it is the responsibility of a good organisation to work with the doctor to evaluate and identify issues or support needed. Those who do not have an organisation may be able to obtain help from one of the organisations listed in Appendix 1. Where doctors do not have employers, they still have a responsibility to manage their own return to practice and ensure that they have the necessary support.

The doctor should take an active part in setting up their return to practice action plan (see [Section 3](#)). This should be done either prior to return or immediately on return. Those carrying out the doctor's evaluation may need to judge what insight the doctor has into their needs in creating the plan. Precisely who undertakes the evaluation is a matter for employers and regulators, but individual needs should be well defined and appropriate to the organisation e.g. Medical Director, Responsible Officer, Clinical Director, Postgraduate Dean or Lead Clinician. Notes should be made and records should be kept. The doctor (and their employer, partner or contracting agency) should review the answers given to the doctors return to practice checklist against the planning an absence from practice checklist (if this was completed) to note any changes from expectations and progress during the period of absence.

If evidence arises at any point that patient safety might be being compromised, the necessary processes must be put into place with the appropriate authorities informed and action taken. For example, a local Responding to Concerns process or if there are even more serious concerns, a referral to the General Medical Council. The name of whoever is empowered by the organisation to agree that any potential patient safety concerns have been met (and thus the doctor can return to practice) should be identified to the doctor.

Specifically regarding maternity leave and shared parental leave, two points should be noted:

- **The law requires employers to assess the risks to their employees (Management of Health and Safety at Work Regulations 1999) including new and expectant mothers and to do what is reasonably practicable to control those risks**
- **Keep in touch (KIT) days are a voluntary arrangement between doctors on maternity/ shared parental leave and their employers. However, it is good practice to offer and facilitate these days if the doctor is able to come in to work.**

Useful resources regarding shared parental leave:

- [Shared parental leave GOV.UK](#)
- [Shared parental leave BMA](#)
- [Shared parental leave NHS Employers](#)
- [Shared parental leave ACAS](#)

The final decision regarding returning to practice rests with the relevant body for example, the employer/designated body, the practice or the regulator. For trainee doctors, plans for a return to learning as well as return to practice, should be made. If an issue arises which creates difficulties in agreement between doctors and employers, normal methods of dispute resolution should be undertaken.

Return to Practice action plan

In formulating the action plan, the following should be included for consideration:

The doctor's learning needs based upon the answers to the planning an absence from work and return to practice checklists

- How the doctor has learned successfully in the past
- How and when it will be assessed whether the learning needs have been met
- Which new learning is necessary to help improve patient care
- How this learning will fit in to the doctor's job plan
- How to fund the learning.

Possible actions to assist the doctor in safely returning to practice

- The doctor should list any plans for education on returning to practice or any CPD that has been completed while away, or can be taken soon after their return, such as specialty specific updates. The doctor should keep a record of any work or CPD that is undertaken during an absence
- Ensuring that, where possible, the first patient list(s) is/are straightforward and that additional support is available. The longer the doctor has been absent, the longer this support may be necessary
- Ensuring that enough time is allowed when first returning to work for discussions with colleagues and managers to respond and assist where necessary. It is likely more time will be needed for those doctors who have been absent longer.

Other important methods to consider using

- Arranging for periods of observation of the doctor (either by the doctor, the organisation/employer or both)
- Supernumerary arrangements for a period of time if needed
- Professional development (e.g. Essential Knowledge Update, or refresher courses where they exist)
- Setting up formal or informal mentoring arrangements
- A phased or staged return to work
- Flexible hours or other flexible arrangements that may be necessary.

Arrangements for ensuring the success of the return to practice process

- Those responsible (e.g. Medical Director, Clinical Manager, Appraiser, Responsible Officer, etc.) should be given updates of the doctor's plans for return to practice, and of their satisfactory completion. The employer and the Responsible Officer should plan to review progress after three to six months, or more frequently if other causes for concern are identified
- A date for a formal appraisal when a doctor returns to practice should be arranged on notification of absence from practice or soon after. At this appraisal evidence of completion of the return to practice action plan should be given. The appraisal should determine whether the questions raised in the checklists have been addressed
- Where doctors do not have employers, they still have the responsibility to manage their own return to practice and ensure that they have the necessary support, and that arrangements are made to support their safe return. They may need to inform their Responsible Officer. Organisations that can provide advice to doctors who are returning to practice are listed in Appendix 1.

In drawing up this plan, targets should be realistic and dates should be set for its review.

Setting up an organisational policy on Return to Practice

For the purpose of patient safety, a clear and supportive process for the return to practice should be in place in all organisations employing or contracting doctors. Doctors themselves also have a professional responsibility to ensure that they are safe to return to practice and follow the guidance set out in this report. All organisations and groups named within this document are responsible for ensuring that they are aware of and use this guidance.

An organisational policy for return to practice should include:

- Preparation before any absence from work (where possible) by the doctor taking absence and those working with them to ensure that there is a supportive plan for the doctor's return – using the checklists and recommendations in this guidance
- An initial evaluation of the individual doctor's needs just before or on return to work, using the suggested checklist and recommendations in this report
- Following this evaluation, a proportionate response to the doctor's needs should be devised which would have different levels of formality depending on the level of the needs. Employers should consider how the process they agree with returning doctors fits with processes for other health professionals working for them
- There should be timelines agreed for the completion of any support or training and the evaluations that are necessary.

Planning an absence from practice – recommended questions and actions

The following checklist of questions is recommended to be used pre-absence, where possible, in order to help with the identification of issues and facilitate support planning. A copy of the completed checklist should be given to the doctor.

1. How long is the doctor expected to be absent? (Is there any likelihood of an extension to this?)

2. Are there any training programmes (including mandatory training) or installation of new equipment due to take place in the doctor's workplace in the period of absence? If so, how should the doctor become familiar with this on return?

3. How long has the doctor been in their current role? Is this relevant in determining their needs?

4. Will the doctor be able to participate in CPD or e-learning to keep up to date?

5. Will the doctor be able to participate in any keep in touch days or other means of keeping in touch with the workplace? If so, how will this be organised? This should also address how KIT days will be organised if the returner is returning to a different Trust.

6. Does the doctor have any additional educational goals, during their absence?

7. What sort of CPD, training or support will be needed on the doctor's return to practice?

8. Are there any funding issues related to question 6 which need to be considered?



9. Will the doctor be able to retain their licence to practise and to fulfil the requirements for revalidation?

10. Are there any issues relating to the doctor's next appraisal which need to be considered? If so, the Responsible Officer/representative may need to be informed.

11. If the doctor is a trainee, how do they plan to return to learning?

12. What will be the doctor's full scope of practice on their return?

13. If the doctor will be returning to a new role, what support relating to this will be needed, and how can the doctor prepare?

Signatures

Doctor *Date*

On behalf of the organisation *Date*

A doctors return to practice – recommended questions and actions

The following checklist of questions is recommended to be used post-absence to help with identification of issues and facilitate support planning. A copy of the completed checklist should be given to the doctor.

1. Was a planning an absence checklist completed? [If so, this should be reviewed.]

2. How long has the doctor been away?

3. 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]

4. How long had the doctor been practising in the role they are returning to prior to their absence?

5. What responsibilities does the doctor have in the post to which they are returning? In particular are there any new responsibilities?

6. How does the doctor feel about their confidence and skills levels? Would a period of shadowing or mentoring be beneficial?

7. What is the doctor's full scope of practice to be [on their return]?

8. If the doctor is returning to practice but in a new role, what induction support will they require and will they require any specific support due to the fact that they have been out of practice? What can the doctor do to prepare themselves?

9. What support would the doctor find most useful in returning to practice?

10. Has the doctor had relevant contact with work and/or practice during absence e.g. 'Keep In Touch' days?

11. Have there been any changes since the doctor was last in post? For example:

- 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 their specialty
- Service reconfiguration
- Changes to procedures as a result of learning from significant events
- Changes in management or role expectations. What time will the doctor have for patient care?

Are there any teaching, research, management or leadership roles required?

12. Has the absence had any impact on the doctor's licence to practise and revalidation? What help might they need to fulfil the requirements for revalidation?

13. 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?

14. Has the doctor been able to keep up to date with their CPD whilst they were away from practice?

15. If the doctor is a trainee, what are the plans for a return to learning?

16. Is the doctor having a staged return to work on the advice of Occupational Health?



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

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

19. Is a period of observation of other doctors' practice is required and/or does the doctor need to be observed before beginning to practise independently again?

20. 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*

Evidence and working arrangements with regard to Return to Practice

As part of the original report published in 2012, an extensive literature review was conducted. In summary, it found that while there is little shortage of opinion in this area, there is little clear evidence. The best published evidence available was from the United States² regarding a re-entry programme run for doctors who had been absent from practice for 18 months or more. It states that:

'The majority (67%) [of doctors] were found to have educational needs requiring moderate to considerable re-education or training [...] many re-entering physicians may not be ready to jump back into practice.'

The study also found that the more years the doctor was out of practice, the more likely they were to have poor performance ratings.

The United States' Federation of State Medical Boards published a report of its special committee on physician re-entry.³ It noted that:

'More than two years away from practice is commonly accepted as the timeframe for when physicians should go through a re-entry process. [...] In the absence of data, the Committee recognizes the need for flexibility when applying the two-years-away-from-practice timeframe to an individual practitioner, as there is great variability in specialty, type of practice, etc.'

In May 2014, the United States' Center for Personalised Education for Physicians and The Physician Reentry into the Workforce Project developed the *Roadmap to Reentry*.⁴ This states that: *'physicians [...] who have been out of clinical practice for two or more years and are applying for initial licensure, reinstatement, or reactivation of a license must demonstrate competence to practice and meet other state medical board requirements [...] The clinician may choose to participate in a formal reentry training program [...] or engage in a self-managed reentry process.'*

Evidence since the 2012 return to practice guidance

In 2014 the GMC published *Skills fade: a review of the evidence that clinical and professional skills fade during time out of practice, and of how skills fade may be measured or remediated*.⁵

The GMC report concluded: *'Similarly to the AoMRC review, this review has found limited and mixed evidence about how skills decline over a fixed period of time. Health professionals may take time out from professional practice for various reasons. This time out may be accompanied by voluntary removal from the register for that profession. It may also be as a result of enforced removal from or suspension from the register. There is little known about the impact that this time out may have on the registrant's competence, performance and skills. Whilst the requirements for registration on returning may be set down in legislation, there is little evidence to demonstrate how exactly the specifics of those reregistration requirements were determined. There is evidence that skills decline according to a curve, with the greatest decline being during the first few months, and subsequent decline being at a much slower rate. However, other studies contradict this. Many studies of retention of specific skills measure retention at six, twelve, eighteen and twenty four months. There is some consensus between health professional stakeholders that two or three years out of practice should signify a need for reassessment and retraining prior to a full return.'*

Having considered this report and its conclusions, the Academy considers that this review of evidence does not change the recommendations set out in this guidance. There is some evidence that skills decline at the greatest rate during the first few months. In addition, and perhaps most importantly, the recommendation to review after an absence of three months or more should be viewed as a supportive review.

In April 2016, the Academy published the results of a survey⁶ regarding doctors and dentists who had taken maternity and paternity leave.

Many respondents had had sub optimal experiences in areas such as keeping in touch while absent, financial issues and childcare. They also raised specific concerns regarding:

- Attrition of clinical knowledge and practical skills
- Expectation of immediately being able to function at a pre-leave level when resuming work
- Working out of hours without supervision from the outset
- Worries regarding missed new developments and changes in local and national guidelines.

The survey also found that 25% of respondents were concerned that their concentration would be impaired in the first few months following return to work. A number of recommendations were made, including:

- *To increase awareness of the Terms and Conditions of Employment in relation to parental leave*
- *To recommend to employers that trainees returning from parental leave have a designated consultant who will be available support and advise during the first three months of their return to work*
- *Employers to make available to those taking parental leave information about changes and developments to guidelines, procedures or equipment during their absence*
- *Recommend that all employers have an obligation to offer work 'shadowing' to employees returning from leave.*

Current working arrangements

In March 2015, a new national scheme, the Induction and Refresher scheme, which aims to support GPs back into practice was launched by NHS England, the Royal College of General Practitioners, Health Education England and the British Medical Association.⁷ Qualified GPs who have not worked in the NHS for more than two years and wish to work in England can access this – they will be assessed and go through a formal re-training scheme. In addition doctors from overseas can access this scheme.

The BMA has produced guidance on their website regarding returning to practice. The guidance is split into two strands – *taking a career break, advice for GPs and returning to clinical practice after absence*.⁸

A number of other professions in the UK have return to practice processes, varying in the degree to which they are compulsory. For example nurses have university led return to practice courses which are approved by the regulator.⁹

Formal retraining schemes do not exist in many medical specialties in the UK (other than for GPs), although it is worth noting formal retraining will often not be appropriate for doctors returning to practice after a shorter period of absence (although doctors should be evaluated after an absence of three months or more).

It is also worth noting that doctors who have given up their registration and wish to have it restored, will need to work in an approved practice setting at first.¹⁰ Any designated body would count as an approved practice setting, but if doctors are not planning to return to work in a designated body, they should seek further advice.

Appendix 1

Organisations who can advise doctors returning to practice

British Medical Association	www.bma.org.uk
General Medical Council	www.gmc-uk.org
Royal College of Anaesthetists	www.rcoa.ac.uk
College of Emergency Medicine	www.rcem.ac.uk
Royal College of General Practitioners	www.rcgp.org.uk
Royal College of Obstetricians and Gynaecologists	www.rcog.org.uk
Faculty of Occupational Medicine	www.fom.ac.uk
Royal College of Ophthalmologists	www.rcophth.ac.uk
Royal College of Paediatrics and Child Health	www.rcpch.ac.uk
Royal College of Pathologists	www.rcpath.org
Faculty of Pharmaceutical Medicine	www.fpm.org.uk
Royal College of Physicians of Edinburgh	www.rcpe.ac.uk
Royal College of Physicians London	www.rcplondon.ac.uk
Royal College of Physicians and Surgeons of Glasgow	www.rcpsg.ac.uk
Royal College of Psychiatrists	www.rcpsych.ac.uk
Faculty of Public Health	www.fph.org.uk
Royal College of Radiologists	www.rcr.ac.uk
Royal College of Surgeons of Edinburgh	www.rcsed.ac.uk
Royal College of Surgeons of England	www.rcseng.ac.uk
Local deaneries	www.copmed.org.uk/hee-offices-deaneries
Medical Women's Federation	www.medicalwomensfederation.org.uk
National Clinical Assessment Service	www.ncas.nhs.uk
NHS Careers	www.nhs.org/careers
NHS Employers	www.nhsemployers.org
Academy of Medical Royal Colleges	www.aomrc.org.uk
NHS Confederation	www.nhsconfed.org
Physician Re-entry Website (USA)	www.physicianreentry.org

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