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Health and social care professionals return to practice

A systematic review

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EXECUTIVE SUMMARY

BACKGROUND

This literature review was jointly funded and commissioned by the Chief Nursing Office in Scotland and the Health and Care Professions Council. It was carried out by researchers from the Nursing, Midwifery and Allied Health Professions Research Unit, in collaboration with the funding bodies.

The goal was to bring together evidence relating to the return to clinical or frontline practice of health and social care professionals following an extended period of absence (of longer than 3 months) not resulting from disciplinary or fitness to practise issues. In particular, evidence was sought about:

(1) the risks associated with return to practice; and

(2) approaches which could support return to safe and effective practice.

METHODS

A systematic literature review was carried out using established methods, following a pre-determined protocol. Comprehensive electronic searches, informed by initial searches of grey literature, were carried out. Rigorous processes were used to identify studies which met defined eligibility criteria. Included studies were full-text peer reviewed publications, including those with quantitative, qualitative and mixed methods, which were focussed on return to practice of a health and social care professionals. This included the 16 professions currently regulated by HCPC plus other relevant professional groups (e.g. doctors, nurses, midwives, pharmacists, dentists), after a period of absence (> 3 months). The transparency, or potential for reproducibility, of publications was appraised, and data extracted and synthesised from studies judged to have sufficient description of the method of compiling evidence to enable reproduction. Extracted data was coded to identify risks/harms associated with return to practice, and factors which positively or negatively contributed to

risks or safe return to practice. Data were tabulated and brought together within narrative syntheses which addressed pre-defined research questions.

FINDINGS

Evidence relating to return to practice

While 226 relevant full-text publications were identified, only 28 of these were judged to have sufficient description of the method and report data relevant to the research questions. These were a diverse group of heterogeneous studies, with a variety of qualitative/quantitative and primary/secondary study designs, with the majority conducted in the US and UK. The length of time that professionals were out of practice varied from 3 months to more than 20 years.

The most common reported reason for return to practice was caring responsibilities, although a number of other reasons were identified. More than half of the studies (15/28) focussed on return to practice of doctors, while the remainder focussed on other nursing, pharmacy and allied health professions.

In general, studies reported largely qualitative results, often in a narrative format, and the majority of evidence extracted related to factors which were implicitly – rather than explicitly - linked to successful return to practice.

Time away from clinical practice

There is widespread consensus that the longer a professional is out of practice the greater the potential risk is to the public, however the actual risks to service user safety are not described in the literature. Time away from clinical practice was associated with “skills fade”, or attrition of clinical knowledge and practice skills; and emotional factors, such as self-esteem and confidence.

Factors impacting on return to practice

Lack of skills, training schemes, placements, supervision, peer and employer support, funding for training, and lack of guidance, and variations in processes and poor administrative practice were all negatively associated with return to practice.

Individual, or personal, factors such as continued breast feeding, or personal feelings could also negatively impact on return to practice. Barriers relating to knowledge, performance and aspects of personal life could also impact on return to work. Age, gender, personal health and marital status were all related to return to practice.

Approaches to support return to practice

Organisational processes, such as well-organised and resourced return to work programmes, training and mentoring schemes, and clear policies and planning, could positively support return to work. National strategies, financial incentives, and improved work conditions/environment could all positively impact on return to practice.

Evidence relating to regulation

There is little research-based evidence available relating to the management of risk at a regulatory level in relation to return to practice, but guidance and recommendations, developed principally through expert opinion and primarily focussed on doctors, demonstrates consistency. To ensure a comprehensive, transparent and feasible regulatory process to support return to practice, recommendations include; the involvement of all relevant stakeholders, clear policy guidelines and mechanisms for clinical supervision, processes for certificating competency, adoption of flexible models, and the formation of a national return to practice database.

Regulators frequently prescribe a minimum number of hours of practice (often arbitrarily) for professionals wishing to return to practice. While there was broad consensus that that the

return to practice policies should be triggered following an absence of between 2 and 3 years, there was variation in this, and the evidence for this is unclear. There is no evidence that completing the required number of hours ensures competence.

IMPLICATIONS

Implications to support return to work

Health and social care practitioners wishing to return to practice would benefit from appropriate planning and preparation for their break and subsequent return; increased awareness of the potential impact of emotional, behavioural and social factors which may impact on return to practice; and early consideration of childcare arrangements (where relevant). Maintenance of social and professional networks during a career break can support subsequent return to work.

To support return to work, employers and organisations should provide well-organised, resourced, flexible return to work programmes, supported by clear policies and guidance. Employers should maintain clear communication with staff, including during the period of absence, and should consider the workload and environment of people returning to work. Provision of adequate breastfeeding facilities and policies can be important.

All relevant stakeholders should be involved in the process of developing guidance and policies relating to return to practice. New policy guidelines must clarify issues relating to time away from practice and what constitutes active practice. Policies should establish and clarify mechanisms for clinical supervision and certification of competency and should incorporate flexibility to accommodate the individual needs of staff and organisations.

A national return to practice database could be beneficial, documenting information such as the number of professionals returning to practice, their professional group, length and reason of absence, and the number of hours of training, supervision or mentoring.

Implications for future research

There are important gaps in the current evidence base. In particular, there is lack of evidence relating to the risks to, or perspectives of, service users. Identification of reliable, validated tools to assess aspects of return to work, including the impact on outcomes such as safety of service users and health and social care professionals, is essential. Further systematic review of evidence focussed on competence to practice, and the association with return to work, which has not been incorporated into this review, is advised.

CONCLUSIONS

A comprehensive review of evidence relating to return to practice of health and social care practitioners has been conducted. While the quality and comprehensiveness of current evidence is limited, a number of key factors which impact on return to practice have been identified. Implications for both health and social care staff wishing to return to practice and their employers and organisations have been highlighted. There is a need for clear guidance, policies and mechanisms in order to enhance the process of return to practice. This should be supported by carefully planned research to establish a high-quality evidence-base in this field.

1. INTRODUCTION

Global shortages of health and social care professionals exist in the workforce, with predictions that by 2030 there will be a worldwide shortfall of 15 million health workers [1]. Workforce shortages are primarily driven by economic and population growth linked to demographic changes in the population, an increasing demand for healthcare, a growing number of chronically ill patients and an ageing workforce [2]. There is a growing recognition of the need to develop effective recruitment and retention strategies for health and social care workers. One approach has been to recruit already qualified healthcare professionals to return to the workforce [3].

Healthcare professionals can be away from their normal working environment for a variety of reasons, and these periods of clinical inactivity can extend from months to years. Protracted leave may occur for a variety of reasons including maternity / paternity leave, carers leave, prolonged illness or an approved break [4]. Although career breaks are now considered a normal part of health and social workers career trajectory [5], there is very little evidence around how long healthcare professionals have to be away from clinical practice before consideration needs to be given to supporting their return to frontline services [5]. Managing a successful return to practice requires balancing the interests of the public – guaranteeing their safety and quality of care – while ensuring that the road to returning to practice is free of any unnecessary barriers.

The Health and Care Professions Council (HCPC) is an independent multi-professional regulator that was set up to protect the public in 2002 [6]. They register members of 16 professions and set and maintain standards which cover education and training, behaviour, professional skills and health. Fifteen of these professions are regulated on a UK-wide basis. Social workers are regulated on an England only basis, with separate regulators in the other UK countries. HCPC approve and monitor education programmes which lead to registration and maintain a register (c. 320,000 registrants) of people that successfully pass those programmes; and take action if a registrant's fitness to practise falls below those standards.

The HCPC requirements for health and social care professionals who have had a break from practice or wish to retain or regain their professional registration is based on a period of updating knowledge and skills. This can include private study, formal study and supervised practice. Private study can make up no more than half of the updating period [6]. The updating requirements and timelines are as follows.

- 0 to 2 years out of practice – no requirements.
- 2 to 5 years out of practice – 30 days of updating.
- 5 or more years out of practice – 60 days of updating.

However, the current HCPC process has been criticised as providing 'guidance at an arms-length'[7]. Specifically, the guidance for health and social care workers has been critiqued as it is self-managed and self-directed with limited availability of formal return to practice courses. Moreover, returners have little or no access to financial support and are often expected to identify their own clinical placements with no guarantee of employment.

The UK Government in alliance with the Department of Health and Health Education England (HEE) recently announced a National initiative to support allied health professions (AHPs) to return to practice based on other programmes for nursing [8-13] and more recently, social workers [14]. The aim of the programme is to support AHPs whose Health and Care Professions Council (HCPC) registration has lapsed or those who have not registered with the HCPC for over 5 years since qualifying. Successful completion of the programme will allow them to return to the HCPC register and will provide access to financial support and advice.

In view of these developments, the Chief Nursing Office in Scotland and the HCPC jointly funded and commissioned this literature review in order to inform the HCPC's work in reviewing its returning to practice requirements. The findings will also be used to inform future initiatives by the Scottish Government and other parts of the health and social care system in Scotland aimed at supporting returners to practice.

2. RESEARCH QUESTIONS

The aims of this review are twofold:

1. To identify the **risks** associated with health and social care professionals returning to practice;

2. To document the approaches which are most effective in **supporting** health and care professionals to return to safe and effective clinical / frontline practice.

This review sought to address the following research questions:

1. What are the risks associated with health and social care professionals returning to practice after a period of inactivity?

2. What factors, for example gaps in knowledge, degraded clinical skills or lack of confidence, contribute to risks to service user safety and to the safety of health and social care professionals in the clinical / frontline environment?

3. What evidence is there relating to the association between the length of time a professional is out of practice and the risks to service user safety on return to work?

4. What are the approaches that have been used to support health and social care professionals to return to safe and effective clinical / frontline practice?

5. What evidence is there about the management of risk at a regulatory level, and how does this evidence relate to existing approaches to managing return to safe and effective clinical / frontline practice?

6. What are the minimum requirements necessary for a health and care regulator to assure themselves an individual is safe to return to practice?

3. METHODS

We conducted a systematic review using well established methods[15] and followed the PRISMA statement for reporting on systematic reviews [16]. The review selection criteria, methods and analysis were prespecified and published in a protocol [17].

3.1 Information sources and search strategy

Because of the complexity of the research area and potential overlap with other related, but distinct research areas (e.g. fitness to practice, competency), we conducted our searches in two stages:

Step 1: We conducted a grey literature search using the information sources described below. We included all studies (or web pages) that were easily accessible and did not require a password, were available in English and published between 2000 – April 2018.
The grey literature included searches of the following pages:

- Google Scholar (first 25 relevant pages)
- Google Search (first 25 relevant pages)

We also retrieved published materials from National and International professional organisations and bodies representing each of the staffing groups (e.g. allied health professions and social workers) that are currently regulated by HCPC [6].

Step 2: Findings from the grey literature were used to refine the search terms and scope of professions and informed our searches of the peer-reviewed academic literature. We included peer-reviewed publications, written in English and published from 2010 onwards. We systematically searched the following major electronic databases: Medline, AMED, CINAHL, Embase, CENTRAL (Cochrane Central Register of Controlled Trials, CDSR, DARE, HTA).

A comprehensive search strategy was developed by combining key terms (using a series of free text terms) and MESH terms for:
1) Professional staff groups currently regulated by the HCPC and other professional groups (see section 3.2) AND
2) Terms for career break career (break or change* or leave or interrupt*), skills (decline or fade), leave (maternity, parental leave, study, sick, carer), absenteeism (sick or absent or ill) AND
3) Returning to practice (e.g. 'return* to practi$e', returners, remediation, revalidation, re-accreditation, re-activation)

Boolean operators were used in order to maximise the penetration of terms searched, and appropriate “wild cards” were employed to account for plurals, variations in databases and spelling.

3.2 Eligibility criteria

We included studies that met with the following criteria:

Professional groups

(A) Health and social care professionals in professions currently regulated by the HCPC:

- Art therapists
- Biomedical scientist
- Chiropodists/Podiatrists
- Clinical scientists
- Dietitians
- Hearing aid dispensers
- Occupational therapists
- Operating department practitioners
- Orthoptists
- Paramedics
- Physiotherapists
- Practitioner psychologists
- Prosthetists/Orthotists
- Radiographers
- Social workers (in England)
- Speech and language therapists.

Following discussions between the review team and the funders it was decided to exclude the following professions as they are not regulated by the HCPC: Chiropractors, Opticians or Osteopaths. However, there were concerns that the available literature may be limited. Consequently, we planned to include other related professional groups including Doctors (medical professionals), Nurses and Midwives, Pharmacists, Dentists and Social services (as described in Scotland, Northern Ireland and Wales).

We included quantitative and qualitative studies of professionals (outlined above) who had returned to practice after a period of absence (> 3months). The reasons for absence could include, but was not limited to: illness, maternity or parental leave, career break or sabbatical from frontline service, extended travel, or other caring responsibilities. We also included studies reporting a population who were out of practice but registered; those professionals who were registered but not practicing and wished to re-register; and those who had been registered in their own country or UK, who wanted to return to practice.

We excluded studies that focused on health and social care professionals:

- in professions currently regulated by HCPC who have been practicing their profession outwith the UK or are in roles related to their profession in education, management or research.
- where reasons for return to practice was following a period of suspension or where the issue pertained to impaired Fitness to Practise (see HCPC Fitness to Practise[18]) (e.g. including 'have health problems that they are not managing well, and which may affect the safety of service users' and 'sexual misconduct or indecency' or 'substance abuse and misuse problem')
- those who have never registered (UK or anywhere)

We included any publication identified in the grey literature (including reports, websites etc), which met our inclusion criteria (i.e. population and intervention, as described above). We applied a judgement relating to the described methods of these publications to inform our data extraction (see Section 3.4)

We included full-text peer-reviewed publications reporting the following types of research studies:

- qualitative studies
- primary (empirical) studies
- randomised controlled trials
- non-randomised controlled trials

- mixed methods studies
- systematic reviews

We excluded the following study designs / publication types: conference abstracts, single case studies, editorials or commentaries.

We also excluded studies that were:

- not focused specifically on health or social care professionals return to work.
- focused on return to work support for people who were not health or social care professionals.
- focused solely on: general return to work principles for general population; retention including job satisfaction, recruitment and workforce planning/service provision; absence management; support for career development; fitness to practice proceedings/ guidance for regulatory bodies.

Return to practice meeting agendas, draft minutes or job advertisements were also excluded.

3.3 Definition of key terms

We used the following operational definitions, pre-stated in the protocol, to support the application of the selection criteria:

Returning to practice as a health and social care professional is used here to denote any health and social care professional who could register with the HCPC coming back into clinical or frontline practice following an extended period of clinical inactivity (> 3 months) not resulting from discipline, for example, as a result of maternity leave, illness or a career break [19].

Service user was defined as anyone who uses or is affected by the services of registrants, for example, patients or clients [20].

Practitioner was defined as a health and care professional who is currently practising in their profession [20].

Colleague is defined as other health and care professionals, students and trainees, support workers, professional carers and others involved in providing care, treatment or other services to service users [20].

Risk was defined as the likelihood of avoidable harm being caused (HCPC personal correspondence).

Contributing factor – we employed the WHO 2009 definition which states that a contributing factor

> *"is a circumstance, action or influence (such as poor rostering or task allocation) that is thought to have played a part in the origin or development, or to increase the risk, of an incident. Contributing factors may be external (i.e., not under the control of a facility or organization), organizational (e.g., unavailability of accepted protocols), related to a staff factor (e.g., an individual cognitive or behavioural defect, poor team work or inadequate communication) or patient-related (e.g., non-adherence). A contributing factor may be a necessary precursor of an incident and may or may not be sufficient to cause the incident". WHO (2009) p16*[21]

Harm – we employed the definition from WHO (2009) which describes a harmful incident

> *"as an incident that results in harm to a patient [service user]. Harm implies impairment of structure of function of the body and/or any deleterious effect arising there from, including disease, injury, suffering, disability and death, and may be physical, social or psychological"* [21]*. (p18)*

Harm was further categorised into:

- **no harm**: outcome is not symptomatic, or no symptoms detected, and no treatment is required
- **mild**: outcome is symptomatic, mental or physical symptoms are mild, loss of physical or mental function or harm is minimal or intermediate but short term and no or minimal intervention (e.g. extra observation, investigation, review or minor treatment) is required
- **moderate**: outcome is symptomatic, requiring intervention, or causing permanent or long term physical or mental harm or loss of function
- **severe:** outcome is symptomatic, requiring life-saving intervention of major surgical/medical intervention, shortening life expectancy or causing major permanent or long term physical or mental harm or loss of function

- **death:** on balance of probabilities, death was caused or brought forward in the short term by the incident

3.4 Study selection

3.4.1 Step 1: Selection of relevant publications

One member of the review team conducted the grey literature search, recording relevant details of the website details (and URL links) in an excel file and downloaded any relevant materials. Two review authors independently screened each of the records, looking at all of the associated materials, and /or websites associated with each entry. They ranked each of the records as relevant, irrelevant or unsure. Records ranked as irrelevant by both reviewers were excluded at this stage of the screening process. The final selection of records (judged as relevant or unsure) were discussed at a consensus meeting, with a third reviewer as required.

3.4.2 Judgement of reproducibility of publication findings

It was anticipated that many of the publications identified from the grey literature would not be designed or presented using standard research designs. There was the potential for valuable evidence relating to risks and supports relating to return to practice to be included within these 'grey' publications. However, for this evidence to be appraised and used to inform the results of this review it was important that there was transparency around how the evidence was compiled.

A process of considered judgement was applied to judge the transparency, or potential for reproducibility, of the findings of each publication. Two review authors independently considered the full publication and applied a judgement of:

- "Red" – no, or very minimal description of the method of compiling the evidence within this publication. Insufficient description of methods to enable any reproduction.

- "Amber" – some limited description of the method of compiling the evidence within this publication, however description of methods insufficient to enable reproduction of the methods.
- "Green" – description of the method of compiling the evidence sufficient to enable reproduction of at least part of the methods

Any disagreements in judgements between independent reviewers were resolved through discussion.

3.4.3 Step 2: Study selection

One review author read the titles of the references identified through the electronic database searches and eliminated any obviously irrelevant studies. Two reviewers screened all of the abstracts ranking them as relevant, irrelevant or unsure. Any disagreements were resolved through discussion involving a third reviewer if required. Studies ranked as irrelevant were excluded. The full text of the remaining studies was then obtained. Two review authors conducted full text screening independently with a third resolving any disputes.

3.5 Data extraction and coding

3.5.1 Data extraction

3.5.1.1 Publications categorised as 'red' or 'amber'

The following information was extracted and tabulated from publications judged as "red" or "amber" (see 3.4.2 above):

- Publication details (Author, year of publication and source of grey literature)
- Author type (e.g. regulator; professional body; health board; education; returner; researcher)
- Profession (e.g. AHPs; Doctors; Nurses and Midwives; Pharmacists)

- Country
- Type of literature/source (e.g. report; research; commentary; scope of practice etc)
- Aim/scope of paper (i.e. overall aim of paper and RTP specific aim if available)
- Methods
- General comments
- Any additional resources available that may be useful (e.g. forms; policies; checklists)

Data extraction from publications judged as "green" was carried out as described for studies identified in Step 2 below.

3.5.1.2 Peer-reviewed literature and publications categorised as 'green'

A standardised, pre-piloted form was used to extract data from the included studies for assessment of study quality and evidence synthesis.

We extracted the following information:

- Study characteristics (author, date of publication, country, study design);
- Other publication details (source - grey literature / academic literature)
- Author type (e.g. regulator; professional body; health board; education; returner; researcher)
- Aim/scope of paper (i.e. overall aim of paper and RTP specific aim if available)
- Methods
- Professional group (e.g. AHPs; Doctors; Nurses and Midwives; Pharmacists)
- Participant demographics (e.g. details about their qualifications, years in practice and other relevant information)
- Study setting and any details about service user population (if available)
- Length of inactivity and reason for the period of inactivity;
- Identified factors/ risks (reported at service user and staff level) of returning to practice;
- Any supports (facilitators) that have been put in place to help staff return to practice;
- Outcomes and outcome measures (i.e.)
    - Risks to service user's safety (e.g. may include death, near death, disability,

adverse events, medication errors, failure to rescue, malfunction of equipment resulting in service user harm;
    - Risks to other health and social care professionals service users (e.g. healthcare associated infections, accidents, aggression and violence, measures reporting risk to mental health and well-being)
    - Organisational risk (e.g. risk to reputation, financial risk)
- Any other relevant factors (e.g. legislation, local recommendations, documentation that have been used to support professionals return to practice).
- Key findings.
- Any additional resources available that may be useful (e.g. forms; policies; checklists)

One review author extracted this data which was cross-checked by another member of the review team. Any ambiguity identified was resolved through discussion with other members of the review team.

3.5.2 Data Coding of harm, level that harm occurred and contributing factors

3.5.2.1 Degree of harm

We employed the WHO 2009[21] criteria of harm and grouped harm into one of five categories: death, severe harm, moderate, mild or no harm (see 3.3). Harm to service users or colleagues was initially extracted and coded only when it was explicitly reported (referred to as 'explicit' in this report). However, it became evident during the coding phase of the review that there was limited information reported across the studies, and a team decision was taken to code user harm when it was implied (referred to as 'implicit') in each paper. Following this, two review authors independently judged the *potential* for harm using the WHO 2009[21] criteria using the same categories for service user harm.

3.5.2.2 Who was harmed?

If harm was identified then we documented which person / group had been harmed using the following codes:

- Service user
- Health professional (colleague)
- Organisational
- Regulator
- Combination of levels

3.5.2.3 Contributing factors

We took a inductive approach to identifying and coding contributing (negative and positive) factors, mapping these to a predefined list of five domains based on WHO classification[21]. These included:

- Service user
- Staff
- Work-environment,
- Organisational – service provision
- External

Factors that could not be mapped to the WHO classification were coded as 'other'. Inductive coding was used to develop themes and subthemes from this additional data. Data about contributing factors were extracted by one review author and cross-checked by a second author.

3.6 Data synthesis

Descriptive data were tabulated within evidence tables. Key findings were brought together within a narrative synthesis. Due to the heterogeneity between studies and outcomes we did not conduct meta-analyses.

4. FINDINGS

4.1 Study selection

The electronic searches identified 3504 records. Information sources identified from the grey literature search including a range of materials from National and International professional organisations and bodies, informed the strategy for the electronic literature searching. After elimination of 3147 obviously irrelevant records and duplicates, two independent reviewers assessed 357 records for the remaining studies; of these, 226 full text publications were obtained and the reproducibility of publication findings judged. 39 studies were judged to have sufficient description of the method (i.e. categorised as 'green') and were included in subsequent data extraction.. The results of the search are detailed in the PRISMA flow diagram (Figure 1).

4.2 Description of included studies

Of the studies categorised as 'green', 11/39 did not report time away from practice, were focused on occupational health aspects (and not return to practice) or only included one healthcare professional in the data [22-30]. These were excluded from any further analysis, leaving a total of 28 studies for inclusion in the final synthesis. Details of the 28 included papers are provided in the Table of included studies (Table 1, Appendix) [3-5,8,14,19,31-52].

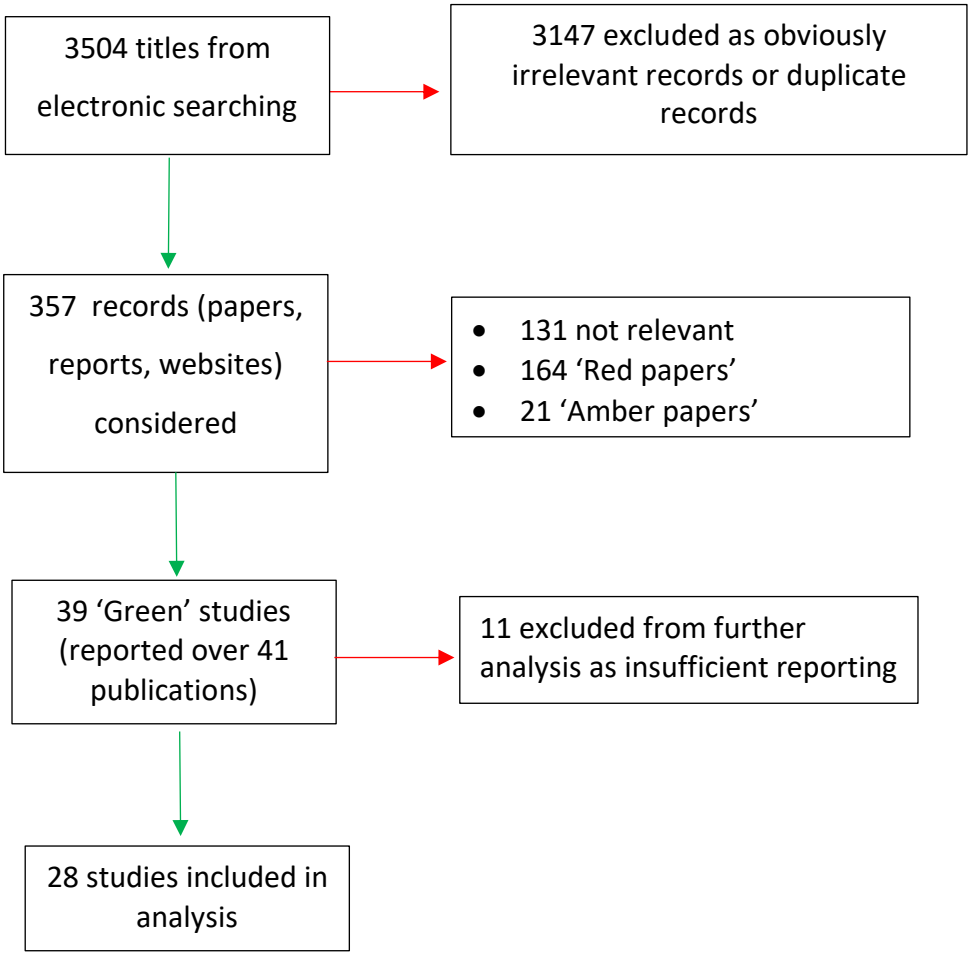
Most studies were conducted in the US [4,19,35-39,41,43-47] and the UK [3,8,14,40,42,48,50,51]. Others included Australia [49] and Canada [31,33]. Three studies reported evidence from more than one geographical region [5,32,34,53].

A variety of study designs were employed including

- Cross-sectional (n=5) [4,36,39,43,49]
- Qualitative (n=5) [14,32,42,47,50]
- Case studies (n=2) [35,37]
- Course evaluation (n=1) [46]
- Database analysis (n=1) [40]

- Descriptive (n=2) [3,41]
- Evaluation (n=2) [44,45]
- Literature review (n=3) [5,31,34]
- Mixed methods (n=5) [8,33,48,51,52]
- Survey design (n=2)[19,38].

Figure 1. PRISMA flowchart



Caring responsibilities [3-5,8,19,32,34,35,37,39,40,43,45,47,49,53] were the most frequently cited reason for being out of clinical practice (see Table 1, Appendix). Four studies reported that professionals had returned to practice following retirement [35,39,45,50]. Other reasons for being out of practice included:

- personal health issues / concerns (mental and physical) [4,35,39,45,46,50,54],
- career dissatisfaction[4,8,19,32,47],
- change scope of practice or pursuing alternate careers [4,19,32,35,39,45,49],

- military deployment [36,38,48],
- financial reasons (e.g. Insufficient reimbursement rate, practice not economically viable, an improvement in personal/family finances, rising medical malpractice premium [4,46]),
- difficulties keeping pace with clinical advances [4],
- the "hassle factor" (i.e. paperwork, compliance issues) [4],
- humanitarian leave [19],
- inflexible work hours [49],
- being registered to practice or licensure [46],
- the burden of on call responsibility [4],
- organisational restructuring [50],
- travelling [50]
- relocation [46,50].

Most of the professionals described in the studies were doctors (n=15)[4,19,34-46]. Two studies reported on mixed professional groups (n=2)[5,8]. Other professions included

- physiotherapists (n=2) [31,32],
- occupational therapists and physiotherapists (n=1) [33],
- social workers (n=1) [14],
- health visitors (n=1)[3],
- nurses (n=3)[47,48,52],
- midwives and nurses (n=1)[49]
- pharmacists (n=2)[50,51].

The length of time that professionals were out of practice varied from 3 months to more than 20 years (Table 1 Appendix).

4.3 Risks associated with returning to practice (Research question 1)?

Nineteen studies each reported at least one risk associated with health and social care professionals returning to practice after a period of inactivity [4,19,31-36,38,40,42-45,48-50,52]. Most of the risks reported involved doctors (47%). Risks were also reported in other professions including nurses (16%), pharmacists (16%), physiotherapists (9%), occupational therapists (4%) and mixed populations (9%).

Risk was explicitly reported in 3 studies [34,40,48] (Table 1, Appendix). Table 1 details these explicitly reported risks, and examples of corresponding evidence (quote).

The *potential* for harm was judged as implicit by two independent researchers in the remaining 16 studies [4,19,31-33,35,36,38,42-45,49,50,52]. The majority of people affected by the risks reported were colleagues (i.e. other healthcare staff) (85%); service users and organisations were less commonly affected (6%) as were regulators (2%). The degree of harm to those affected by the risk was described or judged as mild [4,5,31,33,35,40,42-45,50] or moderate [5,19,31,32,34,36,38,40,43,45,48-50,52,53].

Overall, most of the risks described occurred at a staff level (43%) or at the organisational level (36%). Risks were less frequently reported at the regulator level (6%). No risks were reported at a service user level.

The main risks identified at a staff level included individual factors (e.g. readiness to return to practice [5], negative feelings and depression about returning[40]) posing a risk to them successfully returning to practice. The process was also perceived as 'difficult' [4] because of a lack of clear guidance [34,53]. Studies also reported that the process failed to account for specific individual needs [31]. Risks were also associated with a lack of timely and accurate information provision

> *'better information needs to be provided on the implications of taking time out of general practice' [42] (p255)*

Other studies described issues with funding, limited formal retraining schemes [34,53] and limited employment opportunities [49]. Gender differences (e.g. career progression for women following the break) were identified highlighting a risk to women returning to practice after an absence. While men reported changing employer and finding the same level of job or higher, women reported problems with career progression when they returned [40].

> *"I left a post at senior registrar level and returned to a junior lecturer post "because we only have funding for that level" and "because you are breast feeding" and "because you are working part-time". None of this in writing of course" [40] (p16)*

Over a third of risks identified occurred at an organisational level including weakness in the underpinning infrastructure [52]. For example,

- complex processes linked to a number of bureaucracy and administration challenges [32,33,44]
- wide variation in the process of return to practice [52] including number of hours required for return to practice [33]
- no framework to evaluate return to practice candidates [31]
- limited clinical placements [52] and limited provision of mentors [52]
- a frequent failure to accommodate women returning to practice who are still breastfeeding [40].

Regulatory challenges for returning to practice were described in three studies [19,48,50]. Studies reported divergent views about the pathways for return to practice and no standard processes or clear pathways to prepare for the return to practice.

Table 1. Explicitly reported risks, and examples of corresponding evidence (quote).

Level of risk	Type of risk	Evidence (examples)
Organisational level	Lack of formal retraining schemes	*"Formal retraining schemes do not exist in many medical specialties in the UK (other than for GPs)…"* [34,53] (p17)
Organisational level	Breastfeeding	*"No thought given to allow breastfeeding on return to work – so gave up!"*[40] (p18) *"inadequate support (ignorance really) for my need to express breast milk during work hours"* [40](p18)
Organisational level	Lack of guidance relating to the process of RTP	*"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"*[34,53] (p3)
Staff level / Organisational Level	Lack of skills, fitness or preparation to work	*"With competing demands, clear direction is required to ensure they are prepared in every respect. Failure to do so places patients and clinicians at risk, and risks reputational damage"* [48](p21)
Staff level	Returning to a backlog of work	"*No administrative cover whilst absent so none of my clinical administration was done despite there being clinical cover arranged. This led to a huge backlog for me to deal with on return, including urgent clinical work"* [40](p18)
Staff level	Insufficient funding to support activities to support RTP	*"Difficulty in getting part-time funding as a specialist registrar"* [40] (p18) *"Arranging funding to return to work part-time"* [40](p18)
Staff level	Personal feelings	"*Personal feelings (guilt) on leaving my child in a nursery and general exhaustion as baby didn't sleep"* [40](p18) *"Guilt leaving baby after maternity leave, plus work pressure leading to depression"* [40](p18)

4.4 What factors contribute to risks to service user safety and to the safety of health and social care professionals (Research question 2)?

4.4.1 Evidence focussed on risks to safety

No evidence was found in this review that explicitly identified factors that directly contribute to risks to service user safety and to the safety of health and social care professionals. Following the pre-planned protocol for this review, evidence relating more generally to fitness to practice, competencies and service user harms was excluded. Included studies all focussed specifically on return to practice following an absence (defined in this review as > 3 months). The studies included in this review primarily focussed on addressing gaps in knowledge, skills and / or behaviours **before** a return to work, rather than assessment of safe practice **after** returning to work.

4.4.2 Factors impacting on return to practice

While not explicitly related to risk to service user safety or safety of health and social care professionals, there is an argument that specific factors could impact return to practice by potentially affecting a professional's competency or the safety of service users and health professionals. We have therefore explored this evidence in more detail and present the results in the following section.

4.4.2.1 Factors negatively impacting on return to practice

Organisational (48%) and staff factors (47%) most commonly had a negative impact on return to practice. Service user factors were the least frequently reported (1%). Key examples of the different factors which negatively impacted on return to work are summarised in Figure 2 and Table 2.

Figure 2: Factors negatively impacting on return to practice

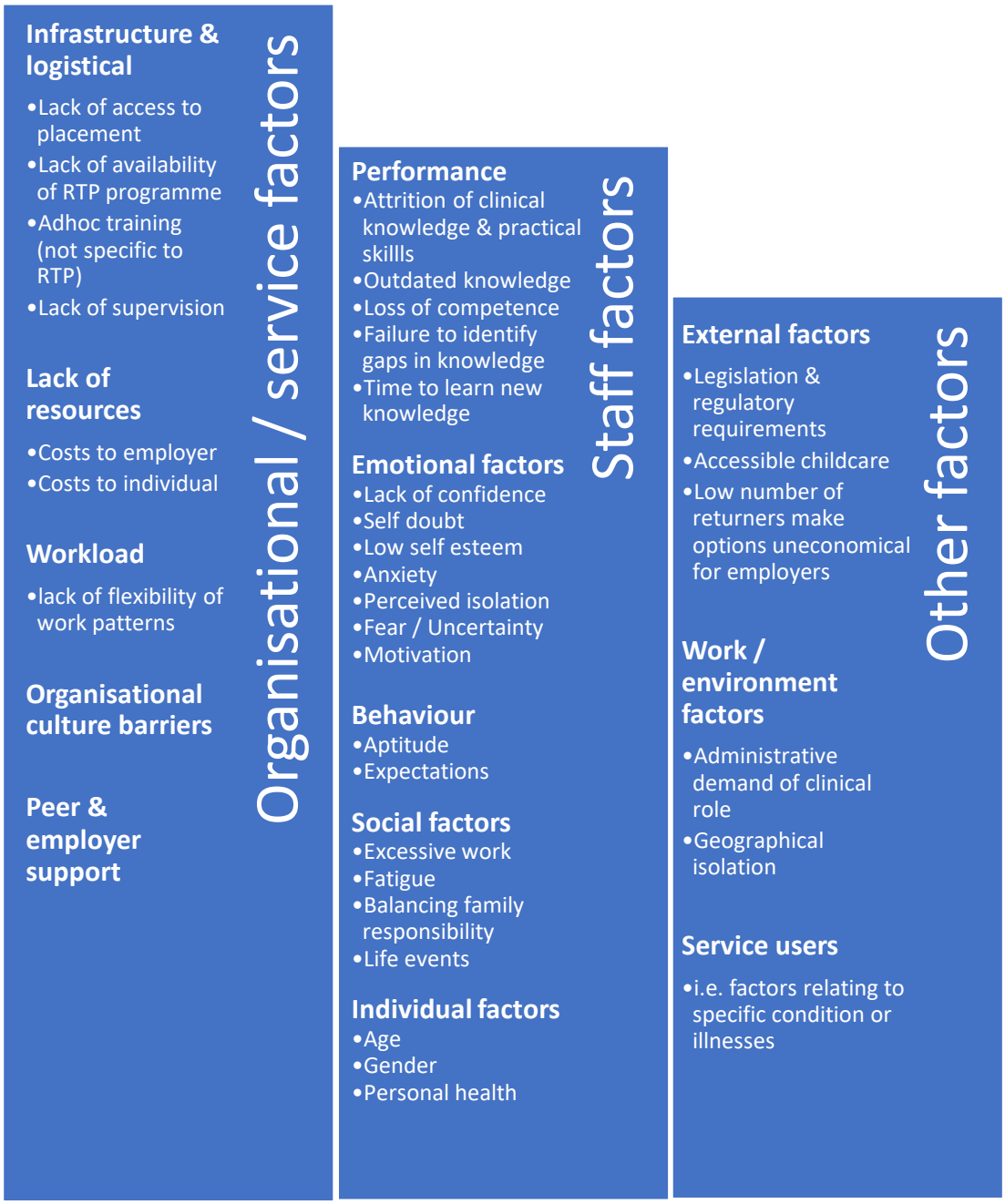


Table 2. Key examples of contributory factors negatively impacting on return to practice

WHO domain	No. of studies (references)	Key example (quote)
ORGANISATION / SERVICE	21 studies [4,5,14,19,31-35,37,39,40,42-45,47,48,50-52]	*"the need for re-entry resources outstrips the resources available. There are a limited number of re-entry programs in the United States that provide detailed evaluation of physicians' medical knowledge, neuropsychological status, and skills maintenance."* [35] *(p93)* *"Although RTP courses are approved by the NMC overall there is significant variation in RTP delivery including: promotion of RTP as a component of a workforce strategy; access to information about RTP; application and interview process; costs to returnees (some don't have to pay course fees while others have to pay around £650 to £1500); provision of clinical placements; mentorship and support on clinical placement; evaluation of courses and so on."* [52] *(p7)* *"returning nurses shared experiences of self-doubt and organizational hindrances in the process of returning within the acute care setting"* [47] *(p14)*
STAFF	22 studies [4,5,14,19,31-36,39,40,42-51].	*"Whilst on maternity leave communication with my department was very difficult as there was no access to my Trust email"* [40] (p18) "Individuals experience a high level of confusion about the processes for obtaining professional registration" [33] (p145) *"Physicians have been shown to be poor at analyzing their educational needs, and the more significant the physicians needs, the more significant the discrepancy in self-perceived versus actual educational needs"*[39]*(p185)* *"When I returned I found that the dynamics of the department had changed and I was no longer welcome as the lead in several research projects. There followed an extremely difficult 2 year period where relationships within the Department became very strained"* [40] *(p18)* *"Balance very demanding busy full-time job with erratic childcare and the high cost that comes with that"* [40] *(p17)*
EXTERNAL	11 studies [4,5,19,31,32,35,40,43,44,50,52]	*"the Australian respondents felt that current legislative requirements were constraints. Registration without conditions was the usual outcome of a re-registration program, with conditional registration usually reserved for overseas physiotherapists training to become*

		Australian registered physiotherapists and those under review" [32] *(p26)* "*Other more administrative issues raised as barriers were availability of insurance when undertaking a re-entry or re-registration program, and the requirement to have information technology skills and access*." [47] (p26)
WORK / ENVIRONMENT	8 studies [4,32,36,40,43,44,47,50]	*"Inability to relocate"* [40]*(p19)* *"[with career breaks]…it depends what the break is to be honest, getting back up to speed and, and that sort of stuff. It also depends what you did on the break. I took a break myself and went and spent two years overseas with VSO and when I came back to the UK, EHC had been introduced…so that was completely new to me, there'd been some minor changes to the structure of the contract, the drug tariff had changed, there was new drugs on the market that hadn't been there two years previously, so that, all that was a real steep learning curve to come back to"[Nurse, p60]* [51]*(p52)*
SERVICE USER	2 studies[4,36]	Meeting the increase in public demands *"for documentation of competence"* [4] *(p7)*

Organisation / Service Factors

Twenty-one studies [4,5,14,19,31-35,37,39,40,42-45,47,48,50-52] described organisational factors that negatively impacted on the return to practice. There were a number of infrastructure and other logistical factors which negatively impacted on return to work. These included: lack of access to clinical placements, lack of availability of return to practice programmed in rural or remote areas [44,49], delivery of ad-hoc training by employers (which was more in line with CPD, and not specifically return to practice training)[50], and a lack of supervision [34].

Limited resources were closely linked to poor infrastructure. These were not just financial; for example, a lack of appropriately trained mentors or professional networks to guide people through the process of return to practice, resulted in competition for resources among people trying to return to practice [33,45].

Kenward (2017) surveyed professionals and asked "what is most challenging about returning to practice? 93% respondents reported

"finding suitable, qualified staff to mentor and support your return to practice"[48]*(p23)*

Providing supervision is time consuming, requiring significant resources which were not always available.

> *"Supervisors "spend time to identify their strengths/weaknesses and support to maximise the experience in a work setting" (Supervisor 4) [32](p27) and "Overall the clinical experience relied on the goodwill of clinical supervisors and their employers to facilitate the clinical placement" [32](p27).*

There were also hidden pressures for supervisors to

> *"get them done and dusted" (Morison 2012). 'It makes the situation slightly unusual in as much as there is pressure on the returner to get through during their time because they need to be earning as soon as they can which sort of puts an artificial pressure on me as their trainer to make sure they are all done and dusted and as good as they can be … they feel they are doing unpaid work and there is a bit of a tension there!' (3.5.1) [42] (p259)*

The costs to the employer[50], costs of delivering the programme and the cost to the individual were all highlighted as potential obstacles, or factors which could negatively impact on return to work [35,47,50]

> *"[The employer is] paying fifteen, sixteen thousand to the [pre-registration] graduate and the rest is absorbed as the training cost to the business. Effectively, their salary is being funded by the Department of Health and at the end of the day, if they're good, you have the option of keeping them as an employed pharmacist or [.] just doing it again with a new pre-reg. [.] [So] why would you take on a potentially rusty return to practice pharmacist who [.] is going to cost you lots of money to mentor in relation to time or just functionality and [then] may walk away and do something else? [.] [Also,] if they give advice or fail to give advice, who would be liable – are they working under my indemnity cover? [.] If this person's work shadowed in my pharmacy [.] then goes out and kills someone, is somebody going to come back to me and say, you said they were okay? [Participant 7]" [50](Phipps, 2013, p194)*

Workload was also reported as a factor which could negatively impact on return to work, and the lack of flexibility and inflexible work schedules /shift patterns were described as a roadblock for those returning to practice[4,40,47,51].

Organisational culture factors which negatively impacted on return to work were described in 7 studies [34,35,40,48,50-52] . Organisational pressure of expectations were raised about how you "should" perform [48] or are expected to return to work [34,50]. Phipps (2013) also described that returners could be

"regarded (rightly or wrongly) as either obsolete or not up to the standard that the employers assumed them to be" [50] (p195)

A general lack of peer and employer support with significant variation in how supportive organisations were to returners was described in two studies [45,50].

One doctor described the experience of senior managers altering timetables

"to a less easy timetable with less approachable consultants" [40](p16)

They also reported

"unhelpful comments from senior management about potential lack of commitment".[40] (p16)

Another study described concerns expressed by employers that they would be accountable or responsible for 'mistakes' made by returners, all of which potentially had a negative impact on return to work [35].

Staff factors

Staff factors were reported as negatively impacting on return to practice in 22 studies [4,5,14,19,31-36,39,40,42-51]. The most frequently reported factors at this level were performance factors in 11 studies [5,19,32,34,39,42,45,47-50], and emotional ('internal') barriers in 10 studies [14,31,32,34,35,42,46-48,50].

Performance factors

Performance barriers were reported in 11 studies [5,19,32,34,39,42,45,47-50]. These factors included the attrition of clinical knowledge and practical skills, motor and technical skills degrade as a result of lack of practice [5,19,32,34,42,45,48], outdated knowledge and skills as a result of being out of *active* clinical practice [48,50]. Other factors described in the studies included a loss of competence[48], loss of corporate and local knowledge that underpins service user care including learning about new policy, equipment, and drug changes [48] and being out of touch

with evidence based practice [48]. While such factors negatively impact on return to work, here it is implicit that these factors could also directly contribute to risks to the safety of service users or health and social care professionals.

Other factors which could negatively impact on return to work included assumptions made about a particular learner and their level of skill or knowledge and educational needs not being recognised [5,34,39]. The failure to identify gaps in knowledge and address these was referred to in two studies [48,50] as

> *"Knowing what you do not know and knowing what you need to know" (P26)*

Insufficient time given to learn new knowledge was also cited as a factor impacting on return to work in one study [32]

> *Experienced supervisors when asked about the difference between returner and new graduates commented: The knowledge and the understanding of the processes and the philosophy (i.e. EBP, clinical reasoning, research and reading the literature), they are along way behind the undergrads and they're expected to go up and overtake them, within a period of 3 or 4weeks. (Supervisor 10) [32] (p27)*

Emotional factors (or internal barriers)

Emotional factors were described in in 12 studies [5,14,31,32,34,35,42,43,46-48,50]. Lack of confidence [35,46-48,50], self-doubt and low self-esteem [31,42], lack of motivation or feeling demotivated [5,43,48] were reported factors which negatively impacted on return to work.

> *"I was completely rusty and I wasn't sure of what I could do. I didn't know if anyone would hire me. Didn't know probably if the refresher course was the right place for me, based on my background as a clinical specialist and master's prepared nurse, but my level of anxiety of being in the hospital again, uhh, it looked like a good place for me to start" [47](p43)*

Other emotional factors included anxiety at being able to cope with changes in roles and the profession [31,35,47], feeling over-responsible [47], returnees feeling judged or stigmatised because they had been out of practice and were concerned about how they would be viewed by employers / peers [14,32,47]. Other studies describe participants feeling that they had lost credibility as a result of being away from practice [48]. Others felt that they had to prove that

they were competent [42], again demonstrating the implicit link between these factors and the potential for harm / risks to safety.

> *'The whole system seems to be "you are guilty until proven innocent", rather than the other way around, in terms of having to prove competencies' (7.3.3)" [42] (p257)*

Perceived isolation and feelings that you "don't really belong"[42,50] or self-employed professionals who felt "alone" in having to organise their own support [34] was also reported. Others described feeling 'overwhelmed' and 'daunted' at the thought of having to study and sit exams [32]. The fear of failure and uncertainty linked to fear of technology and new equipment [47] or feeling intimidated by advances in profession practice and equipment[47] were also all factors identified as negatively impacting on return to work:

> *"When we got back into the hospital setting, I discovered how much all of the equipment had changed, it was intimidating. It was just so much. All the beds are now rotating do this, whereas before I cranked up the bed." [47] (p60)*

Other contributing factors

Behaviour

Poor aptitude was cited as a behaviour that negatively impacted on returning to practice[5]. Unrealistic expectations including overconfidence (i.e. a lack of insight) was also identified as a factor in three studies[34,42,50]. One study observed that

> *" they need a, a reintegration programme because they've been out of clinical practice for six months. There are some who think they don't need that and they would worry me far more than the ones that say, "Yes you know that would be extremely helpful" so again it's about how the level of insight isn't it to sort of help them. [NCAS pharmacist]"[51] (Phipps 2010) (p52)*

Social factors

Excessive work, fatigue, and balancing family responsibilities [4,14,40,47] alongside no local family support [40] or a negative attitude of spouse [40] and /or changes in family circumstances and other life events (divorce, children leaving home) [47] were obstacles for those returning to practice, and factors which could negatively impact on return to practice.

Phipps 2010 acknowledges that there is

"limited information about the risks associated with returning to or changing practice, and suggest that those practitioners…and lacking social support may present more patient safety risks"

Individual factors

Age [5,39], gender [40,42] and personal health issues [44,47,49] were all identified as individual factors that posed a threat to the return to practice process.

Additional factors

Several studies highlighted challenges in finding formal training schemes, and accessing these programmes [4,33,35,47] or creating CVs [50]. Studies also reported that professionals who took a leave of absence were frequently not aware that return to practice requirements existed while other professionals described confusion

"surrounding the 'two year rule" – some clinicians arguing that it does not account for experience or the types of activities that may have been undertaken while they were away from clinical practice [42] p257)

Peer attitudes were identified as factors which negatively impacted on return to practice in 3 studies, with some professionals reporting that they felt that they were taken less seriously by some colleagues

"Colleagues thought that I am not wanting a career as a scientist or surgeon anymore because I have children"[40] p17)

or because they were not longer as familiar with the team as a result of time away from clinical practice [40,41,48]. There was also confusion and ambiguity over team roles when a colleague returned to practice. Manriquez (2012) describes

*"blurred lines of distinction between in-training and re-entry stages may cause awkwardness and confusion as to the specific roles of each team member and thus make fitting into the team difficult" [41] (*p368)

Lack of resources and additional costs of childcare, travel and retraining coupled with limited or no financial assistance (or financial penalties for self-employed professionals) were also identified as factors which negatively impacted on those returning to practice[4,14,32,40,42].

External factors

Eleven studies described external factors as obstacles to returning to practice [4,5,19,31,32,35,40,43,44,50,52]. . Current legislation and variable regulatory requirements were identified as significant factors which negatively impacted on return to practice in four studies [5,19,32,50]. One study highlighted the inconsistencies in regulation in nurses returning to practice after a career break

"Some boards require a refresher course after 4 or 5 years, and others solely require evidence of CPD"[5] p27)

Phipps (2013) argues that the

"challenge is to create a system that sets adequate standards for fitness to practice but that can be applied fairly to pharmacists in a variety of circumstances. Hence, any policy to manage changes in practice needs to accommodate various motivations, levels of experience and working arrangements for the change[50] p192)

Other factors negatively impacting on return to practice included:

- Lack of insurance when returning to practice [4,31,32].
- Accessible childcare (e.g.) nannies leaving, challenges of co-ordinating on-call duties and working outside normal nursery hours as also highlighted as contributing factor [40].
- Financial barriers due to the absence of standardised and accepted RTP pathways [43]
- The number of professionals returning was irregular and low [32,44]. Consequently, the insufficient number of trainees meant that some regulators and providers felt that

"…formalised curricula were also difficult to put in place with small numbers aiming to return at any one time, making this option uneconomical for both the participants and the provider"[32](p26)

Work and Environment Factors

Work and environment were identified as a major factors which negatively impacted on return to work in 8 studies [4,32,36,40,43,44,47,50]. Three studies described the increased administrative demands of the clinician's role as a barrier to returning to practice [36,43,47]. Subsequently, the lack of exposure to clinical work and procedures as a result of these responsibilities were linked to deskilling [36].

Geographical isolation or having to travel long distances to attend a return to practice programme were also reported as factors negatively impacting on return to practice in five studies[4,32,40,44,49]. Sheppard (2010) described geographical barriers

> *"as a problem in the assigning of supervisors and access to training programs in physiotherapy"* [32](p26).

Changes in practice, work processes and procedures and the lack of standardised formal training during a change of practice was highlighted as negatively impacting on those returning to practice in 4 studies [4,32,50,51]. For example,

> *"In the last 10 years, major developments in pharmacology, surgical procedures, medical technology, coding, patient privacy, quality improvement–to name just a few–have dramatically altered practice"*[4] *(p7)*

Service user factors

Two studies reporting factors related to skill fade with concerns about deterioration in skills set for procedures performed in specific service user groups (i.e. neonates, paediatrics and adolescents) [36] and public demands"[4] (p7) which negatively impacted on return to practice.

4.4.2.2 Factors positively impacting on return to practice

Twenty-two studies [3-5,8,14,31,32,34,35,37,40-44,46-52] reported at least one factor which positively impacted on return to practice. Key factors are summarised in Figure 3 and Table 3 and described narratively below.

Staff factors

Staff factors facilitating the return to practice process were reported in 19 studies [3-5,14,31,32,34,35,37,40,42,44,45,47-52].

Performance

Professional development, training and refresher courses were thought to positively impact on self-assessed competence [5,34]. The context in which skills and knowledge were learned was important, with education among a 'community of learners' was also identified as a facilitator [45]. Tailored training, specific to the individual was also highlighted as important in two studies [31,32,42,44]

Figure 3. Key contributory factors positively impacting on return to practice

"When learning needs were tailored to qualifying candidates, the program was successful in returning those physicians to active practice in our state."[44] p22)

Overlearning and overtraining were key factors in retaining skills[5]. One study reported that that level of prior expertise and opportunity to practise similar skills in the interim can positively influence retention of a learned skill [5]. Moreover, the skills fade may be mitigated for through keeping in touch with peers during a hiatus and staying aware of relevant developments [5]. Computer models, simulations, hands-on training[35,37] and summative assessments were identified as

"mutually re-assuring to trainers and returners in complementary ways"[42] p255)

Continuing to practice while on a career break was identified as an important factor positively impacting on the return to practice

Having said that I was quite heavily involved in pharmacy in my two years off because I was working as a Pharmacist, but overseas. If you'd gone and spent two years travelling around the world on a sort of extended gap year as it were the you're not going to be practicing as a Pharmacist so you've perhaps have forgotten a significant chunk of that because if you're not using it, you tend to forget it as a rule. [Superintendent pharmacist, Large chain 2]) [51] p60)

Holdcroft (2013) underlined the importance of keeping records about any plans for education or any CPD that has been completed during an absence.[40]

Behaviour

Characteristics including being able to identify and acknowledge deficits in knowledge, persevering and being proactive and being receptive to feedback were important factors when returning to practice [35]. Studies advocated that professionals should be proactive – actively planning their career breaks. This could include discussing keep in touch days with employers or identifying potential CPD opportunities or developing an individualised plan to maintain professional credentials and relationships during the period of inactivity [4,32,34,40,50] .

"It might be presumed that, all other things being equal, those registrants who do engage in some form of preparation for return-to-practice are less risky than those who do no preparation. This would be due to their having recognised potential gaps in their knowledge and taken action to address them"[50] *p193)*

An individuals' initial aptitude for certain tasks was also linked to skill retention [5].

Emotional factors (i.e. internal drivers)

Emotional factors including determination / motivation were all identified as important behaviours critical to the success of returning to practice [3,34,40,42,45,47,50]. Several studies reported that returners came back because they 'wanted to help' after hearing reports of a staff shortage, or they missed caring for service users, their colleagues and the practice environment [4,47,49].

> *"Most of my students reported that they had actively maintained their license, remained caring and compassionate individuals, and wanted to help address the shortage but did not know exactly what to do and where they could best fit into the healthcare system."* [47] *p18)*

Self-fulfilment [47] and the development of professional self-esteem and confidence allowed the successful return to the workforce [49,50]

> *"I really missed nursing, I missed the intellectual piece of work. I had just a really busy life but wasn't completely fulfilled with all that stuff. It took me a couple of years to get into the refresher course and come back but it had been on my mind for several years, just a piece of it, something was missing in my life"*[47] *p44)*

Following attendance at different return to practice courses, returners reported an improved competence and confidence

> *"Just judging by my level of competence now, compared with when I started back 18 months ago when I first started back, it's just a phenomenal difference (after completing the scheme) … and that's after a huge break' (9.2.1)*[42] *(p257)*

Social factors

Strong family support at home including a supportive spouse or partner and children growing up all enabled applicants to return to practice [40,49]. Changes in family or personal

circumstances including having children, divorce, relocation, increased financial need [3,4,47,49] were all drivers for returning to practice.

> *"Nancy emphatically said, the decision was based largely on finances; it was the impetus for the timing, but I always did want to go back to my career, because I always loved nursing. I was in the middle of a divorce and a mother of four and needed to refinance my house. I needed to get back in, in the shortest pathway as possible" [47]* p46)

Individual factors

Age, gender, marital status, education and prior experience all affected skills retention[5]. It was acknowledged that returners were usually highly experienced practitioners with a wealth of knowledge. Although they might initially lack current nursing knowledge and skills, they had other important skills ('enhanced skills') which they brought back to clinical practice including unique backgrounds, life experience, maturity and good interpersonal skills [35,42,46-48]. Moreover they were likely to work until retirement [47].

Table 3. Key examples of positive contributory factors as described in the literature

WHO domain	No. of studies (references)	Key example of positive contributory factors identified
STAFF	19 studies [3-5,14,31,32,34,35,37,40,42,44,45,47-52].	*"This individualized approach is supported by the literature that indicates re-entry candidates have special issues/needs when they return to work that include feelings of anxiety and low self-esteem, as well as desire for flexible programs that are tailored to their experience, educational needs, and family situations"* [31] *(p3)* *"Doctors RTP value and accept re-entry courses. GP Returner Scheme is valued and accepted amongst all returning GPs."* [42]*(p255)* *"Many inactive registered nurses seek avenues to renew and update their nursing skills before they return to practice"* [47] *(p5)* *"..the sense of responsibility after hearing reports of the nursing shortage"* [47] *(*p12) "responding to a need in the community"[4] (*p5)* *'The scheme helped me get my confidence back and also helped for re-induction, because the NHS has changed (whilst I was away) – the benefit of competence is definitely one of the best things"* [42] (p257) *"Warm, welcoming…encouraging them to pursue nursing again"*[47] *(p23)* *"Colleagues who appreciate that having children means your intellectual abilities are unchanged but are patient while you learn to juggle all the various practical issues of combining work and family"*[40] *(p15)* *"strong incentives during this shortage to encourage nurses to return to practice"* [47] *p90)* *'The practice I did my returners scheme in were very flexible for me, so that I managed to do it without extra child-care or other costs. That's hugely important actually.' (1.9.2)*[42] *(p259)*

ORGANISATION / SERVICE	18 studies [3-5,14,31,32,34,35,37,40-43,46,47,49,50,52].	*"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."* [34]*(p6)* *" Although most trusts do not guarantee jobs after completion of the course, the areas that undertake joint university and trust interviews at the point of application seem to have a different relationship with returnees and view the interview as an opportunity to ensure the 'right' individuals are recruited onto the course with a view to providing employment to them once they are reregistered. These individuals usually go on to fill vacancies in trusts, and in some trusts they do not require the individual to undertake an interview for posts once they have their registration returned – they are simply slotted into a post"* [52] *(p15)* *"'Tailoring the needs and wants of the scheme to the returners would be helpful, perhaps undertaking a needs analysis and, if possible, matching trainers to returners' (6.10.2)"* [42] *(p260)* *'I would have been terrified to have gone straight back in, and I thought it was fantastic to have a mentor, because once you are doing locums and (returned) back into general practice yourself, it's far more difficult to show your weaknesses, where you can be completely honest about that, so I thought that was great' (1.10.1)* [42] *(p259)*
EXTERNAL	16 studies [3-5,8,14,31,32,34,35,37,40,41,43,49,51,52]	*"Feedback from the NHS organisations indicates their valuing of attracting returners back to practice. Often returners are very experienced practitioners with a wealth of knowledge and experience."* [52] *(p5)* *"Our first re-entry graduate joined our teaching faculty for period of time; we were able to do this to enable service at reduced compensation as repayment for faculty supervision and evaluation. This model is one way to make the re-entry program more accessible for fellows who may struggle with the cost of a re-entry program"* [41] *(p368)* *"RTP courses typically have high rates of placing qualified nurses back into the workforce – studies have found that between 70-80% of people who start the course go on to complete it and return to nursing…. Although stakeholders had limited data it was believed most RTP nurses complete the course (with only one or two per cohort of 20 either extending completion of the course due to exceptional circumstances or dropping out)."* [52] *(p5)*

WORK / ENVIRONMENT	9 studies [4,5,32,34,37,40,47,49,50]	*"acknowledges healthcare facilities focus on improving the work environment and providing nurses more voice in their practice. Hospitals that have acquired Magnet status are said to have higher nurse satisfaction and a higher recruitment and retention status"* [47] *(p13)*
SERVICE USER	1 study [42]	*"that the public know that doctors can't just have years out and then walk back in, so there is value in it' (7.2.1)"* [42] *(p257)*

Other factors positively impacting on the return to practice

Supportive professional networks (e.g.) from well-prepared preceptors, supervisors, mentors, co-workers were factors that positively impacted the return to practice[31]. Two studies emphasised the importance that all team members were aware of the objectives and goal of any return to work support or programme that was put in place[35,41].

A positive, supportive team was another important factor particularly as confidence is one of the main issues cited by returnees.

> *"I think it's all down to how you are received and supported on the ward. The nurses on the unit need to understand you need to be supported and welcomed and that would make all the difference." RTP nurse (HEE)* (p20)

Financial incentives and careful consideration of salary arrangements were important factors in supporting the return to work particularly

> *"in the wider context of returner's 'added value' whilst returning to practice". [42]*(p255)

Organisation / Service Factors

Organisational / service facilitators were identified in 18 studies [3-5,14,31,32,34,35,37,40-43,46,47,49,50,52]. There were a number of organisational and other logistical factors which positively impacted on return to practice. These included: structured programmes, clear policies and guidance, information provision, communication, streamlined preapplication and candidate selection processes, mentors and supervision, well organised clinical placements, organisational commitment to return to practice, appropriate resourcing and consideration of workload.

A structured return to practice system with flexibility in how it is delivered (e.g. format, training length) was reported as a positive factor in 8 studies [14,31,32,37,43,46,47,50]

> *"Courses are offered in a variety of lengths as well, from 8 weeks of classroom and clinical work to up to one year of independent study and precepted clinical practicums."[47]* (*p2)*

Manthorpe (2018) also pointed out that return to practice programmes should be longer

*"to provide more reflective opportunities and to be given greater time to complete any assignments. Some suggested this might bring the added benefit of minimising or spreading travel costs.[14]" (*p124)

Four studies highlighted the value of tailored careers advice clearly communicated to those taking a break. Information should be easy to access and provide clear guidance and advice about how to prepare for a career break with consideration for any potential impact on the professionals' career [4,32,34,40].

"The employer should confirm any impact on salary, salary progression and pension of a career break or reduction in hours prior to the career break. All processes for return to work should be clearly identified prior to the career break, agreed and confirmed in writing"[40] (p3)

Two studies highlighted the importance of selecting the right candidates for return to practice programs using robust interviews and assessments, particularly as these individuals may go on to fill a vacancy [37,52].

*"placed high importance in ensuring a robust interview and assessment process with honest conversations with individuals about their motivation to return and ability to work effectively within the new NHS."[52] (*p19)

Strong organisational commitment to support a return to practice coupled with the provision of mentors, supervisors and well-organised clinical placements were considered essential [3,40,42,52]. Manthorpe (2018) argued

*"for earlier involvement by employers in its [RTP] development, which could perhaps be facilitated through regional employer partnerships. This might bring the added benefit of being able to access more opportunities for workplace shadowing (which were highly valued but not always provided), as well as providing direct links to employers' recruitment processes" [14] (*p124)

The role of mentors and supervisors who had a clear understanding of the unique needs for those returning to practice was a critical factor in the success of those returning to practice in 10 studies [3,5,14,31,32,34,35,42,46,52]. Two studies highlighted the value of conducting a needs analysis to match needs of the returner to trainer [31,42]

"A learning needs analysis and an individualized approach was recommended to provide an informed assessment of the re-entry candidate's current knowledge and experiences and help develop a plan that will assist the return to practice"[31.(p37)

The provision of flexible clinical placements was another important factor positively impacting on the return to practice

> *"The placement would also need to be on a part-time basis: Potentials with very young children or other careers stated they could allocate up to 1 day a week to clinical placements, whereas those with older children stated that they could allocate 2 to 3 days a week to clinical placement"*[32] (p308)

Five studies[5,14,34,35,48] emphasised the importance of 'protecting time', ensuring that sufficient time was allowed for those returning to be able to have discussions with colleagues and managers and to be able to *"devote more time to RTP and less to current job"*[35]

External factors

External factors were reported in 16 studies [3-5,8,14,31,32,34,35,37,40,41,43,49,51,52]. There were a number of external factors which positively impacted on return to practice. These included: national return to practice programmes, providing financial assistance, investment and incentivising.

Nationwide return to practice programmes were embraced for their consistent approach and broad range of experiences. These programmes were seen as providing value for money in 3 studies[8,14,52].

Crichton-Jones 2018 [8]argues that

> *"These are just the sort of people the NHS should seek to attract back. Many are highly experienced and skilled and encouraging and supporting them back into substantive NHS employment is a highly cost effective way of growing the workforce."*[8] (p48)

Return to practice models and programmes that considered providing financial assistance were particularly welcomed by returners[8,32,35,52].

> *"Where funding is provided direct to a trust there seems to be more success in obtaining returners and supporting students. For example, several trusts were found to be using funding from their local Health Education organisations and offering to pay course fees,*

and provide RTP nurses with a health care assistant salary while undertaking their clinical placement (at £9.50 an hour)" [52] (p14)

Another study highlighted the importance of lower subscription fees for professional bodies while professionals were inactive or reducing meeting fees so that professionals could access professional development training while on leave[40]

Work and environment factors

Improved working conditions and a better work environment were positive factors in facilitating the return to practice in 9 studies [4,5,32,34,37,40,47,49,50]

Service user factors

One study stressed the importance of public confidence [42]. They stated that is important

that the public know that doctors can't just have years out and then walk back in, so there is value in it' (7.2.1) [42] (p257)

4.5 Length of time a professional is out of practice and the risks to service user safety on return to work (Research question 3)?

Nine studies describe the importance of time away from clinical activity [5,19,32,34,36,39,42,48,51]. Four key themes relating risk to time away from practice were identified: individual factors, emotional factors, skills fade, performance and other factors. These are illustrated in Figure 4 with evidence for each of these themes supported by examples (quotes) in Table 4. Across these studies there was a general consensus *that the longer a professional is out of practice the greater the potential risk is to the public*, however the actual risks to service user safety were not described.

Multiple individual factors were associated with time away from practice. This included age, gender, marital status, education aptitude and level of motivation [5,39]. Older doctors were reported as "signifying greater risks on return"[34] based on Grace (2011) which found a correlation between increasing age and poor performance on competency assessment in

different physician populations [39]. Emotional factors linked with periods of clinical inactivity included lowered self-esteem, lack of confidence and a loss of credibility [42,48].

Figure 4. Key themes linked to time away from practice

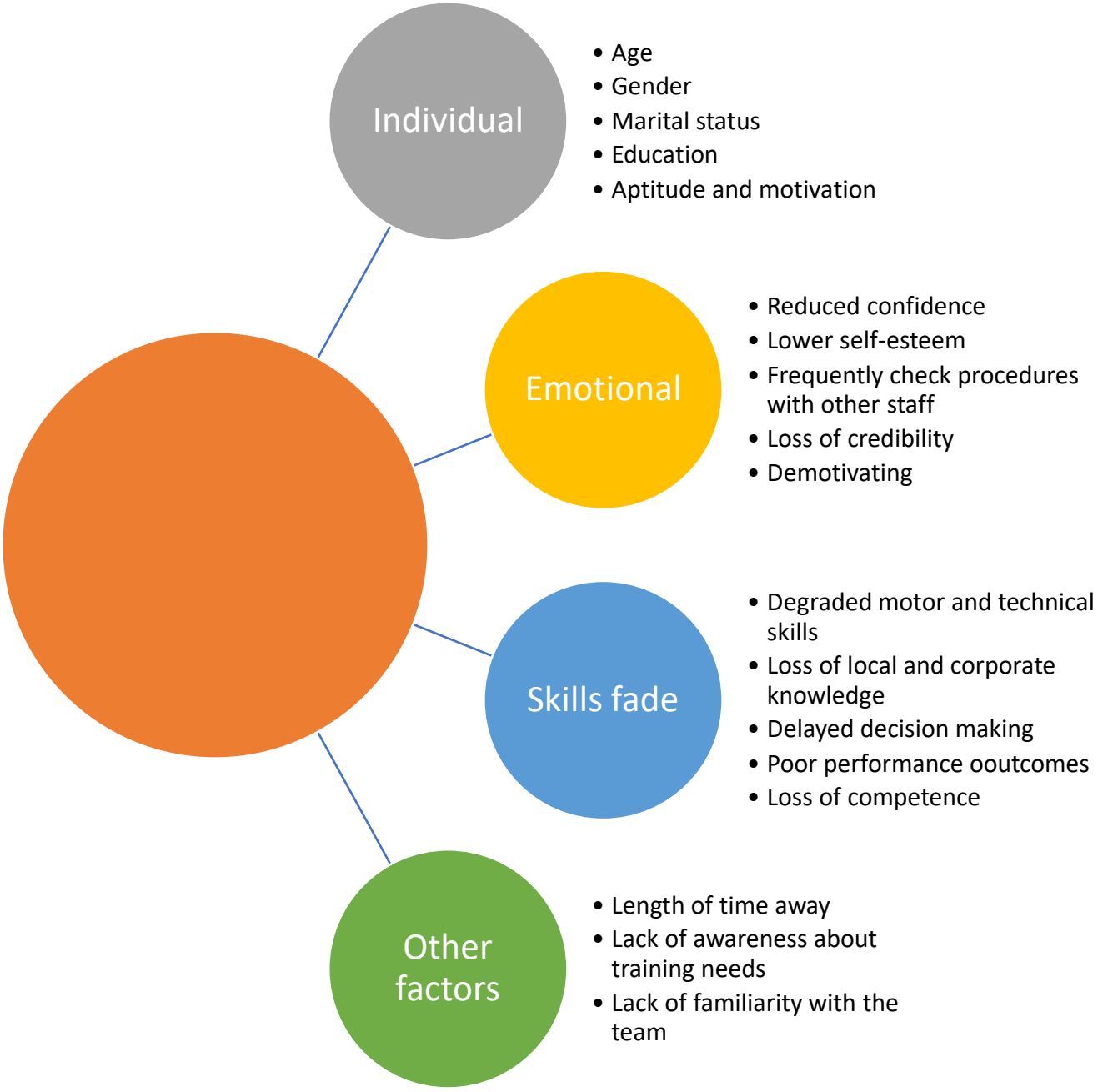


Table 4. Examples from studies reporting on the effects of time away from practice.

Theme	Evidence (Quote)
Individual	<u>*Age, gender, marital status, education, aptitude and motivation*</u> *"A report on a large-scale US study on CPR and AED skills learning in lay people. They find age, gender, marital status, education and prior experience all affected CR skills retention"* [5] (*p16)* "Grace et al found that two factors impacted on performance as assessed on return: age and years out of practice, with older doctors and those with more time out having statistically significant lower performance scores on return to practice assessments. They also found that of the 62 doctors assessed, one quarter had minimal educational needs on return, but 67% had moderate to considerable re-education or updating, with 6.5% having educational needs to the extent that a residency programme was suggested." [5] (*p16)* "Individual factors that Stothard and Nicholson say may affect retention of skills are aptitude and motivation, however, the evidence they found on aptitude is mixed. There is a skill loss curve in both people with and without initial aptitude, and, according to some earlier military studies, once training is given to enable proficiency to a specific level, the retention of skills does not vary" [5](*p9)*
Emotional factors	<u>Self-esteem and confidence</u>: *"My self-esteem and confidence were (both) low and so I had to come back and jump through all those hoops but I must say I cleared everything and my self-esteem rose (again) but psychologically there were a lot of barriers … if I wasn't so determined then it would have been very difficult' (7.6.2)"* [42] *(p259)* *"What is most challenging about returning to practice? Coping with reduced levels of confidence (90% agreed)"* [48] *(p23)* *"What is most challenging about returning to practice? Regaining the clinical confidence and competence required to make you clinically deployable (85% agreed)"* [48] *(p23)* *"Most of [the delegates on a return-to-practice course] had lost confidence and were very much more concerned about being a risk than they probably would have been in practice"* [51] *(p52)* <u>Demotivating:</u>

	"Effects of time away from clinical practice: It is demotivating, as you can never achieve the seniority in a department you deserve (83% agreed)" [48] *(p23)* Loss of credibility: *"Effects of time away from clinical practice: Loss of credibility (88% agreed)"* [48] *(p23)*
Skills fade	Experience: "[from a] systematic review of the medical literature to study the relationship between experience in caring for patients and performance quality, it was concluded that physicians who have been in practice longer have less factual knowledge then their less-experienced counterparts even after adjusting for patient volume." [19] (*p13)* *"Experienced supervisors when asked about the difference between returner and new graduates commented: The knowledge and the understanding of the processes and the philosophy (i.e. EBP, clinical reasoning, research and reading the literature), they are along way behind the undergrads and they're expected to go up and overtake them, within a period of 3 or 4 weeks. (Supervisor 10)"* [32] *(p27)* Benefits of time away from practice: *"GP returners working in low- and middle-income countries bring unique experiences which may be usefully transferred back into UK general practice"* [42] *(p261)* *"Effects of time away from clinical practice: Time away can enhance the wider skill set, and bring more breadth to an individual and their branch (95% agreed)"* [48] *(p23)* Case volume and context: *"…Evidence that case volume can impact on a doctor's clinical acumen, in that the more opportunities doctors have to practise a skill, their competence and acumen will be better. . Doctors who have more contact with trauma patients consistently performed better for all time interval "* [5] *(p9)* *"Having said that I was quite heavily involved in pharmacy in my two years off because I was working as a Pharmacist, but overseas. If you'd gone and spent two years travelling around the world on a sort of extended gap year as it were the you're not going to be practicing as a Pharmacist so you've perhaps have forgotten a significant chunk of that because if you're not using it, you tend to forget it as a rule. [Superintendent pharmacist, Large chain 2]"* [51] *(p52)*

	Type of task and skill retention: *Ali et al (2002) compared retention of ATLS skills in doctors who had fewer than 50 trauma patients per year versus a group who saw more than 50 trauma patients. They measured retention of skills and knowledge via an objective structured clinical examination (OSCE) and a multiple choice questionnaire (MCQ) in doctors who had undertaken the ATLS course 2, 4, 6 and 8 years previously, with 12 doctors in each group. They found that cognitive skills attrition was progressive with a decline in knowledge as measured in an MCQ happening after 6 months. OSCE performance also declined, but doctors maintained a high level of global skill even up to 8 years* [5] *(p16)* *"Wik et al (2002, 2005) measure 6 and 12 month retention of CPR skills in 35 lay people, with one group receiving booster sessions and feedback during the time period and another group not. They found the 'overtrained' group to have better retention of skills than the control group."* [5] *(p16)* *"The concept of over learning is key here, given that evidence from military studies shows that the higher the level of learning and proficiency prior to hiatus the higher the level of retained skill will be." (Stothard and Nicholson (2001) review the evidence on skill retention and decay in an army context in order to develop a theoretical model useful for army training. They argue for over training based on evidence that proficiency declines subsequent to training, but it will stay at a maintenance level. They say that, according to a curve, decay in skills drops most in the first few months after training (month zero to two) but this decline slows down over time"* [5] *(p9)* *Stothard and Nicholson summarise the factors affecting retention as being the task, the training, the retention interval and the individual. Training factors aff*ecting retention include whether the skill has been learned just to proficiency level or over learned. *The reviews also surmise that over learning is a key factor in skills retention, with over learning being the extent to which an individual has learned and practised a skill beyond initial proficiency. Over learning leads to a reduction in but not an eradication of the drop off of skills after a period of non-use."* [5] *(p15)* Loss of competence: *"Effects of time away from clinical practice: Loss of competence (89% agreed)"* [48] *(p23)* *"Effects of time away from clinical practice: Speed of decision making is delayed (92% agreed)"* [48] *(p23)* *"Payne's (2010) mixed methods study looking at the experiences of midwives who had undertaken return to practice courses found that only one third of course attendees stayed on in the profession. Whether this was due to competency issues is not considered, although midwives tell her that one reason is that time out of practice has left them out of step with new approaches to the work"* [5] *(p27)* Reduced motor and technical skills *Effects of time away from clinical practice: Your fine motor and technical skills degrade (77% agreed)"* [48] *(p23)*

	Perez,et al (2013, p76) survey the military literature from the perspective of surgical skills in the military. They cite Arthur et al's 1998 finding that: 'after 365 days of non-use or non-practice, the average participant's performance was reduced by almost a full standard deviation {d = -0.92).' [5] *(p8)* <u>Knowledge:</u> *"Effects of time away from clinical practice: There is a loss of corporate and local knowledge that underpins patient care (75% agreed)"* [48] *(p23)* *"They also found that skill refreshers impacted only on retention of knowledge but not on practical abilities. Henik et al found that procedural knowledge (knowledge of processes, for example performing a procedure) decayed slower than declarative knowledge (knowledge of principles or facts)."* [5] *(p8)*
Other	<u>Length of time away from practice:</u> *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"* [34] *(p15)* *"The study also found that the more years the doctor was out of practice, the more likely they were to have poor performance ratings"* [34] *(p15)* *"Grace et al's (2011) study suggests that older age and length of time out can lead to lower performance scores when returners' skills are assessed. The results of this study speak so clearly to the questions of this review, just as they did to the AoMRC return to practice review"* [5] *(p15)* *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* [34] *(p5)* <u>Inaccurate self-assessment:</u> "*Physicians have been shown to be poor at analyzing their educational needs, and the more significant the physician's needs, the more significant the discrepancy in self-perceived versus actual educational needs."* [39] *(p185)*

The attrition of clinical knowledge and practical skills or "skills fade" was reported in 9 studies [5,19,32,34,36,39,42,48,51], with a general agreement that time away from practice is linked with a reduction in skills. The degree of skills fade differed depending on the individual, their experience, the context and the type of task"[5]. Specific examples of how these factors impact on skills fade are detailed in Table 4.

> *" There is substantial evidence that time out of practice does impact on skills retention. Skills have been shown to decline over periods ranging from 6 to 18 months, according to a curve, with a steeper decline at the outset and a more gradual decline as time passes. The amount of time between learning and losing a skill varies between skills and between individuals, with many mitigating factors"[5]* (p6)

Kenagy (2011)[19] argues that

> *"There is little comprehensive information about the decay rate of specific areas of knowledge and skill. Thus, a physician's need to update his or her knowledge, skills and practice prior to re-entry is not clearly* defined" (*p13)*

> *Other factors associated with risks following time away from clinical activity was the length of time away (i.e.) longer breaks (classified as over three months, based on a consensus of the working group members) were thought to signify a greater risks [34,53].*

One study [32] points out that time away from practice and experience are different, and both factors may need to be considered in any return to practice programme.

Sheppard (2010) argues that

> *"You cannot assume that everyone that has not worked for 5 years is at this point, and everyone who's not worked for 10 years is at this point. (Supervisor 10) [32]" (p27)*

In New Zealand returner physiotherapy programs vary based on experience prior to ceasing practice but Canada, and the UK only the length of time away from practice is currently considered [32].

> *Comparing the returner with an experienced physiotherapist, a supervisor commented: They're at a very inexperienced level, the working experienced physio is kept up to date with technology and is competent with that and comfortable with it, whereas the refresher student's been out of the loop but once they're working the refresher student comes back to the level of the experienced working physio much quicker than a new graduate would. They just take off and do really, really well. (Supervisor 10) [32]* (p27)

There is a consensus that skills fade may be mitigated for through keeping in touch with peers during a hiatus and staying aware of relevant developments [5].

4.6: Approaches to support health and social care professionals to return to safe and effective clinical / frontline practice (Research question 4)?

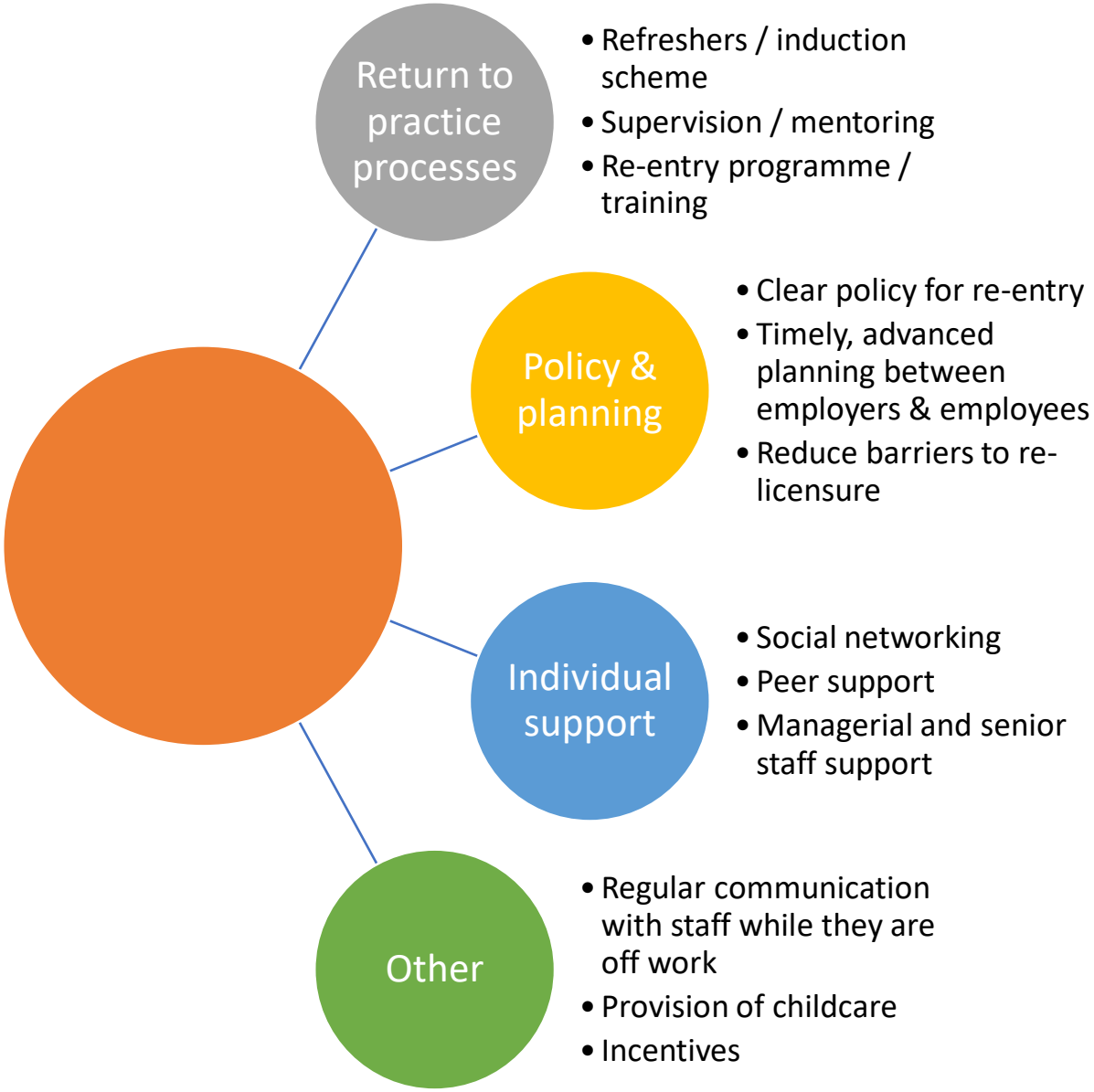
Sixteen studies reported at least one approach that has been used to support health and social care professionals return practice after a period of inactivity (> 3 months) [4,5,31-36,38,43-45,48-50,52,53]. Most of the supportive approaches reported involved doctors (61%). Fewer supports were described in the other professional groups: AHPs and social workers (16%), nurses and midwives (11%) and pharmacists (3%).

A number of clear approaches which could support return to practice were identified; these are illustrated in Figure 5.

Overall, the majority of approaches to support professionals back to work were identified at an organisational level (71%). Streamlined return to practice processes and the availability of return to practice schemes were reported as the most important organisational approaches to supporting professionals return to practice [5,8,14,32,34,35,37,39,41,45,47,53] . Establishing clear organisational policies "to support effective return to practice in the interests of patient safety" was also strongly recommended in four studies [34,39,44,48,53].

The importance of ensuring professional continuity in practice by developing action plans, job plans [48] and other strategies to ensure that professionals continued to meet a minimum level of professional and clinical activity during their absence [43] and during the transition to return to practice [34,53] was highlighted in four studies. Critical to the success of returning to practice was the use of effective communication strategies with studies reporting the need for regular communication with staff during the career break and making work-based intranet available at home to all staff during their absence [5,40].

Figure 5. Approaches to support health professionals return to practice



Training (e.g. identifying the skills and previous experience of candidates and tailoring the support accordingly) [32,49] or developing practical and feasible methods such as simulation based training for professionals who may not have the opportunity to participate in clinical practice on a regular basis [36] were described as supports. Supervisors, mentors and preceptors were all seen as positively impacting on preparation for RTP [33], as well as employers and organisations providing appropriate clinical placements[3].

Staff-level approaches (11%) to support were less frequently reported. Financial incentives [47], strong social and professional networks, childcare (e.g. workplace nursery or being able to bring a baby into the workplace) to ensure a smooth transition to RTP [40] and access to an 'approved' RTP programme [52] were common themes in obtaining support for returners [40,50]

Regulator approaches to support (3%) were limited. One study described the value of supervision models as an important approach in the registration process to physiotherapists seeking support to return to clinical work [31]. Another study argued that all interested stakeholders were responsible maintaining that

> "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" [34] *(p5)*

4.7: What evidence is there about the management of risk at a regulatory level, and how does this evidence relate to existing approaches to managing return to safe and effective clinical / frontline practice (Research question 5)?

Five papers reported limited evidence about the management of risk at the level of the regulator; these are summarised in Table 5 [5,14,19,34,51].

Paper	Year of publication	Profession of focus	Type of paper	Evidence considered
Kenagy	2011	Doctors	Recommendations	Output from a 2010 conference titled "Physician Re-entry to Clinical Practice: Overcoming Regulatory Challenges Conference
Phipps	2010	Pharmacists	PhD	Literature review, focus groups and interview data
AoMRC	2017	Doctors	Guidance	"The recommended guidance is based on the considerable experience of

				the working group involved and a review of the limited evidence available."
GMC	2014	Doctors	Review of evidence	Commissioned literature review focussed on "skills fade resulting from a career break"
Manthorpe	2018	Social work	Description of a return to work programme	Reflections from the team that delivered the programme and comments from participants

These papers primarily comprise a series of recommendations, developed based on limited available evidence. The majority of the available evidence, and the identified papers, relate to return to practice of medical doctors, but these arguably have application to other professional groups. The recommendations within these papers are generally in agreement, and emphasise the need to assess competency, as well as highlighting some key guiding principles for return to practice programmes:

> *There is a growing need for regulation to assess competency so that patient safety and quality of care are ensured. Access to current medical knowledge, including changing technologies, must be factored into physician re-entry policies that address education and training* [19] *(*p13)

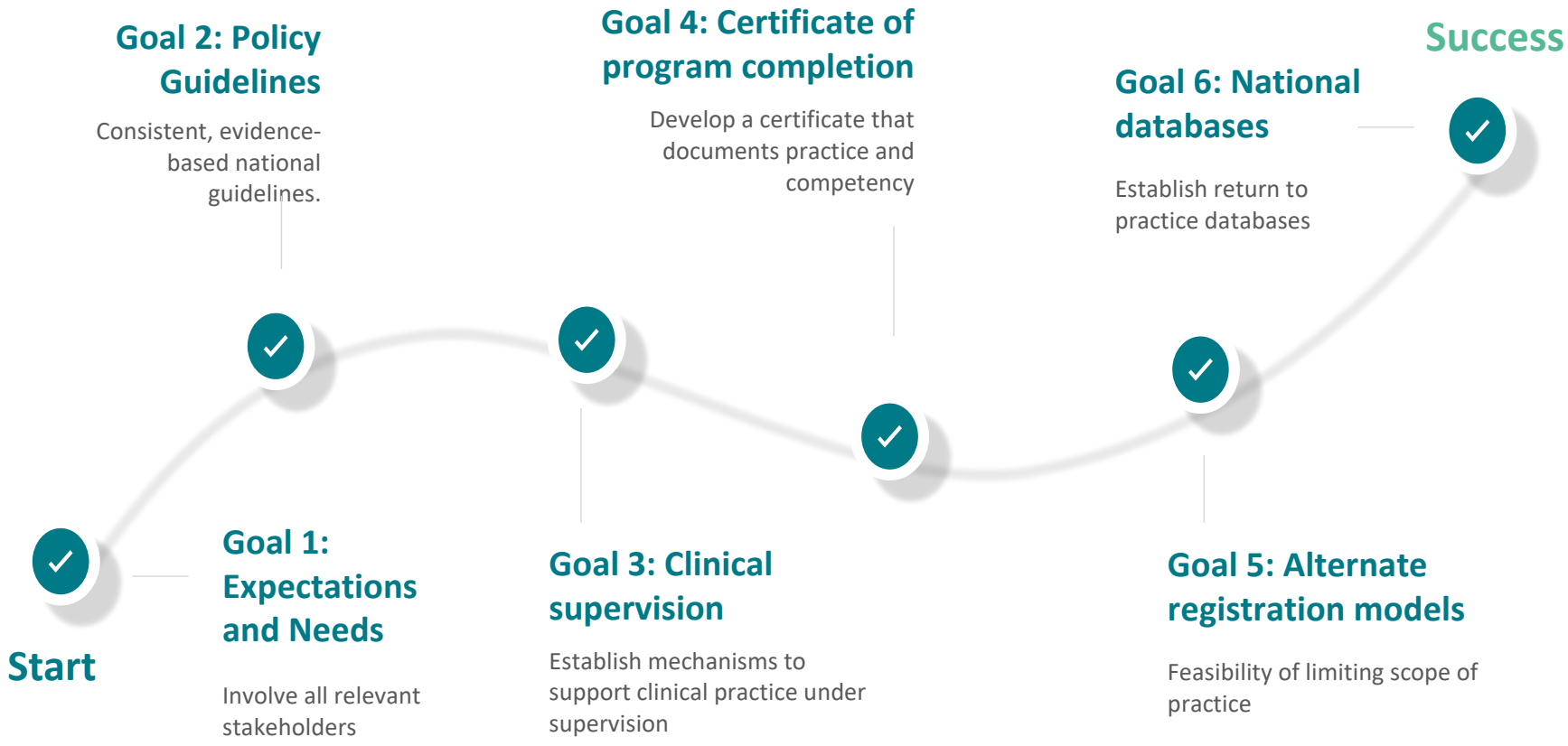
> *"[return to practice programmes should be] accessible, collaborative, comprehensive, ethical, flexible, individualized by taking into account experience and plans for future practice, innovative by incorporating simulation and electronic evaluation tools, accountable, stable, and responsive"* [41]*(* p368)

> *"[regulatory process should be] comprehensive and inclusive, involving all relevant stakeholder groups".* [19] *(p14)*

In relation to the role of regulators in ensuring safe return to practice, Kenagy (2011) identified six goals as outlined in Figure 6. These goals were

> *"to ensure that there is a comprehensive, transparent, and feasible regulatory process that also ensures public safety for use with physicians …returning to clinical practice"(*p14)

Figure 6. Six goals outlined in Kenagy (2011) to ensure the safe return to practice following a period of absence



Below we describe each of these 6 goals in more depth, synthesising relevant examples from the other papers.

Goal 1: Expectations and Needs: Stakeholder involvement

Guidance with improved governance from regulators clearly outlining the needs and expectations of a return to practice system involving all relevant stakeholders was considered a first essential step (Fig 6).

Phipps (2010), when describing 'risk' in pharmacy, highlighted the importance of stakeholder involvement:

> *"a ubiquitous concept, there are varying views as to how it should be defined in practice. In the context of pharmacy work, risk can be viewed purely in technical terms – for example, the probability of an adverse event combined with an assessment of severity. However, it can also be viewed in terms of the relationship between the pharmacist and the various stakeholders who are involved in his or her work. From the latter view, it becomes important to consider what risk means to these different stakeholders" (*p v)

Manthorpe (2018) argued that the needs and expectations of employers must be considered:

> *"Consideration might be given to endorsement by central government or by the new regulator of future return to social work programmes to promote more consistency. Any such guidance needs to be developed with employers to reach a consensus about what constitutes appropriate experience, skills and knowledge and how these might be assessed or demonstrated"[14] (p124)*

The identification of, and meaningful engagement with and involvement of, all relevant stakeholders is therefore an important step when developing regulatory processes relating to return to practice.

Goal 2: Policy Guidelines

Kenagy (2011)[19] recommended that clear, evidence-based consistent guidelines should be developed, and that they should clarify:

- length of time away from clinical practice which necessitates participating in a reentry process;
- definition of how much involvement in clinical care constitutes active clinical practice
- clinical practice requirements for maintaining registration

A real-world application of this recommendation is the AoMRC checklist [34]. Two checklists were developed to identify the needs, and document any supports of those returning to practice as part of their appraisal. Ideally one of the checklists would be completed **before** the absence (Figure 7) and one immediately on return at a formal appraisal (Figure 8). The appraisal should determine whether the questions raised in the checklists have been addressed and supporting evidence of completion of the return to practice action plan should be given.

Goal 3: Clinical supervision

Kenagy (2011) recommends establishing mechanisms to allow professionals returning to practice to be able to "engage in clinical practice under supervision". They highlight the importance of having the proper infrastructure to support this process, involving educators, organisations (hospitals, employers) and regulators working together. This would also involve establishing a conditional registration option (or non-disciplinary licensure status) for those returning to help obtain clinical experience[19,31]. Other studies have also identified the need for regulators to support a flexible approach to reregistration[31,32,37]. Sheppard (2010) states that

> *"For the regulators, their position must be to protect the public, but a clear understanding of the need to consider the individual's position and circumstances was demonstrated by the regulators" [32](p26)*

Cass (2012) also mentions the importance flexible regulation

> *[It is important that there is] "reciprocity among the states regarding short-term licenses and monthly malpractice coverage for re-entry candidates while they are involved in a re-entry program. Such flexibility would allow physicians to travel to re-entry programs of their choice around the country" [37]* (p364)

Figure 7: Absence checklist. A modified checklist of questions recommended by the AoMRC [34] to be used before an absence to help identify needs of practitioner returning to practice.

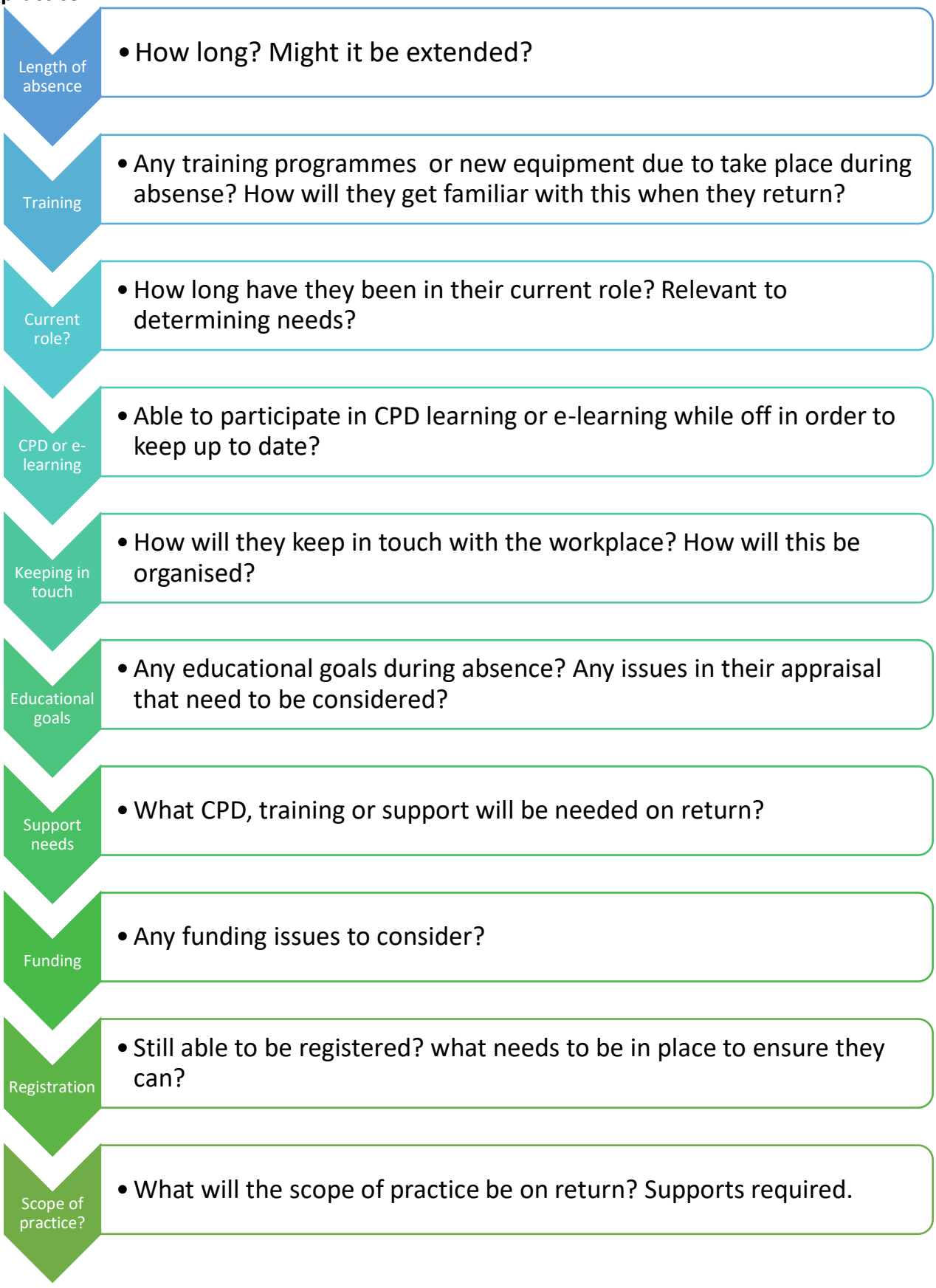


Figure 8: Post-absence checklist. This is a modified checklist of questions recommended by the AoMRC [34] to be used on return to help identify needs of practitioner returning to practice.

Goal 4: Certificate of program completion

The fourth recommendation (Fig 6) is the development of a process for a certificate of program completion that document competency relating to a practitioner to return to practice. Other regulators have noted the importance of competency, with some arguing that those returning to practice should complete profession-specific competency exams [31]. Other regulators have also identified an important role in monitoring and examining evaluation tools designed to evaluate competence [31].

Goal 5: Alternate registration models

Kenagy (2011) advocated that regulators need to consider the feasibility of introducing alternate registration models for professional returning to practice that allow a limited scope of practice. Regulators may need to provide additional flexibility to offer a tailored approach to match the candidate's anticipated scope of practice, which is currently lacking [37].

Goal 6: National databases

Kenagy (2011) also recommended establishing national return to practice databases to:

- Provide programmatic information to professionals returning to practice; and
- Track trends in returning, such as number of professionals returning, program costs and outcomes.

The formation of these databases could be used to send practitioners updated communication policies from regulators or professional bodies delivered using electronic alerts. Taking advantage of technological advances means that regulators could provide easy access to up-to-date information on changes in policies and/or procedures.

4.8: Minimum requirements for a health and social care regulator to assure themselves an individual is safe to return to practice (Research question 6)?

Examples of national and international minimum requirements for allied health professions and social work are summarised in Appendix Table 2. This data was pooled from the literature judged as 'red' or 'amber'. In Table 5 we have highlighted the period of absence which

triggers the return to practice process. There appears to be broad consensus across regulators and professional bodies that the return to practice should be triggered following an absence of between 2 and 3 years (Table 6) and a mix of evidence to support that a minimum number of hours have been completed is required (Appendix Table 2). A period of prolonged absence (> 5 years) requires significantly more proof of training and practice and are typically dealt with on a case-by-case basis (Appendix Table 2).

Regulators and professional bodies specify a minimum number of hours of supervised clinical practice required for re-entry, generally based on one (or more) of the following criteria:

- Profession
- Recency of practice
- Whether or not the practitioner still holds a current annual certificate of competence (APC)
- Experience.

Consequently, the prescribed minimum requirements vary widely according to the profession and geographical location. For example, a podiatrist in the UK who had not practiced for 2 – 5 years would be expected to show evidence that met the HCPC criteria of 30 days of updating (Appendix Table 2). However, a podiatrist planning on returning to practice who has not practiced for 3 or more years (but <5 years) must fulfill the following minimum criteria in New Zealand:

- CPR certificate (including AED and anaphylaxis) required prior to starting work,
- Self-directed return to work practice plan. (i.e. PBRCF form 1 "Self-directed professional development needs analysis" page in APC application form),
- Police check for every country lived in for past 5 years, Certificate of Good Standing from every registration authority practiced under since last practiced in NZ.
- Two-character references if practiced in an unregulated country
- An initial 40 hours of planned clinical supervision prior to full APC being granted. A supervisor agreement must be completed and sent to the Registrar. The criteria for establishing supervision hours: is based on length of previous experience before ceasing practice, health related professional involvement during period of non-practice and feedback from the initial supervision. Areas of weakness or risk identified.

- Audit in 1st year returning to practice. (See Podiatrists Board Recertification Framework)

The evidence-base for how these prescribed number of hours required for health and social care professionals were determined is unclear. We also found no evidence that shows definitively *how much* recent practice a practitioner needs to maintain their skills and knowledge, or whether these hours and suggested training are sufficient to ensure competence. (Appendix Table 2).

Table 6. The period of absence which triggers the return to practice process in National and International professional and regulatory bodies (where data was available). Yellow cells = < 12 months; Green cells = 2+ years; Blue cells = 3+ years. Orange cells = no details available on website.

PROFESSIONAL GROUP	UK AND IRELAND	AUSTRALIA	CANADA	NEW ZEALAND
Art therapist	British Assoc Music Therapists	-		
Biomedical Scientists	Institute of Biomedical Science IBMS*	-		
Chiropodists / Podiatrists	Alliance of Private Sector Chiropody and Podiatry Practitioners	AHAPRA Podiatry board		Podiatrists Board of NZ site
Clinical Scientists	Association of clinical scientists	-		
Dietitians	British Dietetic Association**		College of Dietitians Ontario	Dietetics board NZ dietetics board site
Hearing Aid Dispensers	British Society of Hearing Aid Audiologists			
Occupational therapists	Royal College of Occupational Therapists^	Australian Health Practitioner Regulation Agency (AHPRA) website – Occupational Therapist Board		
Operating Department Practitioners	College of Operating Department Practitioners	-		
Orthoptists	British and Irish Orthoptic Society			

Paramedics	College of Paramedics	Australian Health Practitioner Regulation Agency (AHPRA) website - Paramedicine Board		Toronto Paramedic RTP course (absence > 90 days)
Physiotherapists	Irish Physiotherapy Registration Board	Australian Health Practitioner Regulation Agency (AHPRA) website - Psychology Board		Physiotherapy Board of NZ RTP programme
Practitioner psychologists		Australian Health Practitioner Regulation Agency (AHPRA) website - Psychology Board		New Zealand Psychologists board RTP site
Prosthetists / Orthotists	British Association of Prosthetists and Orthotists[$]			
Radiographers	Society of Radiographers RTP site			
Social workers	British Association of Social Workers - England Care Council for Wales			Social workers (Wellington)
Speech and Language Therapists	Royal College SLT		Alberta College of Speech and Language Pathologist and Audiologists	

Notes:

* In addition to meeting the HCPC criteria, The IBMS makes the **additional recommendations**: Individuals wishing to RTP in a clinical laboratory should use the institute portfolios as a framework for updating their knowledge and skills, for example, the Specialist Portfolio in discipline specific areas. A self-assessment of knowledge and skills achieved prior to a break in practice should be conducted against the portfolio to identify training needs (gap analysis) Training should be carried out in an institute approved training laboratory and in accordance with these IBMS Good professional practice guideline. The period of updating should be signed off by a registered biomedical scientist as a record of areas of the specialist portfolio completed and whether competence to practice was achieved.

** In addition to meeting the HCPC criteria, the BDA “advise all returners to gain some supervised practice before they return to practice, alongside some formal and private study”

^ This period of updating is a MINIMUM REQUIREMENT. You may need longer if you feel, or you are advised, that you cannot yet practise safely and effectively in a certain area or role.

$ Limited details about insurance only

5. CONCLUSIONS

5.1 Summary of findings

This systematic review of evidence relating to return to work of health and social care professionals following a period of absence, and the risks to service user safety and safety of health and social care staff, identified a wide range of heterogeneous studies. A total of 28 studies met the criteria for inclusion within this review. Studies reported evidence relating to a wide range of different professionals, including: doctors, nurses and midwives, physiotherapists, occupational therapists and social workers. In general, studies reported largely qualitative results, often in a narrative format, and the majority of evidence extracted related to factors which were implicitly – rather than explicitly - linked to successful return to work. Most commonly, studies focussed on successful return to practice, and very little evidence was found relating to competency to practice, and potential risk to service user safety or health and social care professional safety, after return to work. Below we summarise the key findings from this review.

5.1.1 Risks associated with return to practice

Mild or moderate harms to the individual practitioner returning to practice were commonly reported within the evidence, as a result of the risks associated with return to practice. No risks were reported at a service user level.

Reported risks associated with return to practice included:

- lack of skills, training schemes or funding for training,
- lack of guidance and variations relating to return to practice, administrative challenges at an organisational and regulatory level
- individual factors, such as continued breastfeeding or personal feelings about return to practice

There were gender differences reported relating to difficulties associated with return to practice.

5.1.2 Approaches to support health and social care professionals return to practice

A number of approaches to support health and social care professionals return to safe and effective practice have been reported. The approaches considered to be most important were:

- Return to practice processes such as return to work programmes, training and mentoring schemes
- Clear organisation policies and planning to support return to work

Other approaches which were considered to support return to work included communication with staff during their career break, networking and peer support, and provision of childcare facilities.

5.1.3 Factors negatively and positively impacting on the return to practice

A wide range of different factors negatively impacting on return to practice were reported in the literature. These included:

- Organisational and service factors, such as lack of access to placements, training or supervision and (linked to these) lack of resources. There were also factors associated with workload, organisational culture and the availability of peer and employer support.
- Staff factors which negatively impacted on return to practice could be broadly grouped into barriers relating to cognition and performance, emotion, behaviour and personal life. Individual factors such as age, gender and personal health could also negatively impact on return to practice.
- Other factors related to a range of external and work / environment factors. There were also potentially factors specific to individual service user groups, relating to their condition, illness or particular health needs.

A wide range of factors positively impacting on return to practice were identified. In particular, these included:

- Strategies to improve performance and knowledge

- Individual staff behaviours and emotions, and factors relating to personal and social circumstances
- Individual factors such as age, gender, marital status and education
- Organisation and service factors, such as well-organised and resourced programmes, provision of guidance, mentoring and supervision
- External factors such as national programmes and financial incentives
- Improved working conditions and work environment

5.1.4 Time spent away from clinical practice

Current evidence demonstrates consensus that *that the longer a professional is out of practice the greater the potential risk is to the public*, however the actual risks to service user safety are not described. Four key themes relating risks to time away from practice were identified:

- Individual factors, including age, gender, marital status, education and motivation.
- Emotional factors, including self-esteem and confidence
- "Skills fade", or attrition of clinical knowledge and practice skills
- Other factors, such as length of time away from practice, awareness of training needs and familiarity with the team

5.1.5 Management of risk at a regulatory level

There is little research-based evidence available relating to the management of risk at a regulatory level in relation to return to practice, but guidance and recommendations, developed principally through expert opinion and primarily focussed on doctors, demonstrates consistency. To ensure a comprehensive, transparent and feasible regulatory process to support return to practice, regulators should:

- Involve all relevant stakeholders
- Introduce policy guidelines which clarify key parameters
- Establish mechanisms for clinical supervision, supported by appropriate infrastructure and registration options
- Develop a process for certification of competency for return to practice
- Consider flexible models

- Form a national return to practice database

5.1.6 Minimum hours of practice to assure a safe return to practice

Regulators frequently prescribe a minimum number of hours of practice (often arbitrarily) for professionals wishing to return to practice. There was broad consensus that that the return to practice should be triggered following an absence of between 2 and 3 years, but the minimum requirements varied widely across professions, and geographical location. The evidence for these prescribed *number of hours* required for health and social care professionals is unclear. There is no evidence that completing the required number of hours ensures competence.

5.2 Limitations

Our systematic review sought to answer a series of broad questions aimed at identifying risk to service users, health and social care professionals and regulators. We found little explicit evidence for harm or adverse events at the level of service users or health professionals. It is plausible that the lack of evidence is not due to the absence of evidence, but simply that this work is captured by a different body of literature. For example, relevant evidence may be published in the fitness to practice area and / or competency literature, which was considered out of scope for this review. Furthermore, the majority of data included in the review has come from professions outwith allied health care and social work. (i.e. from nursing and medicine) which may limit some of the generalisability of the findings and not fully represent some of the unique risks and supports of health and social care professionals.

Our review identified a significant number of publications with were categorised as 'amber' or 'red' because of poor reporting. It is possible that some of these studies could provide further detail about risk or supportive approaches to service users or healthcare professions, but our ability to extract these details were limited by the quality of the reporting. Finally, we found no rationale for the minimum number of hours prescribed by national and international regulators and professional bodies. This may be because regulators and professional bodies

have developed guidance based on in-house data which we were not privy to or data that is not in the public domain.

5.3 Implications

5.3.1 Implications for Clinicians returning to practice

Our review synthesised evidence relating to a number of implications for those individuals returning to practice. In particular, the following may be beneficial to return to practice:

- Planning of career breaks and preparation
- Awareness of the potential impact of emotional, behavioural and social factors which may impact on return to practice
- Utilising and maintaining social and professional networks
- Early consideration of childcare arrangements

5.3.2 Implications for Employers and Organisations

In the course of completing this review, we identified a number of factors that negatively and positively impacted on the return to practice. Employers and organisation should consider the following:

- Providing return to practice training programmes, with flexibility
- Having clear guidance, policies and support
- Clear communication with staff, including while they are off
- The workload and environment of people return to practice
- Providing adequate breastfeeding facilities & policies to support breastfeeding mothers

5.3.3 Implications for Researchers and Funders

Return to practice evidence was identified from a wide range of stakeholders, but no risks or supports from a service user's perspective were identified. This highlights an important gap in the existing evidence base. In order to manage risk appropriately, all stakeholders,

including service users, should be included in developing return to practice processes. In addition to strengthening the existing evidence base, we have identified two key areas for future research:

- Reliable, validated assessment tools to identify return to practice needs and evaluate the impact of return to practice on a range of outcomes, including risks to service user safety and safety of health and social care professionals are essential. A systematic review to identify reliable assessment tools, relevant, applicable and feasible for each professional group on the HCPC register would be beneficial.
- A systematic review of evidence focussed on safety / competence to practice, specifically seeking evidence associated with return to work is required. Specifically, this review should document the following:
  - information about the educational content (i.e. types of knowledge, assessment and application and the skills required for competent practice,
  - pedagogical approach,
  - the structure of the programme / intervention (i.e. delivery and format, frequency and timing, assessment and evaluation of the programme
  - participant characteristics

5.3.4 Implications for Regulators and Policy makers

Leaving clinical practice and returning to practice is commonplace and should be factored into any new guidance. In order to ensure a successful transition back to practice, regulators should:

- Involve all relevant stakeholders in the process of developing return to practice guidance, including identifying potential areas of risk based on multiple perspectives. An important part of this process should also include an opportunity for regulators to be consulted by other organisations and professional bodies as they develop their return to practice guidance or policies ensuring a more streamlined process across those working in this area;
- Introduce clear policy guidelines which clarify the length of time away from practice, what constitutes active clinical practice, and the scope of practice for those returning to practice;
- Establish mechanisms for clinical supervision (e.g. detailing what constitutes a suitably qualified mentor, providing specific details regarding the level and degree of clinical supervision (Hands-on / remote supervision) and supervision timeframes;
- Develop a process for certification of competency for return to practice which is not based solely on self-assessment.

- Consider flexible models regarding the scope of practice so that a professional returning to practice may have the opportunity to have more opportunities to practice
- Form a national return to practice database which could document the number of professionals returning to practice, professional group, length and reason of absence, the number of hours of supervision etc.

Finally, there was insufficient evidence within this review to determine risk to the service user, healthcare professional or regulator. However, it may be helpful to develop different risk profiles for each profession based on their scope of practice. Given the current evidence constraints, evidence for regulatory risk should be sought from alternative information sources. For example, information could be gathered from fitness to practice complaints, audits, conducting a review of serious incidents, service user complaint websites, interviews and surveys with key stakeholders involved in the return to practice process.

Appendix: Table 1: SUMMARY OF INCLUDED STUDIES

Abbreviations: AHP: Allied health professionals, CE: course evaluation; CS: case study, CSS: Cross-sectional study, D: Descriptive, DA: Database analysis, E: Evaluation study, HV: Health visitors, LR: literature review, MM: Mixed methods study, OB-gyn: obstetrics and gynaecology, OT: Occupational therapist, QS: Qualitative study, S: Survey, U: unclear,

Reasons for being out of practice: [1]Career dissatisfaction; [2]Caring responsibilities; [3]Change scope of practice; [4]Financial reasons; [5]Hard to keep up with clinical advances [6]"Hassle factor (i.e. paperwork, compliance issues); [7]Humanitarian leave; ; [8]Inflexible work hours; [9]Licensure; [10]Military deployment; [11]On call responsibility; [12]Organisational restructuring; [13]Personal health issues / concerns; [14]Pursue alternate careers; [15]Relocation; [16]Retired; [17]Rising medical malpractice premium; [18]Travelling; [19]Other (not specified)

First Author (Yr) [Country, Study design]	Aim	Methods	Participant demographics [Professional group]	How long out of practice? [Reasons for being out of practice]	Outcomes	Key findings
AHPS AND SOCIAL WORK						
Canadian Alliance [31] 2012 [Canada, LR]	A five-year review of the strengths and weaknesses of the various supervision models currently used by physical therapy regulators in Canada and four selected international countries (i.e., Australia, Great Britain, New Zealand, and United States);	Review of supervision models used by physiotherapy regulators in Canada and internationally, Focused interviews, Literature review models of regulatory supervision and quality practice outcomes and supervision of adult learners. Review of best practices in selected other professions	NR [Physio]	U [NR]	Needs of re-entry candidates	Literature reviewed suggested that re-entry candidates have special issues/needs when they return to work that include feelings of anxiety and low self-esteem, as well as desire for flexible programs that are tailored to their experience and educational needs, and family situations. Programs involving role models and mentors can play an important role in facilitating entry

First Author (Yr) [Country, Study design]	Aim	Methods	Participant demographics [Professional group]	How long out of practice? [Reasons for being out of practice]	Outcomes	Key findings
	A literature review with an analysis considering models of entry level supervision and quality practice outcomes; A review of regulatory entry to practice supervision models used by eight selected other professions, including non-health in Canada (i.e., architecture, chartered accounting, chiropractic, dietetics, engineering, law, occupational therapy, and pharmacy); An analysis of current PT supervision models against the findings/ evidence.					or re-entry to practice and a shift towards more structured transition programs for new graduates and internationally educated health professionals were noted.
Sheppard 2010 [32,55] [Mixed: Australia, Canada, NZ, South Africa, UK / QS]	To better understand physiotherapy RTP, by exploring the experience of RTP practice from the perspective of those who have returned to practice, those thinking of returning, and clinical supervisors who have	Australian and international physiotherapy regulatory bodies which were interviewed using focus groups and individual interviews. Semi-structured interviews were also	7 international interviews with the Chairs and Registrars in New Zealand, provinces in Canada, and the United Kingdom.	24-120 months out of practice (2-10 years out of practice) CPD policies - requirements for re-entry/ re-registration:	NR	No evidence found in the literature or from the interviews with returners, potential returners, or clinical supervisors to indicate that a certain amount of time out of the physiotherapy workforce should preclude an individual from being allowed the opportunity to RTP

First Author (Yr) [Country, Study design]	Aim	Methods	Participant demographics [Professional group]	How long out of practice? [Reasons for being out of practice]	Outcomes	Key findings
	worked with people that have returned to practice.	conducted with returners, potential returners, and clinical supervisors who had directly supervised re-entrants or re-registrants.	A total of 56 people from the second group (returners, potential returners, and clinical supervisors) responded to the calls for participants. [Physio]	Australia: supervised practice/ clinical practice/ theory/ re-education/ practical assessment - practice report/ uni report New Zealand: 3-6 months oversight/ supervision retraining plan if fail - report 1,3 and 6 months UK: 30-60 days updating - any combination of supervised practice, formal study or informal study. Updating forms to be countersigned by peer Canada:310-480 hours clinical		Model that provides flexibility to recognise the diversity of the returner group and their progress towards re-registration and re-entry is needed. A model that reinforces reflection, peer discussion, and application to practice seems appropriate for professional learning. The model developed incorporates four key aspects in response to the literature and interview data but requires further testing beyond the initial interviews asking for feedback on the model. An application to actual cases of returners is needed to understand the implementation of the model.

First Author (Yr) [Country, Study design]	Aim	Methods	Participant demographics [Professional group]	How long out of practice? [Reasons for being out of practice]	Outcomes	Key findings
				practice. Physiotherapy competence examination/ physiotherapy national examination for most areas - examination/ evaluation [1, 2, 14]		
Baptiste 2010 [33] [Canada, MM]	To describe a project designed to support entry or re-entry to active practice for occupational therapists and physiotherapists who were internationally educated or seeking a return to practice after a prolonged absence	The evaluation of the SEPP project focused on the qualitative experience of all the participants. Information was gathered through the mid-project and final summary workshops, two different surveys distributed to mentees and to mentor/ preceptors, and also through a series of individual interviews at the end of the project.	17 (re)entry candidates who registered to participate in the SEPP project. Of this number, 15 actively participated in project activities. Two registrants did not participate in any SEPP activities although they registered in the project.	>3 years [NR]	NR	Successful "micro-project" that has achieved its major objectives, highlighted some of the challenges and impediments faced by individuals seeking to (re)enter professional practice in Ontario, and resulted in the development of a model of a future mentorship/ preceptorship program for occupational therapists and physiotherapists.

First Author (Yr) [Country, Study design]	Aim	Methods	Participant demographics [Professional group]	How long out of practice? [Reasons for being out of practice]	Outcomes	Key findings
			[OT / Physio]			
Manthorpe 2018 [14] [UK, QS]	Reports on the set up of the national Return to Social Work pilot programme 2006–2017.	Describes the model adopted and reflections upon it by the delivery team and comments made by those participating at the end of the programme in a brief feedback exercise.	19 participants, wide range of experience among participants with some still being relatively newly qualified, while others had substantial experience, some of which was at managerial levels [Social workers]	24-50 months (2-5 years) Programme content consisted of five reflective supervision sessions, five action learning sets and four coaching sessions with a further post programme coaching session [NR]	NR	Do not know if, which and how skills fade after time away from practice in social work and no real way of establishing how to determine this has been developed. It may be easier to address out-of-date knowledge and new procedures on short programmes but harder to address the loss of skills other than in practice or simulations. Cost-effectiveness of such programmes can only be established if data are collected on the longer-term outcomes of such investment. Need to establish agreement on what should be the metrics for assessing any such programme as a success
DOCTORS						
AoMRC 2012, 2017[34,53] [US, LR]	This paper considers evidence and anecdotal information from a range of contributors (including	Recommended guidance is based on the considerable experience of the working group involved		>3 months An absence of two years or more seems	Competence (loss of during absence from work); skills and knowledge; safety	Checklists (see Sections 5 & 6) should be used pre [where possible] and post absence to conduct an individual evaluation of the doctor RTP.

First Author (Yr) [Country, Study design]	Aim	Methods	Participant demographics [Professional group]	How long out of practice? [Reasons for being out of practice]	Outcomes	Key findings
	Medical Royal Colleges, a UK medical Dean and international medical regulators) it also: • Compares the diverse RTP policies of Royal Colleges in the UK • Highlights RTP policies of UK regulators in professions inside and outside of medicine • Compares RTP policies, practices and views of medical regulators and other bodies internationally • Includes views from medical educators (such as American universities and UK Deaneries).	and a review of the limited evidence available. The 2017 revised RTP guidance replaces that which was published in 2012, providing updated information on RTP in line with new thinking.		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. [2]		The guidance also gives recommendations for a return to practice action plan and suggests an organisational policy to ensure an effective RTP 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.

First Author (Yr) [Country, Study design]	Aim	Methods	Participant demographics [Professional group]	How long out of practice? [Reasons for being out of practice]	Outcomes	Key findings
						A key factor affecting a doctor's successful RTP 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 RTP 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.
Bower 2011 [35] [US, CS]	To describe an 'innovative' intervention using a GME model to prepare doctors return to clinical activity	Case-study of education designed to return nonpracticing physicians to clinical activity was undertaken	14 participants from a range of specialties incl. family medicine, general surgery, internal medicine, paediatrics, OB-gyn, and urology.	Most states recommend, and 6 require, physicians who take a leave of absence for more than 24 months to complete an RTP programme. [2, 13, 14, 16]	Programme completion; clinical proficiency, level of independence	13/14 completed the program and are engaged in clinical practice Focus is on updating current medical knowledge. Effective self-assessment is important for ongoing improvement, and the RTP programme using a GME model is one way physicians can improve their self-assessment skills
Braun 2014 [36] [US, CSS]	To identify which specific pediatric clinical skills were felt to be most affected by deployment.	Email survey sent to army paediatricians determine their comfort level and experience with clinical encounters and procedural skills	NR	7 – 12 months. 54% respondents were deployed > 6 months during their most recent deployment, and	Redeployment Specialty Skills Matrix Survey was developed by Specialty Advisors to the Central	After deployment, US Army paediatricians have limited opportunities to practice the full range of their paediatric skills. This gap in clinical practice is associated with a significant

First Author (Yr) [Country, Study design]	Aim	Methods	Participant demographics [Professional group]	How long out of practice? [Reasons for being out of practice]	Outcomes	Key findings
		prior to and after military deployment.		32% were deployed > 12 months [10]	Simulation Committee	decline in perceived comfort with both routine and acute paediatric care. Simulation-based training opportunities could be expanded to assist paediatricians in maintaining their clinical skills during deployment and refreshing them upon return The same refresher training used in the US Army for paediatricians returning from deployment could be used to assist civilian paediatricians in re-establishing clinical skills upon return to work after long breaks in practice
Cass 2012[37] [US, CS]	Describes two doctors experience of RTP program	10 step tailored programme with preceptorship. Based on advances in the field since they left practice.	Ob-gyn training; RTP took 3 months to complete using cases from most recent clinical rotation	6 years [2]	Monthly evaluation and clinical presentation plus exit interview	Need to enhance opportunities for external RTP candidates to have access to preceptors and their patients. Programs need flexibility to offer a tailored approach to meet candidates anticipated scope of practice. Report that they need to better screen candidates to identify those who are planning to return to active clinical practice.

First Author (Yr) [Country, Study design]	Aim	Methods	Participant demographics [Professional group]	How long out of practice? [Reasons for being out of practice]	Outcomes	Key findings
						No longer will accept a case log
Deering 2011[38] [US, S]	To determine the perceived changes in clinical skills in this deployed population.	Questionnaires were sent to 1,500 active duty US Army physicians of all specialties who had deployed Questionnaire regarded deployment experience of the queried physician, type of deployed unit and position, demographics of specialty and subspecialty training, board certification, years of experience, and perceived changes in clinical, surgical, and trauma skills. Perceived skill assessments, before and after deployment, were assessed using Likert-type scales ranging from 1 (worst) to 7 (best)	673 full responses (response rate of 45%). 135 responses (20%) from surgeons and 538 from Non-surgeons (80%). Physician responders represented a broad cross-section of deployable surgeons and physicians	Significant perceived degradation in both the surgical and clinical skills of those deploying for 6 months, and the degradation was correlated with the length of time deployed. [10]	impact on skills; percentage of clinical practice while deployed.	Surgeons and non-surgeons reported significant improvements in their trauma management skills after their deployments Most surgeon and non-surgeon respondents felt that it took approximately 6 months to regain clinical skills to their former baseline after returning from deployment and that the longest they could deploy without a significant loss of clinical skills was between 3 and 6 months
Grace 2010 [39] [US, CSS]	Describes the characteristics, participant performance, and	Structured educational process. Clinical skills assessment that	40% F Average age 53.7 yrs	Time out of practice averaged 8.1 years (97	Performance rating, completion of education program	Physicians who leave practice for a prolonged break are a heterogeneous group, the majority of whom demonstrate

First Author (Yr) [Country, Study design]	Aim	Methods	Participant demographics [Professional group]	How long out of practice? [Reasons for being out of practice]	Outcomes	Key findings
	licensure status of those physicians RTP.	included 23 90-minute interviews. Participants completed 2 (psychiatry) or 3* (all other specialties that involve patient contact) simulated patient encounters, a documentation exercise, cognitive function screen and, depending on the physician specialty, written testing. *3 interviews for physicians who had been out > 10 years	Eligible for this study if they left practice voluntarily, were under no state licensure board discipline or sanction, and were RTP in the same discipline as their previous practice. Variety of specialties: including primary care (internal medicine, family medicine, paediatrics, and general practice), surgery and surgical specialties, psychiatry, OB-gyn,	months), and ranged from 1.5 (17 months) years to 23 years (276 months) [2, 13, 14, 16, 19]		educational needs that warrant some structured education before RTP

First Author (Yr) [Country, Study design]	Aim	Methods	Participant demographics [Professional group]	How long out of practice? [Reasons for being out of practice]	Outcomes	Key findings
			anaesthesiology and others			
Holdcroft, 2013[40] [UK, DA]	To report on the subject of career breaks and contains research and advice to employers and doctors who undergo breaks in their career for a variety of reasons	Data and comments are analysed from Athena Survey of Science Engineering and Technology Questionnaire. Includes NHS and University employees, but may have only partially sampled the numbers of doctors taking a career break, because the purpose and employment models of, and what constituted a 'career break' were not specified.	NR	Varied (less than 3 months to > 15 years) Men had much shorter career breaks than women. [2]	Length of career break; what is most important in helping the transition back to work after career break; return to same employer or same level; most useful while on career break; type of contract.	General information on the transition back to work is variable. The NHS offers brief online advice to doctors of all grades on RTP, and the Medical Women's Federation website lists tips for career breaks and gives personal experiences. For men the most important part of transition back to work was keeping in touch while away from work, compared with women for whom the availability of childcare was most important. 'Keep in Touch' days that can be negotiated with employers during a career break offer an excellent opportunity to achieve a good transition back to work. Other factors identified included support at home and at work, employment availability, structured RTP through supervision/appraisal, a

First Author (Yr) [Country, Study design]	Aim	Methods	Participant demographics [Professional group]	How long out of practice? [Reasons for being out of practice]	Outcomes	Key findings
						salary that can support childcare costs and information on process. It was clear from respondents' replies that the return to work may follow different routes depending on the reason for the career break, such as through access to occupational health, further training, or simply supervision.
Jewett 2011[4] [US, CSS]	Surveyed inactive physicians younger than typical retirement age to determine their reasons for clinical inactivity and what barriers, real or perceived, there were to re-entry into the medical workforce	A questionnaire was developed using an iterative process with input from members of the AAP Re-entry Project Workforce Workgroup and others with expertise in physician workforce issues. Questions were based on those used in the AAMC Survey of Physicians Over 50, conducted in 2006. The questionnaire, with a post-paid return envelope, was mailed to a random sample of 4975 out of 14 113 inactive physicians	Mean Age: 54.9 Gender: F: 50.4 (114); M: 49.6 (112)	>=6 months Those who have re-entered active medicine reported a mean of 40.6 hours worked per week. Among these respondents, the average length of time they had been away from active medicine was 4.3 years (51.6 months) [1, 2, 4, 5, 6, 11, 13, 14, 17, 19]	Questionnaire included separate sets of questions for physicians not currently active in medicine and those currently active in medicine. The latter were asked about their experiences leaving and re-entering the workforce. Areas of inquiry included reasons for not being active in medicine, planning and experiences related to becoming active again, and several	Availability of part-time work and flexible scheduling have a strong influence on decisions to leave or renter clinical practice. Lack of retraining before re-entry raises questions about patient safety and the clinical competence of re-entered physicians.

First Author (Yr) [Country, Study design]	Aim	Methods	Participant demographics [Professional group]	How long out of practice? [Reasons for being out of practice]	Outcomes	Key findings
		under the age of 65 years drawn from the Physician Masterfile of the American Medical Association (AMA).			demographic questions	
Kenagy 2011[19,54] [US, S]	A better understanding is needed of how state boards currently address physician RTP. This paper addresses that need by presenting survey data on current physician RTP polices of state medical licensing boards	AMA annually publishes the State Medical Licensure Requirements and Statistics, which is based on a survey that includes questions on physician RTP policy. 59/64 medical boards (92%) responded to the survey. The findings represent a "snapshot" of specific physician RTP-related regulations and procedures	Most recent survey was sent to 64 State Boards of Allopathic and Osteopathic Medical Examiners in the U.S.; medical boards in U.S. territories were excluded.	30 medical boards with a physician RTP policy were asked "What is the length of time out of practice after which your board requires re-entering physicians to complete a re-entry program?" 25 medical boards that responded to the question, the average length of time was 2.8 years, and ranged from 1 to 10 years. The modal (most common) response was 2 years.	Length of time out of practice; patient care requirements for relicensure; data collection on re-entry; presence of physician re-entry policy	51% of the responding medical boards agreed that they have a policy on physician RTP Of the 29 medical boards without a physician re-entry policy, 16 (55 percent) are either currently developing or planning to develop a policy. This is an indication of the growing importance of physician re-entry within medicine and the recognition by boards of medicine of the need to address the issue. Medical boards were asked "Does your board require a physician to engage in a certain amount of patient care for relicensure?" The vast majority of medical boards (92 percent) do not. Medical boards were asked "Are you keeping records on the number of physicians the board considered for re-entry?" Most

First Author (Yr) [Country, Study design]	Aim	Methods	Participant demographics [Professional group]	How long out of practice? [Reasons for being out of practice]	Outcomes	Key findings
				[1, 2, 7, 13, 14]		(90 percent) medical boards are not collecting this information. Boards of medicine seem to be developing physician re-entry policies and processes independent of one another; the scope and direction of these policies remain unclear consequently a lack of consistency among state medical licensing boards may be increased difficulty for physicians to renter clinical practice
Manriquez 2012 [41] [US, D]	Describes the process of how we developed our RTP program, challenges encountered, and solutions used to overcome these challenges.	Formal instruction, evaluation, and documentation of competency are presented. Process improvement has been based on feedback and evaluation from the RTP fellows and from staff and residents.	6/9 RTP candidates accepted. Age range: between 52- 61 years	3- 11 years [NR]	Variety of tools incl. specific evaluation - the procedure logger -as a competency measurement tool, which is accessed through the New Innovations medical education management system. Using this tool, the fellow identifies a supervisor	RTP fellow often provides additional assistance with rounding and "scut" work required on each service. There has been a perceived reduction in surgical exposure by the residents even though the program has been careful to comply with ACGME requirements of not reducing experience. Assigning more formal responsibilities to the fellow may help delineate his or her role

First Author (Yr) [Country, Study design]	Aim	Methods	Participant demographics [Professional group]	How long out of practice? [Reasons for being out of practice]	Outcomes	Key findings
					who has directly observed RTP fellow perform a particular procedure desired for fellowship completion. The tool gives dropdown choices on a scale of 0–4 (0 being poorly or never to 4 being always or excellently) to rate the fellow's independent knowledge of or ability to execute steps of this procedure. `Objective structured clinical examination or standardized patient evaluation tools have not been incorporated yet.	within the team and to reassure the residents that the evaluation of components, rather than the majority, of the surgeries is acceptable for the RTP fellow. Blurred lines of distinction between in-training and RTP stages may cause awkwardness and confusion as to the specific roles of each team member and thus make fitting into the team difficult. Suggest a refresher course on history and physical examinations and progress note writing, as many RTP fellows have been out of practice and are used to writing attending level notes that are brief but often incomplete. Highlight the "10 guiding principles are given for a physician RTP program system. These principles note that the program should be accessible, collaborative, comprehensive, ethical,

First Author (Yr) [Country, Study design]	Aim	Methods	Participant demographics [Professional group]	How long out of practice? [Reasons for being out of practice]	Outcomes	Key findings
						flexible, individualized by taking into account experience and plans for future practice, innovative by incorporating simulation and electronic evaluation tools, accountable, stable, and responsive"
Morison 2012 [42] [UK, QS]	• To examine the value and acceptance of the I&R scheme amongst GP returners. • To assess the impact of the I&R scheme on GP training practices and trainers. • To 'triangulate' GP trainers' and GP returners' views on the GP returners' scheme in terms of host practice experiences (e.g. workload, supervision, trainer's report and assessment techniques).	Explored issues around such placements and involved in-depth telephone interviews. Participants were encouraged to share their perceptions of the I&R scheme. Most interviews lasted between 25 and 30 minutes.	Opportunistic sample of 14 GP returners and five trainers on their experiences of the GP returner scheme within Severn Deanery. This represented 70% of the total sample of GP returners – responses from both returners and trainers were triangulated to enhance validity.	The current national 'Induction and Refreshment' (I&R) scheme runs for six months and is available for those with more than two years away from clinical general practice [NR]	Interview schedule: 1 Reasons for applying for the scheme: 2 Experience of application process: 3 Suitability and appropriateness of placement 4 Perceived value of the scheme: 5 Current activities: 6 Experience of host practice	Unequivocal and universal support from both returners and trainers for the value of the scheme. Issues around the 'two-year rule' and funding arrangements whilst RTP may need to be re-addressed. Returners reported significant improvements in their clinical skills and knowledge, understanding of changing NHS policy/protocols and enhanced perceived self-confidence

First Author (Yr) [Country, Study design]	Aim	Methods	Participant demographics [Professional group]	How long out of practice? [Reasons for being out of practice]	Outcomes	Key findings
Mulvey 2010 [43] [US, CSS]	The American Academy of Pediatrics (AAP), in conjunction with the Association of American Medical Colleges and eight medical associations, conducted a cross-sectional survey examining physician re-entry in 2006	Questionnaires were mailed to 1,600 paediatricians aged 50yrs+	Respondent population is older (mean age = 68) than the AAP over-50 population (mean age = 60). The respondents are also more likely to be male (73%) than the target population	6 months to 13 years with an average duration of 22 months and a median duration of 12 months. [2]	Questionnaire regarding work status, work history, education, and demographic information. Those who reported having taken a leave of absence were asked how long it lasted and the reasons for taking a leave. They were also asked whether the leave was to care for children or other family members and whether they received any retraining prior to RTP	Extended leaves of absence are not tied to generalist or specialist practice, career satisfaction, or desire for a part-time practice arrangement. Women were more likely than men to take extended leaves of absence from clinical medicine, and these leaves were longer than those for men. Additionally, very few re-entering paediatricians had any retraining before returning to practice. In the future, policymakers, educators, state medical and osteopathic boards and others will need to collaborate to design a re-entry system that addresses physician readiness to return to the workforce — as well as patient safety issues — and to tailor education to the needs and focus of individuals re-entering physician's practice.
Rayburn 2016[44] [US, E]	To describe how these two institutions worked closely in facilitating physician relicensure and	Board assesses all physicians wishing to RTP determine their background and needs,	Majority were 48 to 63 years old, similar in gender. Most	2 - 13 years [NR]	Course completion	Physicians considering relicensure and RTP face many challenges: acceptable health, licensing and credentialing requirements, competence in knowledge and

First Author (Yr) [Country, Study design]	Aim	Methods	Participant demographics [Professional group]	How long out of practice? [Reasons for being out of practice]	Outcomes	Key findings
	RTP. Lessons gained from this 10-year relationship and the evolution of an innovative mini-sabbatical program is also reported	and the medical school's continuing medical education then evaluates candidates for their retraining goals, coursework, and faculty involvement. Progress is measured weekly, at course completion, and three months thereafter. Each mini-sabbatical course was designed to last 3 to 8 weeks (in most cases, four weeks) since this period was deemed by the Board and medical school to be reasonable for assessing progress.	that completed the coursework were general internists or family physicians, except for one psychiatrist and one paediatrician.			clinical skills, and cost and geographic barriers of retraining programs. Step-wise effort encouraged a dialogue between both institutions to advise a physician more realistically about relicensure requirements and retraining options. When learning needs were tailored to qualifying candidates, the program was successful in returning those physicians to active practice in our state.
Varjavand 2012 [45] [US, E]	To describe the Drexel Medicine Physician Re-entry/Refresher course and present our findings on participant demographics, performance, and goal attainment following course completion	Daily formative assessment and feedback, 360 evaluation of professionalism, and assessments of Web-based exercises, standardised patient examinations with faculty observation and	Median age of the participating physicians was 55 years (range, 38–66 years. Most physicians (72%) chose the internal	Mean: 10 years but range from 0-20 years. [2, 3, 13, 14, 16]	National Board of Medical Examiners (NBME) Comprehensive Clinical Medicine Self-Assessment (CCMSA) (NBME CCMSA) examination	Developing a standard yet individualized program to meet the unique needs of each returning physician is complex, and the road to RTP is filled with numerous obstacles for the inactive physician. 36 physicians completed the course and 31 achieved their

First Author (Yr) [Country, Study design]	Aim	Methods	Participant demographics [Professional group]	How long out of practice? [Reasons for being out of practice]	Outcomes	Key findings
		feedback and the NBME CCMSA examination on completion of the preceptorship. During the structured preceptorship, physicians build a portfolio of accomplishments, documenting knowledge acquired, skills learned, and assessments received. At the end of the course, physicians receive a certificate that documents their accomplishments, assessments, and faculty feedback	medicine preceptorship. All physicians who left clinical practice for family obligations were women			stated goals. Both residents and teaching faculty reported that they, too, learned from the experiences of these physicians. Our course could be a model for returning physicians to clinical practice.
Varjavand 2015 [46] [US, CE]	Describe the refresher / TRP program and the lessons learned in our efforts to facilitate OB-gyn clinical re-entry	Structured, tailored 6-week blocks for 6 or 12 weeks, depending on goals and recommendations.	9 OB-gyn who successfully completed the course between November 2006 and November 2012.	Average: 5 years (range .5–12 years). [4, 9, 13, 15]	Accomplished main goal	More than half (n = 6, 67%) stated they achieved their main goal; (34%) did not. Of the re-entering physicians, 71% (5 of 7) said they achieved their goal within 1 month of course completion. Returning physicians bring their unique backgrounds, skills and knowledge, future career needs, reasons for leaving medicine, and

First Author (Yr) [Country, Study design]	Aim	Methods	Participant demographics [Professional group]	How long out of practice? [Reasons for being out of practice]	Outcomes	Key findings
						reasons for returning. Refresher programs must provide flexible re-education for these varying needs. We believe that to ensure quality, re-education is best rendered by clinician-educators—faculty who are not only up to date clinically but are also at the forefront of education
NURSING						
Amin 2010 [UK, D] [3]	Outlines an RTP health visiting scheme. The scheme aimed to encourage and provide a route for HV whose NMC registration had lapsed back into the profession.	Describe how the cohort went through the course; students were evaluated in their reflective accounts; mentors experiences reported. 12 week course; 75 hours practice 75 hours theory	4 participants recruited to the scheme [HV]	Three had been out of practice for between five and 10 years, and one for over 10 years. [2]	Mentors and students' opinions	Offering students financial and placement support within the organisation was used to attract RTP students. A one-year preceptorship programme has been set up for these staff to be supported further as they develop their skills and knowledge while as a proficient health visitor Scheme provided an inexpensive and rapid way to recruit already trained health visitors back into practice within the organisation
HEE 2014 [52] [UK, MM]	Review to identify current nursing RTP landscape; to identify what works well and the	Literature review, stakeholder interviews, 'WeNurses' chat,	30 stakeholder interviews with return to practice	"variation in the number of years RTP students	Varied. Barriers and facilitators focussed on current RTP courses	"Significant variation in the delivery of RTP across the country and variation in the engagement of all stakeholders in RTP.

First Author (Yr) [Country, Study design]	Aim	Methods	Participant demographics [Professional group]	How long out of practice? [Reasons for being out of practice]	Outcomes	Key findings
	challenges; Scoping what the opportunities are for the future	stakeholder forum and focus groups	nurses, education providers, NHS trusts and national stakeholders. 65 stakeholders attended focus groups	have been out of practice and also variation in the experience of undertaking a level 5 or 6 HEI course. However, most participants of RTP courses are women around 40-50 years with dependents and who go on to part-time employment until retirement after regaining their licence." [1, 2]	supplemented by series of case studies.	Challenges identified included variations in: • Accessing RTP information • identifying local RTP contact • Lack of clinical placements including who is responsible for identifying / organising placements • Capacity and quality of sign-off mentors • Support available for returnees • Funding issues • Gap in RTP options in the community
Hobbs 2011[47] [US, QS]	Describes the experiences of inactive registered nurses in their journey returning to nursing practice and the perceived and unexpected barriers and	17 face-to-face interviews modelled using Maxwell qualitative research design.	Purposive sample was of inactive registered nurses who had been inactive for at least five years and had completed	Each participant had been inactive for at least 5 years. Nursing review and update course: a continuing	Guided interview with prompts (e.g. how they made decision to RTP, ease of finding out what they needed to do to RTP, description of the RTP journey, barriers and	Seven categories for nurses RTP were revealed: the reasons to return, factors that inhibit returning, barriers of a refresher course, rewards of completing a refresher course, roadblocks of employment, rewards of returning to practice, and advice for all registered nurses

First Author (Yr) [Country, Study design]	Aim	Methods	Participant demographics [Professional group]	How long out of practice? [Reasons for being out of practice]	Outcomes	Key findings
	successes they met and overcame on their way to RTP.		a refresher course between 2007 and 2008 at either a community college or university [Nurses]	education course 8 weeks to 1 year in length, offered to licensed inactive RNs for the purpose of reviewing basic medical-surgical theory and updating clinical skills. Some of these courses require 64 to 160 clinical hours. [1, 2]	facilitators about RTP) (Appendix 1)	
Kenward 2017[48] [UK, MM]	Service evaluation was conducted to investigate issues related to clinical contact time (CCT) and to return to practice (RTP) for military nurse	Modified Delphi approach was adopted for the initial consultation. A literature review identified themes related to CCT, including time required in practice, skill depreciation, returning to practice, leadership, and confidence in practice.	NR [Nurses]	When asked what period of absence would trigger a formal RTP programme, the panellists showed strong support for a range of options between 12 months and three years (Table 3). NMC revalidation	NR	Maintaining clinical skills, and the challenges of returning to practice, require careful consideration in a mobile workforce with wide-ranging commitments. Prescribing CCT (Clinical Contact Time) , ensuring assignment orders specify CCT and the introduction of job plans should help military nurses maintain their core and specialist nursing skills, guide commanders and reinforce the culture

First Author (Yr) [Country, Study design]	Aim	Methods	Participant demographics [Professional group]	How long out of practice? [Reasons for being out of practice]	Outcomes	Key findings
				guidance (NMC 2016) provides a template for registrants to demonstrate their ability to practise safely and effectively, it does not prescribe an RTP timeframe. Results were therefore put before the MJP, which agreed that a period of between two and three years' absence from practice should trigger a formal RTP programme. (p.23) [10]		of 'hands-on nursing' as a valid use of time
McMurtie 2014[49] [Australia, CSS]	To provide an understanding of how non-practising nurses and midwives may be	Used an anonymous participant survey to collect data from nurses and midwives who had	Majority of respondents with aged 51 years+;	60 months < 5years [2, 8, 14]	Questionnaire aimed at capturing applicant's satisfaction with	Responses indicated that clinical supervision and contract learning should be central to an RTP programme.

First Author (Yr) [Country, Study design]	Aim	Methods	Participant demographics [Professional group]	How long out of practice? [Reasons for being out of practice]	Outcomes	Key findings
	supported back into the workforce.	applied to participate in the Queensland Health Refresher Program.	94 % F, Registered nurses were the largest group of respondents (74.6%). Midwives (14.3%) [Nurses and Midwives]		theoretical content, placement experience and employment outcomes	Majority of RTP respondents were approaching retirement age in 10-15 years.
PHARMACISTS						
Phipps 2010[51] [UK, MM]	To advise the pharmacy regulator on the assessment and management of risk in pharmacy practice to underpin the development of revalidation standards and processes.	Literature review. A retrospective record review of the RPSGB's disciplinary records was conducted, comparing characteristics of pharmacists who had been referred to the Disciplinary Committee were compared with the characteristics of those who had not been referred. Interviews was carried out with pharmacy staff, managers and service users in order to understand how they	Majority were male based in England working in the community [Pharmacists]	Overlap with 2013 study suggests $\geq$ 2 years [NR]	Do demographic factors predict a pharmacist being referred to the Disciplinary Committee? What are the other characteristics of disciplinary referrals?	Study has examined the use of risk assessment in pharmacist revalidation, and in doing so has offered a definition of risk, a set of criteria for assessing risk and a model for risk-based revalidation. It is recommended that these are used as the basis of a revalidation process. Several potential risk indicators were identified using both previous studies of healthcare regulation and empirical data collected as part of the current study

First Author (Yr) [Country, Study design]	Aim	Methods	Participant demographics [Professional group]	How long out of practice? [Reasons for being out of practice]	Outcomes	Key findings
		distinguish between "high-risk" and "low-risk" practitioners. Finally, focus groups were conducted with subject matter experts in pharmacy risk management in order to obtain feedback on a revalidation model and risk assessment criteria proposed by the researchers.				
Phipps 2013 [50] [UK, QS]	To explore: (i) the experiences of pharmacists who either return to practice following a career break or move from one sector of practice to another; and (ii) the experiences of those who support or observe pharmacists undergoing one of these changes	Telephone-based interview	18 registered pharmacists in Northern Ireland, all of whom had either undergone a change in practice themselves or had supported another pharmacist through a change in practice	≥ 2 years [12, 13, 15, 16, 18]	NR	A revalidation scheme for pharmacists should make provision for registrants who have taken a career break or changed sector. Registrants would benefit from resources to support them through the change in practice; these resources could come from peers, employers, or the regulator

First Author (Yr) [Country, Study design]	Aim	Methods	Participant demographics [Professional group]	How long out of practice? [Reasons for being out of practice]	Outcomes	Key findings
			[Pharmacists]			
MIXED PROFESSIONAL GROUPS						
Crichton-Jones 2018 [8] [UK, MM]	Strategy document which describes actions to: • Grow capacity and capability • Build on NHS global reputation • Meet future service requirements	Draft workforce document building on HEE 2014 [52] document but expanded to include wider range of workforce professional groups	RTP identified as a key area to meet future workforce demands	Cites NMC requirements [1, 2]	NR	Growing the NHS AHP workforce is further supported by the expansion of a HEE pilot extending RTP initiatives to AHPs and healthcare scientists. "To date more than 4,200 have commenced the practice programme and over 2,400 have completed and entered NHS employment. This programme is being expanded with a target of 1,000 each year. This is seen as a blueprint for other professions with a new pilot scheme started to bring 300 AHPs back into the NHS before 2019. A GP return to practice scheme is covered in the primary care section of this document"
GMC 2014 [5] [Mixed: EU, NZ, UK, US / LR]	An exploratory study looking at skills fade in the health sector, particularly in doctors. It does not seek to make policy	A systematic review of the medical literature has been undertaken using online databases.	NR but evidence was sought for medical profession, other regulated	> 3 months [2]	Impact of time out on work-related skills and competence; review of requirements for return to the	Found limited and mixed evidence about how skills decline over a fixed period of time Time out may be accompanied by voluntary removal from the

First Author (Yr) [Country, Study design]	Aim	Methods	Participant demographics [Professional group]	How long out of practice? [Reasons for being out of practice]	Outcomes	Key findings
	recommendations, rather to survey the evidence on the topic. The scope of this review is to identify what evidence exists to say when and how time out of practice impacts on skills, competence and performance. The review has sought evidence on: the impact of time and length of break from practice - how this impact differs by type of practice - mitigating factors for any diminution or loss of skills		health professionals and other relevant professions		respective professional registers	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. 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 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. 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

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						years out of practice should signify a need for reassessment and retraining prior to a full return. Limited evidence to determine exactly how time out of the profession affects doctors and other health professionals' skills.

Appendix Table 2. SUMMARY TABLES OF AHP and SOCIAL WORK (red and amber literature) tables

1. Author (year of publication) 2. Author type 3. Country 4. Comprehensive judgement 5. Type of literature 6. Profession	Aim	Key findings (quote)	Useful resources?
1. DOH Australia (2015) [56] 2. Government 3. Australia 4. AMBER 5. Guidance (RTP - guidance) 6. AHPs	Recommendations regarding best practice for supporting allied health professionals and technicians who wish to return to practice after a period of absence. This Guideline provides information for all allied health employees, clinical supervisors, managers, contractors and consultants within Hospital and Health Services (HHSs). A diverse group of professions comprise the allied health workforce within Queensland Health. These include nationally registered, self-regulated and unregulated allied health professionals and assistants. This guideline has been developed to guide and help develop consistent governance processes regarding return to practice for professionals and technicians outlined in Table 1. Registered professions	<u>Eligibility:</u> Re-entrants are eligible to request participation in a return to practice program through Queensland Health, regardless of whether they have previously held a position of any nature within the organisation. <u>Determining skill set and best placement:</u> When an allied health professional or technician approaches an HHS with a desire to re-enter the workforce after a period of absence or to change their area of clinical practice, the Questions for Potential Re-Entrants (Appendix B) may be of use to establish previous experience, recency of practice and any other needs of the re- entrant. The responses to these questions should be assessed by a manager from the same allied health profession as the re-entrant. <u>Duration of return to practice program:</u> Some of the re-entry guidelines and programs that have been developed for specific allied health professions by their registration boards or professional associations have policies on recency of practice and/or previous experience. They specify the number of hours of supervised clinical practice required for re-entry, based on recency of practice and experience. Due to the range and diversity of allied health professionals and technicians that make up the Queensland Health allied health workforce, this guideline does not outline specific requirements. Rather, it advocates for the development of an individualised learning plan for each allied health re-entrant, based on their current knowledge and skills, and also based on what will be required of them in their new working environment. The learning plan should, however, be developed with deference to any existing specifications from registration boards and professional associations.	Yes – see Learning plan template (appendix a p 15) Questions for potential AHP re-entrant (appendix b p 17)

1. Author (year of publication) 2. Author type 3. Country 4. Comprehensive judgement 5. Type of literature 6. Profession	Aim	Key findings (quote)	Useful resources?
	• Nuclear medicine technologist • Occupational therapists • Pharmacists and technicians • Physiotherapists • Podiatrists • Psychologists including clinical and neuropsychologists • Radiation therapists • Radiographers/medical imaging technologists Self-regulated professions: • Audiologists • Dietitians/nutritionists • Exercise Physiologists • Leisure therapists • Music therapists • Orthoptists • Orthotists, prosthetists and technicians • Physicists, including radiation oncology, nuclear medical and radiology medical	<u>Classification:</u> It is expected that allied health professional re-entrants be classified at HP3 as a minimum level, because they are degree qualified, regardless of their registration or accreditation status. Technicians are expected to re-enter at HP2 as a minimum level. Classification level (including increment levels) for re-entrants may be awarded at the discretion of the operational manager in consultation with the profession-specific manager, taking into account previous relevant experience and time away from clinical practice. Experience may include administrative duties within the health sector, overseas clinical experience or other experience that is deemed relevant. <u>Probation:</u> a six month probation period applies to permanent health practitioner, professional and technical stream employees. For employees undergoing the return to practice program, the probation process could be linked with the return to practice supervised clinical practice process. The results of reassessment against profession specific standards should be well-documented by clinical supervisors and profession-specific managers, in order for the results to be used as the basis for any probationary issues. <u>Insurance:</u> Re-entrants who are functioning in a permanent, temporary or volunteer capacity by Queensland Health are indemnified under Queensland Health's Professional Indemnity insurance policy. HHSs may require re-entrants to register as volunteers with the organisation in order to access professional indemnity insurance. It is at the discretion of the individual re-entrant as to whether they organise additional personal professional indemnity. If they wish to do so, re-entrants should contact their union or professional association to find out how to organise this.	

1. Author (year of publication) 2. Author type 3. Country 4. Comprehensive judgement 5. Type of literature 6. Profession	Aim	Key findings (quote)	Useful resources?
	physicists, and health physicists • Social workers • Sonographers (including echo-sonographers) • Speech pathologists Unregulated professions: • Anaesthetic technicians • Clinical measurement scientists and technicians • Rehabilitation engineers and technicians • Welfare officers	<u>Guide to implementation of a RTP programme</u>: Health practitioners or technicians returning to the workforce or changing their area of clinical practice should be supported by a structured Return to Practice program, that involves appointment of a supervisor, formalisation of a supervision agreement, observational and discussion supervision sessions, and assessment of progress and competence. The steps involved in conducting a Return to Practice program for allied health re-entrants are outlined in Figure 2 (figure 2 flowchart: different stages from appointing a clinical supervisor to assessing against discipline specific standards to developing supervision agreement, re-assessing competence, re-entrant applies for removal of conditional registration and accreditation from professional today as required. <u>Other types of support for re-entrants</u> • *Membership of the relevant professional association* Re-entrants from all professions (registered and unregistered professions) should be encouraged to join their professional association. Membership is desirable in order to access continuing professional development activities, be aware of professional and accreditation standards and access the association's learning resources. • *Mentorship* Support from a mentor before, during and after return to clinical practice can be useful for general guidance, support and to help identify learning needs. Having a mentor is not compulsory. The mentor does not need to be from Queensland Health or from the same profession, as long as they are able to offer support and guidance. The re-entrant may seek out their own mentor, or they may require assistance from Queensland Health to find an appropriate individual to fill this role. A mentor does not replace the need for a designated clinical supervisor from the same profession. • *Peer support* Support from a range of sources, including peers, has been identified as being a crucial	

1. Author (year of publication) 2. Author type 3. Country 4. Comprehensive judgement 5. Type of literature 6. Profession	Aim	Key findings (quote)	Useful resources?
		component to the success of a return to practice process. Peer support relies on the experiences and skills of others to provide support to their colleagues, to help reduce stress, anxiety and help build confidence. Peers also provide an additional source of clinical practice expertise. Information provided for supporting supervisors of re-entrants including face to face training, written supervision resource, supervision competencies	
1. New South Wales Allied Health Reconnect (2007) [57] 2. Government 3. Australia 4. AMBER 5. Review 6. AHPs	Synopsis of the findings of recent literature on topics related to re-entry of out of practice professionals into the workforce.	<u>Triggers for re-entry program development</u>: • Re-entry programs may be useful to address workforce shortage, and the predicted decrease in workforce supply over the coming decades. • Studies indicate there is interest from out of practice professionals in re-entry programs. • Refresher programs could be considered not just for out of practice individuals, but also for individuals currently working, to ensure a minimum level of skills and knowledge. • Re-entry programs may also be useful to assist individuals currently in the workforce to change speciality, increase their confidence, refresh their knowledge or "re-energise" in their job. • Re-entry programs may assist individuals to find employment after a significant period out of the workforce. • Re-entry programs should consider delivery options to cater for individuals who would find a 'campus based' program difficult to access. <u>Re-entry programs in New South Wales:</u> In NSW, there are currently four allied health professions that require registration. These are pharmacy, physiotherapy, podiatry and psychology. At present, there are no formal re-entry programs in operation for these professions. It is at the discretion of each registration board to determine on a case-by-case basis whether an individual requires additional qualifications or training to become registered. However, some other allied health professions do currently have re-entry programs available	No

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		to individuals wishing to return to practice in NSW. Most programs are offered by the professional associations and may be recommended to ensure eligibility for practising membership of the association. Re-entry programs exist in nuclear medicine, radiation therapy, radiography and speech pathology, and are described below. Speech Pathology: To be eligible for practising membership of the professional association, Speech Pathology Australia, individuals must undertake a re-entry program if they have practiced for less than 1000 hours over the previous five years. The purpose of the re-entry program is to update an applicant's knowledge base, re- establish professional networks and act as a mechanism of support to the applicant when returning to the profession. <u>Re-entry participant profile:</u> The literature profiles individuals most likely to participate in re-entry programs in the health professions. Nursing and allied health literature in Australia and the United States report that between 90% and 94% of re-entry program participants are female, with the average age of a participant being in their early forties (Andre & Hall, 1999, Rader & Clendenin, 1991). The mean length of time since practicing varied from between 7.7 years (Andre & Hall, 1999) and 12.7 years (Baker & Copp, 1993). The importance of considering family friendly work practices is highlighted by Andre and Hall (1999) who found that the majority of students in their nursing re-entry course in Australia had previously left the profession to attend to families, and 83% were continuing to care for children at the time they applied for the course. <u>Structure of re-entry models</u> *Format:* • Various formats for teaching knowledge and skills can all be effective. • Flexibility is the key factor; Program structure must be flexible and staff involved in teaching the program must be adaptable. • A supervised clinical component is required.	

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		• Private study can be a useful component for highly specialised professions. • Individualisation of the program for each participant is required. • A mentor and/or individualised support should be available to each participant. *Content:* • Certain core knowledge and skill areas should be included in a re-entry program. • Participants' learning styles must be considered when preparing and presenting content. • Flexibility with the content covered is required, considering individual need. • New information taught should be related to previously learned information. • Comprehension of mathematical concepts and computer use may present difficulties for some participants. • Course content should be based on entry-level professional competencies wherever possible. <u>Length of re-entry program:</u> • Allied health re-entry programs discussed in the literature are shorter in length than those discussed in nursing literature. In some programs, the length was not considered adequate to teach a sufficient amount of content. However length of programs did not influence program outcomes. • Nursing literature suggested programs that contain both theoretical and clinical components, and are at least 144 hours in length, should be effective in re- entering nurses to the workforce. • Nursing literature suggests that effective re-entry programs contain a clinical component that is of equal or greater length than the theoretical component. • Any proposed length of time for a re-entry program should be considered a minimum, as some individuals may require greater theoretical or practical experience to become comfortable to return to their profession.	

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		• Due to the variations in experience, knowledge and skills between individuals who are preparing to re-enter their profession, level of competency should be used to determine readiness for return to work, and not the length of the course. • Options for individuals who do not suit an intensive, institution based re-entry program should be available. <u>Suggested audience:</u> • Allied health professional groups have suggested an individual needs to take part in a re-entry program if they have not practised in their profession for a specific amount of time. The times stipulated range from between 2 and 5 years. • Some professional groups indicated additional requirements above a re-entry program e.g. completing university units, may be needed if an individual has been out of the workforce for longer than 15 years. <u>Re-entry classes</u>: • Class formats are effective if class size is restricted to 15. • Alternatives, such as an online course or correspondence course are required in rural or geographically isolated areas, as long as opportunities for peer and educator support exist. <u>Critical success factors for re-entry models</u> • Participants require support from the point they enquire about the re-entry program up until program completion. • Support could be provided by the re-entry program coordinator, instructors, preceptors, peers or the professional association. • Preceptors also require support. Support could be provided by running a mentoring workshop, or supplying preceptors with a mentoring package before the program commences. • Recommended that preceptors should have at least two years post graduate experience	

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		before supporting re-entry program participants through clinical placements. • Assessment of participants' knowledge and skills should be a core component of a re-entry program, but should remain sensitive to the anxiety participants may feel towards testing. • Assessment should be based on entry-level competencies of a profession, if available. • Assessment should occur for didactic, laboratory and clinical components of a re- entry program. • Developing a portfolio of professional development experiences could be considered as part of the assessment process. <u>Barriers to workforce re-entry</u> In a survey of nurses who had undertaken a re-entry program in Australia, Andre & Hall (1999) reported the following difficulties experienced by course participants when they tried to secure employment: • Employers perceived re-entrants to have a lack of recent experience in acute care, most often citing 2 months experience in the last 2 years to be the minimum requirement for employment; • Some employers were concerned about employing older nurses; • Availability of child care, particularly if nurses were expected to work on an on-call roster system; and • Fewer employment opportunities being available near the end of the financial year. Baker & Copp (1993) also reported that some inactive radiologic technologists who had attempted to re-enter the workforce had experienced difficulty because employers were concerned about the length of time the individual had been out of practice. In grey literature, OT Australia Victoria (2004) discussed a number of challenges to individuals returning to the workforce. These included: • A lack of flexibility in workplaces e.g. limited opportunity for flexible working hours, part time employment and availability of job share;	

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		• Availability of child care facilities when individuals returned to work; and • Financial disincentives, after considering childcare fees, tax and travel costs.	
1. Health careers website [58] 2. Health education 3. UK 4. RED 5. RTP guidance 6. AHPs	Return to practice for allied health professionals (AHPs) is a programme for AHPs who have left their profession to re-enter and gain their registration with the Health and Care Professions Council (HCPC). .	<u>Register your interest</u> The first step on your RTP journey is to let HEE know that you are thinking of returning to practice. They can then keep you up to date with any new courses, funding and support that is available to you. Follow this link on the HEE website to register your interest. RTP requirements for your profession: • Your professional body will be able to let you know the specific RTP requirements and courses available for your profession. • Find the web page for your profession from the list below and use the contact details provided in the Further information section to contact your professional body. <u>Supporting your study</u> A number of local universities and NHS trusts are encouraging returnees to work with them to gain the relevant skills and knowledge to meet the re-registration requirements for the HCPC. HEE can provide funding for out-of-pocket expenses and any relevant RTP course or appropriate postgraduate study delivered by English universities running pre-registration programmes for allied health professionals.	No
1. HEE website [13] 2. Health education 3. UK – England 4. RED 5. RTP programme 6. AHPs	If you trained as an allied health professional (AHP) or a healthcare scientist (HCS), but have since left the profession, we run a programme that can provide help and information if you want to	<u>Am I eligible?</u> The programme is open to and supports: • All AHPs or healthcare scientists who live and plan to work in England, once returned to the Health and Care Professions Council (HCPC) register. • AHPs or healthcare scientists who have previously registered with the HCPC or qualified in the UK but have not registered in the last five years.	No

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	return to practice. Currently HEE AHP/HCS RTP programme is unable to support Social Workers to return to the HCPC register.	• Registrants who remained on the HCPC register for more than two years but have not practiced. <u>Currently the programme is not open to:</u> • Overseas AHPs or HCSs that qualified abroad and have never been registered with the HCPC. • Returnees looking to work outside England when they have returned to the register. • Returnees that have any fitness to practice issues cited against them by the HCPC.	
1. Scottish Executive Health Department Website 2006-2007 [59] 2. Government and NHS 3. UK – Scotland 4. RED 5. RTP information 6. AHPs	Guidance on RTP for AHPs 2006-2007. Funding support is now available to NHS Boards supporting individuals returning to practice in one of the nine allied health professions within NHSScotland *who have been out of practice for a period of 2 years or more.*	• Funding for each individual returning to practice is linked to an offer of employment within NHSScotland, either in a permanent post or on a temporary contract of at least 6 months duration. • Funding will be made to the service supporting the returner and will be not be made available directly to the individual. Funding will only be available to NHS organisations that have an existing vacancy that they are able to fill • Funding for returners to practice will be made available to employers only on the understanding that the returner will take up a contract of employment once their period of supervised practice and registration is completed. • All returners are expected to participate in an interview process and establish an agreed return programme based on Health Professions Council guidance and individual development needs prior to an offer of supported return to practice being made. • A supportive clinical learning environment must be provided during the period of supervised practice to ensure that the appropriate experience is gained.	Yes: Managers information pack Returners information pack.
1. British Association for Music Therapy (BAMT) [60] 2. Professional body 3. UK 4. AMBER	BAMT aims to promote the highest standards of professional music therapy practice. This page gives information on the standards governing practicing music therapists in the UK, including	Registered music therapists *must meet the HPCs Standards of Conduct, Performance and Ethics* and the Standards of Proficiency- Arts Therapists. The HPC will investigate complaints against registered music therapists and can impose sanctions if a registrant is found to have failed to meet their standards. <u>The Role of BAMT</u>	No

1. Author (year of publication) 2. Author type 3. Country 4. Comprehensive judgement 5. Type of literature 6. Profession	Aim	Key findings (quote)	Useful resources?
5. Professional practice guide 6. Art therapists	professional members of BAMT. It also gives information about guidance on different aspects of music therapy practice in the UK.	Professional members of BAMT are encouraged to use BAMT's Guide to Professional Practice. BAMT also provides guidance on aspects of music therapy practice. This guidance aims to help practitioners, employers and members of the public understand what constitutes 'good practice' in music therapy. Following the Guide and this guidance should help ensure that practitioners more than meet minimum standards of practice. Currently BAMT has the following guidance documents available: • Guide to Professional Practice (previously the APMT Code of Ethics) • Guidelines for Freelance Music Therapy work- Revised Sept 2012 • Supervision/Consultation Register Guidelines • Guidance on CPD • Guidance on Health and Safety • Guidance on Returning to Practice • Guidance on Personal Fitness, Health and Hearing (in preparation) • Guidance on Clinical Supervision • Guidance on Professional Titles - Draft (2 Apr 2013)	
1. Institute of Biomedical Science IBMS (2015) [61] 2. Professional body 3. UK 4. RED 5. Professional practice guide 6. Biomedical Scientists	Good professional practice is a professional best standards policy document produced by the IBMS. This document has been developed to help those who work in biomedical science to reassure their employers, professional colleagues, service users and the wider general public that any decisions made will be well-informed.	<u>Professional competence section: Section 2.4 RTP</u> • Biomedical science professionals RTP have a responsibility to undertake a period of re-familiarisation and, if necessary, retraining. Those responsible for the supervision or retraining of staff have a responsibility to ensure an appropriate period of re-familiarisation and training is undertake and competence assessed prior to full resumption of duties. • the *HCPC has published a guidance* document. • The IBMS makes the **additional recommendations**: o Individuals wishing to RTP in a clinical laboratory should use the institute portfolios as a framework for updating their knowledge and skills, for example, the Specialist Portfolio in discipline specific areas. o A self-assessment of knowledge and skills achieved prior to a break in practice should be conducted against the portfolio to identify training needs (gap analysis)	No

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		○ Training should be carried out in an institute approved training laboratory and in accordance with these IBMS Good professional practice guidelines ○ The period of updating should be signed off by a registered biomedical scientist as a record of areas of the specialist portfolio completed and whether competence to practice was achieved.	
1. Alliance of Private Sector Chiropody and Podiatry Practitioners [62] 2. Professional body 3. UK 4. RED 5. RTP course 6. Chiropodists and Podiatrists	Works on behalf of its members to promote and develop the occupation, represent members in national negotiations, and obtain recognition for private sector practitioners.	Alliance insurance covers members for up to £6m, and its rolling programme creates CPD opportunities, disseminates information and provides a spectrum of educational events. In addition, the Alliance provides practitioner support, business advice, fellowship and social interaction. The Journal, Annual Conventions, and more are all accessed by membership. A *register is maintained for Foot Health Practitioners which meets the standards imposed by the Professional Standards Authority for Health and Social Care*. The Alliance supports and enhances practice by providing: • CPD network • Promotion of skill development • Translation of skills into practice • Setting standards of education • Recognition of advanced courses, masterclasses, study groups, mentoring, practice guidance • Remote triage • Return to work and refreshment training • Fellowship awards for completion of advanced studies	No
1. Association of Clinical Scientists (ACS)[63] 2. Professional body 3. UK 4. RED 5. Guidelines for application	The prime role of the ACS is to assess trainees as a preliminary to registration as a Clinical Scientist with the HCPC and to liaise with relevant professional bodies to set standards for training and training	RTP advice: "Applicants who have been away from work for some period e.g. on maternity leave or on an extended gap period immediately prior to interview, have been noted as having difficulties at ACS interview and are advised to consider delaying" p10 submission *until they have returned to work and are up to speed again.*	No

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6. Clinical Scientists	centres to include availability of appropriate resources, regular assessment, pastoral care and mechanisms for addressing students training issues.		
1. British Dietetic Association (2017) [64] 2. Professional body 3. UK 4. RED 5. RTP guidance 6. Dietitians	Dietitians, for various reasons, often take breaks in their careers and there are some, having graduated, that do not take employment in their profession. This page will provide you with information if you are thinking about returning to the dietetics profession.	• Dietitians, for various reasons, often take breaks in their careers and there are some, having graduated, that do not take employment in their profession. This page will provide you with information if you are thinking about returning to the dietetics profession. Follow the HCPC RTP guidelines ("If you have been out of practice for more than two years and you were previously registered as a dietitian in the UK or have undertaken your dietetic qualification in the UK you are required by HCPC to undertake a period of updating your skills and knowledge before you can become re-registered with the HCPC") <u>Advice for returners</u>: 1. Join the BDA: We would strongly recommend that you join the BDA if you are planning to return to practice. We have a vast number of resources available to members that will help you for your period of updating. These include Continuing Professional Development tools and resources, opportunities to network with practising dietitians through Specialist Groups and Branches, professional and education advice from the experts in the BDA office, practice and professional guidance documents, information on key policies affecting dietitians, copies and on-line access to Dietetics Today and the Journal of Human Nutrition and Dietetics, Trade Union cover and professional indemnity insurance. It also provides access to the Practice-Based Evidence in Nutrition (PEN)database. *For those returners living/working in England:* • Health Education England (HEE) have rolled out a scheme across England to support AHPs to return to the HCPC register and back into practice. Dietitians have already returned and you can too.	

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		• It is recognised that those that have left the register have a wealth of skills and experience that they can bring back to practice. For example, on average a returner has 9 years clinical experience and has worked to band 6 level. The scheme provides not just support to the returner but also to managers and departments to encourage them to welcome returners and provide placements and CPD opportunities. The HEE scheme provides financial support to both the returner and departments offering a placement. • It is our understanding that the scheme is open until sometime in 2019. We encourage all those returning to practice to register interest on the HEE website and complete the form. 2. Supervised Practice • We advise all returners to gain some supervised practice before they return to practice, alongside some formal and private study. Firstly, contact your local dietetic department and speak to the dietetic manager to make a request. Or alternatively get in touch with any of your ex-employers that are local to you. You may need to contact a number of departments as some may not be able to take you on due to other demands. • If you are working in a department, even unpaid, whilst updating your skills and knowledge prior to getting back on the HCPC register, we suggest that you might ask to have an 'honorary contract', which would make your position as a supernumerary member of staff clear. • An honorary contract, or a letter to you from the supervisor/manager, should make your situation clear and define what you can and cannot do. There are procedures to be followed that protect you, the hospital and, most importantly, the patient. Most health organisations should have an honorary contract and may also require you to prove your identity and have a recent CRB check. 3. Funding In Scotland and Northern Ireland there is currently no specific funding available for returners to update their skills and knowledge. The BDA do not provide funding for members returning to practice. If you are a resident in Wales you may apply for funding through the National	

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		Leadership and Innovation Agency for Healthcare (NLIAH). Please note funding available in England via Health Education England can be used for BDA CED courses.	
1. British Dietetic Association (2017) [64,65] 2. Professional body 3. UK 4. RED 5. Commentary / news 6. Dietitians	Government announcement	• The British Dietetic Association (BDA) has today welcomed the announcement by government of £5 million of funding to support AHPs and other specialist professions to return to work after career breaks. The Department for Health will work with Health Education England to run a returner programme for 300 AHP returners across England, including dietitians. This will include education, re-training and tailored support with the aim of having returners ready to practice within six to 12 months. • Rosanna Hudson, BDA Policy Officer (Education), said; "This is really positive news, and a valuable way of ensuring the skills and experience of dietitians who choose to take time away from work are not lost to the profession permanently. We hope this will complement the support the BDA already offers, including our professional development toolkit, shadowing and placement materials and of course direct advice and support over the phone."	
1. College of Dietitians Ontario reg policies (2017) [66] 2. Regulator 3. Canada 4. RED 5. Registration policies 6. Dietitians	The College of Dietitians of Ontario is responsible to develop, establish and maintain the standards of qualifications for persons to be issued certificates of registration. The College considers that ensuring the currency of an applicant's dietetic knowledge, skills and judgment is in the public interest.	The requirements for ensuring the currency of an applicant's knowledge, skills and judgment are set out in Section 6.(2) of Ontario Regulation 72/12: 2) If the applicant has not completed either of the requirements set out in paragraph 1 or 2 of subsection (1) *within the three years immediately before the date that the applicant submitted his or her application*, the applicant must: • have successfully completed a refresher or upgrading program approved by the Registration Committee; • hold a certificate of registration in another class with the College; or • satisfy the Registration Committee that he or she has been registered as a dietitian in another jurisdiction and has practiced safely as a dietitian in that other jurisdiction within the three years immediately before the date of the application. Applications will be assessed on an individual basis, considering the following principles:	Flow chart p27 useful breakdown of the different upgrading required depending on whether 3-10 years out of practice or >10 years.

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		• Current demonstration of knowledge skills and judgment as defined in the national competency standards (the Integrated Competencies for Dietetic Education and Practice, or ICDEP), • The Canadian Dietetic Registration Examination (CDRE) is a non-exemptible requirement. An applicant must successfully complete the CDRE once. • Length of time since last practice, • Quality and quantity of efforts to maintain currency while not practice, • Applicants plants for RTP Further details are given (see flow chart p27) for anyone RTP > 3 years.	
1. Dietetics board NZ dietetics board site [67] 2. Regulator 3. New Zealand 4. RED 5. RTP guidance 6. Dietitians	Recertification (Return to Practice) requirements aim to protect the quality and value of the Boards Registration policy, according to the HPCA Act, thereby protecting the health and safety of members of the public, by making sure that dietitians possess the current knowledge and skills required to practise competently and safely.	<u>Returning within two years of practising dietetics in NZ (holding an APC)</u>: • Registered Dietitians will be required to fill in an Application for an APC on the current form for these purposes. At the time of applying the applicant must have met any continuing competence requirements including successful completion of the annual prescriber update, if applicable. Failure to complete the current prescriber update will mean that the prescribing endorsement will be removed until such time as the requirement has been successfully fulfilled. <u>NZ dietitians returning from practising dietetics overseas</u>: • Registered Dietitians who have practised dietetics overseas and who wish to return to work in New Zealand within 2 years of last APC (NZ) should follow the steps outlined above. <u>More than 2 years since last APC (NZ), then applicants will need to provide</u>: • Return to Practice application form and payment • Cover letter • Summary of work experience – CV • Proof of dietetic competency and practice, e.g. two recent Performance Appraisals • Two references • Information about continuing competence programmes in which they have participated, and	No

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		• Certificate of Good Standing and/or proof of Registration with Health Professions Council/credentialing agency/regulatory authority. All assessments will be made on a case by case basis, taking into account time spent overseas and career pathway followed overseas. In some cases, the Board may apply a period of supervision or require a candidate to pass the Board examination before an APC is issued. <u>Returning after an absence of more than two years but less than five years</u> : Registered Dietitians who have not held an APC/worked as a dietitian for more than 2 years, but less than 5 years and who wish to return to dietetic work, must provide: • Return to Practice Application form and payment • Cover letter • CV • Identify a mentor • Develop and submit a professional development learning plan focused on transition back to practise which must be signed by the mentor. • Criminal check is required if you have lived overseas • Any Dietitian who wishes to prescribe must sit and pass the Prescriber Training Course which is offered annually by the Board before their APC can be endorsed. • You may be required to sit and pass the Boards Oral Registration Examination. All assessments will be made on a case-by-case basis but Registered Dietitians who have not worked as a dietitian for more than 2 years, but less than 5 years may be required to undertake up to 15 months supervision, fortnightly for the first three months and then on a monthly basis. <u>Returning after an absence of five years or more:</u> Registered Dietitians who have not held an APC/worked as a dietitian for 5 years or more, and who wish to be assessed as eligible to return to dietetic work must provide: • Return to Practice Application form and payment	

1. Author (year of publication) 2. Author type 3. Country 4. Comprehensive judgement 5. Type of literature 6. Profession	Aim	Key findings (quote)	Useful resources?
		• Cover letter • CV • Identify a mentor • Develop and submit a professional development learning plan focused on transition back to practise which must be signed by the mentor. • Criminal check is required if you have lived overseas All assessments will be made on a case-by-case basis but Registered Dietitians who have not worked as a dietitian for 5 years or more may be required to sit and pass the Board's Oral and Written Examinations before being permitted to practise dietetics. Following that they *should also expect to be required to undertake 15 months supervision fortnightly for the first three months and then on a monthly basis and will be called for audit after one year*.	
1. Bradley et al., (2017) presentation [68] 2. Returner and mentor 3. UK- England 4. AMBER 5. Case study presentation 6. Occupational Therapy	To evaluate the effectiveness of using a preceptorship in supporting return-to-practice occupational therapists. To explore how the Kawa Model can be used to identify barriers to a successful placement; and how to overcome them.	<u>Differences Between Return-to-Practice and Student Clinical Placements</u> RTP: identify own placement(s); limited support network; RTP process may have to fit around other work/personal commitments; financial commitment; learning is guided by the individual. OT student: placements Identified via universities and in accordance with the student's learning needs; supported by university and peers; submersed in learning and education; access to student grants; clear development goals set out by the university. <u>Benefits and barriers to using preceptorship model:</u> <u>Benefits:</u> opportunity to set learning development goals; provides an opportunity for reflection and reflexivity; develops confidence; encourages communication; enhances clinical reasoning & problem solving. <u>Barriers</u>: perceived as a tool for newly qualified staff; requires engagement from both parties; time. <u>Challenges arising from placement</u>: • Resistance to undertaking the preceptorship process and working towards Knowledge and Skills Framework (KSF) (DH 2004). • Poor engagement in reflective practice. • Different opinions of goals of the placement.	Preceptorship references

1. Author (year of publication) 2. Author type 3. Country 4. Comprehensive judgement 5. Type of literature 6. Profession	Aim	Key findings (quote)	Useful resources?
		• Lack of support for the learner and mentor from professional bodies • Disclosure of a self-diagnosed disability. • Difference of learning styles. <u>Reflections on the RTP process:</u> • The role of the mentor. • Should clinical placement be a stronger element to the return-to-practice process. • Skills fade quicker than we realise. (GMC 2014) • Return to practise is not just about updating clinical skills, but also about preparing for a return to work. • Using a preceptorship framework provides a structured approach to guide learning. • There needs to be clear competencies such as the KSF to work towards. <u>Top tips for RTP OTs:</u> • Organise things from the beginning. • Be clear on the process. • You must be motivated to undertake this. Is this what you really want? • Consider the costs of undertaking this process and how long it will take you. • Take opportunities to learn new skills. • Be honest and communicate. • Link in with different resources and networks. • Update your IT skills. • Embrace change. • Engage in reflective practise from the beginning. <u>Top tips for RTP mentors:</u> • Consider the impact that the placement will have on your service and other members of staff. Be sure that you can commit to the process. • Have several meetings prior to committing to the placement. • Be clear of what is expected of one another.	

1. Author (year of publication) 2. Author type 3. Country 4. Comprehensive judgement 5. Type of literature 6. Profession	Aim	Key findings (quote)	Useful resources?
		• Consider what skills you have to be a mentor and what additional training or support you may need. • Set time frames and be clear of the plan before you start. • Use a preceptorship framework. • Be flexible on your approach. Goals can change. • Use professional bodies for guidance and support. • Have the confidence to address challenges and barriers. • Reflect on the process. <u>Summary:</u> • Duty to support return-to-work practitioners to retain the occupational therapy national workforce. • It will become more challenging in the current climate for return to practice occupational therapists to find placements. • Better networking and support needs to be available across the UK to support mentors / return-to-practice occupational therapists. • Preceptorship model provides structure to support transition. • Using an holistic model such as the Kawa enables us to evaluate the barriers to a successful clinical placement and can be applied to student placements as well.	
1. AHPRA website - Occupational Therapy Board of Australia[69] 2. Regulator 3. Australia 4. RED 5. Fact sheet 6. Occupational therapy	This fact sheet provides supplementary information about how to meet the Occupational Therapy Board of Australia's (the Board's) Registration standard: Recency of practice. This fact sheet also provides information for people who hold, or have previously held, registration as an occupational	<u>Never registered/not currently registered then need to submit</u>: • supervision agreement • supervised practice plan [must be submitted prior to practice or within first two weeks of practice • recency of practice - supplementary information for current CV • application for general registration If you <u>have returned to practice after an absence of five or more years you will be required to complete a minimum of 30 hours continuing professional development</u> as set out in the Registration standard: Continuing professional development (CPD). • This must be completed in the 12-month period prior to applying for registration.	Recency of practice supplementary information form; Pathways diagram for re-entry to practice

1. Author (year of publication) 2. Author type 3. Country 4. Comprehensive judgement 5. Type of literature 6. Profession	Aim	Key findings (quote)	Useful resources?
	therapist in Australia, who are seeking general registration but do not meet the recency of practice registration standard, including those who: • have had a lapse in practice of five years or more • have held non-practising registration for five or more years, or • are no longer on the Register of practitioners.	• If you have not completed the required CPD before applying to re-enter, the Board reserves the discretion to impose a condition on your registration requiring you to complete CPD in addition to the required 30 hours for General registrants). • The Board will determine the *level of supervision required on a case-by-case basis*. Supervision requirements will be tailored to the purpose of the supervision, the practitioner's circumstances, practice setting, experience and learning needs. The commencement level of supervision will usually be set out as a condition of your registration that has been imposed by the Board. • Supervision is likely to encompass a *minimum of 360 hours, or three (3) months full-time equivalent of supervised practice to be completed at different supervision levels* as determined by the Board. • Typically, you will be required to progress through each of the following levels of supervision: o Level 1 direct supervision: your supervisor must be physically present at the workplace and be providing direct supervision when you are providing occupational therapy services o Level 2 indirect supervision: your supervisor must be physically present at the workplace for the majority of the time when you are providing occupational therapy services. When the supervisor is not physically present they must always be accessible by phone or other means of communication. o Level 3 remote supervision: you are permitted to work independently provided your supervisor is readily contactable by phone or other means of telecommunication. In most cases, supervision is likely to commence at a higher level of supervision (Level 1) and progress to a lower level of supervision (Level 3) following the submission of an acceptable supervisor report.	
1. AHPRA website - Occupational Therapy Board of Australia [69]	This standard applies to all persons applying for initial registration or renewal of registration.	Board's assessment of applications and renewals that do not meet the recency of practice requirement will consider the following: • The practitioner's registration and practice history	No

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2. Regulator 3. Australia 4. RED 5. Recency of practice 6. Occupational therapy		• The period of absence from the profession • Activities related to the practice of occupational therapy undertaken in the previous five years • History of CPD completed • Any additional study undertaken, or qualifications obtained during the period of absence from practice	
1. RCOT website [70] 2. Professional body 3. UK 4. RED 5. Return to practice information 6. Occupational therapy	Welcome to the Royal College's resource for occupational therapists who want to return to professional practice. The resources in this section are designed to equip and enable you to return to the workforce with confidence after a career break and help you meet the requirements of the Health and Care Professions Council (HCPC) to return to their register. In addition, they contain advice on finding a job, how the Royal College of Occupational Therapists (RCOT) and other resources can support your return and on-going practice, plus how to use the HCPC updating process to underpin your Continuing Professional	• By law, you have to be registered with the Health and Care Professions Council (HCPC) in order to use the title and be employed as an occupational therapist. • The HCPC requires you to have adequate skills and knowledge to practice safely and effectively. In order to return to the HCPC register, they require you to carry out a period of updating your skills and knowledge. The length of this period will depend on how long you have been out of practice. 0-2 years - no requirement 2-5 years - 30 days of updating 5 years and over - 60 days of updating • This period of updating is a MINIMUM REQUIREMENT. You may need longer if you feel, or you are advised, that you cannot yet practise safely and effectively in a certain area or role. The updating period has to be completed within the twelve months prior to your application to return to the HCPC Register. • Your period of updating needs to be a combination of: o Private study o Formal study o Supervised practice You can choose how you split your time. The only specification that the HCPC makes is that private study cannot make up more than half of your total time. <u>RTP-identifying your learning needs:</u>	Skills and knowledge audit [in AHPRA and other resources doc in grey lit search]

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	Development (CPD), maintain registration and develop your career.	In order to register with the Health and Care Professions Council (HCPC) and to get back into practice you will need: • awareness of current developments in health and social care • knowledge of the expectations of the Health and Care Professions Council and the Royal College of Occupational Therapists • enough skills and knowledge in your chosen field of practice to be a safe and effective practitioner Practical steps to help identify your needs • Have a look at these very simple capabilities audit tool [copy saved to AHPRA and other resources folder] as a starting point. • The College's Learning and development standards for pre-registration education may be useful to identify the profile of a graduate level entrant to the profession. • The preceptorship framework which provides a structured way to support new graduates can also be a means of looking at your own key skills. • Looking at job descriptions in areas of practice might highlight topics for which you would like to know more. • List the topics and areas that you think you need to update or develop. • Consider how you can best meet these learning needs. • Would it be through private study, formal learning or whilst on supervised placement? • Begin to plan your learning.	
1. AHPRA website - Optometry Board of Australia [69] 2. Regulator 3. Australia 4. RED 5. Recency of practice standard	This registration standard sets out the Optometry Board of Australia's minimum requirements for recency of practice for optometrists. This registration standard applies to all registered optometrists except those with student or non-practising registration.	• While there is not yet research that shows how much recent practice a health practitioner needs to maintain their skills and knowledge, National Boards have drawn on the research that is available as well as their regulatory experience to set requirements for recent practice. National Boards consider that 450 hours of practice over three years provides an appropriate balance between ensuring that practitioners have undertaken sufficient recent practice to maintain the knowledge and skills to safely practise the profession; and providing reasonable flexibility for situations such as part-time work, study leave and parenting leave.	Preceptorship references

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6. Optometry		• If you don't meet this standard, you will need to provide information to help the Board decide if you are able to continue or return to practice. If you do not meet the standard the Board may allow you to return to practice following successful completion of one or a combination of the following: a. a competency assessment approved by the Board b. a period of supervised practice approved by the Board, or c. a program of study approved by the Board.	
1. AHPRA website - Optometry Board of Australia [69] 2. Regulator 3. Australia 4. RED 5. FAQs 6. Optometry	FAQs on recency of practice standard	National Boards consider that 450 hours of practice over three years provides an appropriate balance	Supervised practice plan - plan for professional development Supervision guidelines Supervised practice agreement template Supervised practice report template FAQ recency of practice
1. Toronto Paramedic RTP course [71] 2. Education 3. Canada	Four documents provided: 1. The 2018 RTP program guide is our in house program manual that is a resource to assist the	In the province of Ontario paramedics are certified to preform controlled medical acts by working under the medical license of a physician who works with a regulating authority known as a Base Hospital Program. The physician is known as the Base Hospital Medical Director. After being initially certified by the Base Hospital Program a paramedic must maintain their	Toronto Paramedic RTP ACP and PDP skills

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4. RED 5. Personal communication 6. Paramedics	supervisor in setting up and administrating an RTP. I have redacted the pages that are purely administrative. In the references section, include are policies that are set up by our governing bodies: Sunnybrook Base Hospital and the Ontario Ministry of Health Advanced Live Support (ALS) standards. [data extracted from this document] 2. The RTP ACP and PCP skills sheets are examples of the in-house training that occurs to help prepare the paramedic for the Base hospital skills review.[added to AHPRA and other resources folder] 3. The RTP requirement letter is a form letter that is used to set the RTP process up for the returning paramedic and will give you an idea of the requirements..[added to AHPRA and other resources folder] 4. The TPS standard Operation is the section of the Toronto Paramedic Services' standard operating procedure related to the accommodation of an employee in	certification by providing patient care to at least one patient every 90 days with a minimum of ten patients per year as well as continuing medical education (CME) requirements. If a paramedic does not maintain the minimum requirement for any reason such as: long term injury; illness; leave of absence; maternity / paternity leave; administrative assignment etc. the paramedic is administratively deactivated by the base hospital and they require to complete an RTP prior to re-activation. A paramedic must be fully fit for duty with no restrictions prior to the commencement of the RTP process. After administrative deactivation, once a paramedic is fully fit for duty as declared by their health practitioner or upon the completion of their leave (if the leave was for non-medical / psychological reasons) the paramedic will return to work performing modified duties until the completion of an RTP. The RTP requirement for the Base Hospital consists of a skills review session with a Base Hospital educator as well as completion of any missed Base Hospital CME requirements. To ensure successful completion of the Base Hospital requirements the Toronto Paramedic Services (TPS) schedules several pre-requisite RTP components as preparation material and as a knowledge refresher. These components include: 1. A Driver training day consisting of an in class didactic component and a practical component (driving the service vehicle at our skid pad), 2. Online course material (consisting of: ECG review; policy changes; a MSD prevention video; online version of missed service based CMEs; reference material and knowledge review assessment). 3. In class knowledge and practical skills review day with a TPS field training officer (FTO).	sheet [in AHPRA and other resources folder] Toronto Paramedic RTP letter [in AHPRA and other resources folder]

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	regards to appropriate modified work while they are injured or ill.[this is a RTW issue not RTP therefore not extracted]	As you can see, these RTP components are geared to returning healthy paramedic to practice. Document 1 (RTP program guide): Program outline The Return to Work (RTW) Program coordinates delivery of education to facilitate a Paramedic's Return to Practice following and absence from practice > 90 days. This includes skills review, missed CME content and refresher driver education. The goal is to return to the Paramedic to Practice quickly, in a safe and efficient manner, typically with training commencing within 2 weeks of the paramedic's full fit status, and notification from the service district. Program requirements may include: • practical scenario/skills review session/s with a TPS FTO • online didactic material through the TEMS Education Portal • online didactic material as assigned by the Base Hospital on the paramedicportalontario.ca site • driver education session/s • a Base Hospital skills review session led by a Base Hospital educator that includes outstanding CMEs • a Sunnybrook Centre for Prehospital Medicine MD interview for ACP paramedics. The content of individual programs is based on the length of time the paramedic has been absent from practice, and content the paramedic has not completed during their absence from practice through Continuing Medical Education. RTW communication should include dates of RTW requirements, location of each training session, hours of each day, and expectations for the Paramedic. (e.g. Full uniform, etc.) If components of the RTW require scheduling changes, these should be noted to ensure these	

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		are communicated with the Paramedic. 2.3.1 Driver Training Programs for Modified Duties and Return to Work Where an employee has been absent from practice from his normal position for a period of > 90 days, Driver Training for a Modified assignment where use of a division vehicle is required, or for Return to Practice will be completed as follows: 1. Employee has been on modified duties, and is utilizing a divisional vehicle that they would normally utilize in the course of their normal position, no driver training will be required, provided that there is no break > 90 days from operation of such vehicle 2. If the employee returns from a leave, to modified duties, and this leave was > 90 days, the employee will complete a driver training session before operating divisional vehicles. 3. If the employee returns from a leave, directly into Return to Practice, and such leave was > 90 days, the employee will complete a driver training session as a component of their Return to Work sessions. Sunnybrook RTP policy (included in document 1): Policy statement: this policy applies to all paramedics, who RTP after an absence from clinical practice at their current certification and require recertification as per the ALS standards upon the request of the service. Sunnybrooke responsibilities: - arrange a mutually satisfactory time date and location within one week form receipt of written request from service to c omplete the RTP process. - provides the service and paramedic with the outline of the process that will be following including terminal objectives - provides all mannequins simulators and other testing materials as required - ensures that the equipment review documentation is complete prior to sunnybrook session - provides the service and paramedic with the written outcome of the process within 3 days	

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		RTP according to duration of time away from practice: 90 days <6 months no missed CME (?clinical medical education?) 90 days <6 months missed CME >6 months and <36 months missed CMEs >36 months If the paramedic is unsuccessful a re-evaluation may be scheduled within 7 days of initial certification attempt. If unsuccessful at 2nd recertification attempt a remediation plan will be developed after consultation with sunnybrook.	
1. Physiotherapy Regulators in Canada (2014) framework [72] 2. Regulator 3. Canada 4. AMBER 5. Framework document 6. Physiotherapy	This Framework and its principles serve as a guide for all entry-to-practice supervisory relationships for all physiotherapy regulatory Colleges in Canada. The Supervisory relationships apply primarily to first-time physiotherapists, either Canadian- or internationally- trained. The scope of this framework is limited to the supervision of physiotherapists on temporary licenses and does not include best practices for mentorship. Background:	The Framework is based on the following core principles: • Evidence based: This Framework has been informed by best practices for supervision identified through review of relevant literature, an environmental scan including review of practice in other professions, as well as expert key-informant opinion; • Flexibility: The Framework recognizes the need for a flexible approach within a "gold standard" that considers the variations in regulatory contexts across the country, as well as the different experiences and needs of the individuals being supervised. As such the guidelines outlined in this framework should be considered as recommended best practice rather than regulatory requirements; • Accountability: Both the supervisor and the supervisee are responsible for safe accountable practice and public safety during the period of supervised practice; • Equity: The expected level of competency at the point of full registration is the same for all applicants; • Fairness: All registrants involved in entry to practice supervision situations will be treated fairly;	No

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	A literature review commissioned by The Canadian Alliance of Physiotherapy Regulators' (The Alliance) Registrars' Committee identified a number of specific needs/issues associated with each of three target groups that are candidates for supervised practice. 1) For new graduates, the transition from training to practice can lead to feelings of stress, insecurity and potential safety issues. This period also involves a number of important stages necessary for the development of the professional; 2) Internationally educated health professionals (IEHPs), entering the workforce also experience challenges including: language/communication and differences in practices (e.g., technology, autonomy, accountability and scope) that can affect professional relationships and potentially patient safety; and 3) Re-entry candidates have special issues/needs when they return to	• Public Protection: Protection of the public is paramount during the period of supervised practice; • Responsibility: Individual regulatory authorities are responsible for regulating the practice of physiotherapy in their respective jurisdictions. <u>Target Groups:</u> The three target groups for entry to practice supervision are: New graduates of Canadian Universities: Should be eligible for a period of entry to practice supervision after passing the written component of the Physiotherapy Competency Examination (PCE) and prior to passing the clinical component. Internationally educated physiotherapists seeking licensure in Canada: Should be eligible for a period of supervised practice after passing the written component of the PCE and prior to passing the clinical component. Re-entry candidates: Should be evaluated on a case-by-case basis and the requirements for re- entry should be identified based on the individual's experience and needs. Requirements may involve a period of supervised practice, completion of the PCE, individual (self-directed) study, and coursework. <u>Responsibilities of the Supervisee:</u> • The supervisee may be in either a part-time or full-time position. The supervisee is accountable for his/her actions and should have the same requirements for liability insurance as a full registrant. The supervisee is also responsible for notifying the regulatory authority of changes in supervision. <u>Evaluation/Monitoring</u>: *Evaluation Requirements*: The supervisor must evaluate the supervisee within the first 30 days of the period of supervised practice to determine an appropriate level of supervision.	

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	work that include feelings of anxiety and low self- esteem, as well as a desire for flexible programs. In terms of best practices in entry level supervision, programs involving role models and mentors can play an important role in facilitating entry or re-entry to practice and a shift towards more structured transition programs for new graduates and internationally educated health professionals was noted. Consistency through an evidence-informed framework is needed to help each group succeed in professional practice.	Regulatory authorities and supervisors should consider arrangements for ongoing monitoring and a progress report given to the supervisee during longer periods of supervision so that the level of supervision can be adjusted accordingly. A final evaluation should be completed at the end of the period of supervision and sent to the regulatory authority. *Evaluation Tool:* Whenever possible, an evaluation tool that has been determined to be valid and reliable for measuring entry level competence of physiotherapists should be utilized to evaluate supervisees in entry to practice supervision situations (e.g., Clinical Performance Instrument – CPI or equivalent). *Monitoring of Supervisee Evaluations by Regulatory Authority:* The regulatory authority is responsible for monitoring the evaluations of supervisees that have been identified as having performance issues during the supervised practice or failure(s) on the examination. When possible, the regulatory authority should consider conducting random reviews of the final evaluations.	
1. AHPRA website - Physiotherapy recency of practice [69] 2. Regulator 3. Australia 4. RED 5. Guidelines 6. Physiotherapy	These guidelines supplement the requirements set out in the Board's Recency of practice registration standard. They explain the importance of maintaining recency of practice and how you may return to practice after a break.	You are required to submit a plan for re-entry to practice for the Board's approval. This is regardless of whether you currently hold registration. If you are not registered, a re-entry to practice plan must accompany an application for registration. Appendix A provides information on the requirements for a plan for re-entry to physiotherapy practice after a break of three years or more. The plan for re-entry to practice will be different for each applicant. It should be tailored to your particular circumstances and your individual learning needs. It is therefore not appropriate for the Board to issue a standard re-entry plan with set tasks or supervision levels. Supervision - The majority of applicants seeking registration to return to practice after a break of three years or more, or who are applying for renewal but don't meet the recency of practice	Plan for re-entry to practice after a break of 3 years or more (Recency of practice guidelines p.4) Recency of practice guidelines

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		requirements, are required to be supervised for a period of time. <u>All applicants must submit:</u> • an application for general registration, including a curriculum vitae in the AHPRA format which details any gaps in your practice history since you obtained your qualification a completed Appendix A from this document: • a re-entry to practice plan which details your previous field of practice, recent CPD you have done and propose to undertake and details of the proposed area of practice and a description of your past experience and its relevance to the proposed role; and completed requirements contained in the Supervision guidelines for physiotherapy, which include: a position description, contact details and signed supervision agreements and a supervised practice plan.	Supervision guidelines Supervision agreement Supervision practice plan Supervision report template FAQ recency of practice Fact sheet RTP Fact sheet for plan for development and RTP Overseas trained applicants registration information
1. Irish Physiotherapy Registration Board site [73] 2. Regulator 3. Ireland 4. RED 5. Bye-law 6. Physiotherapy	The Physiotherapists Registration Board, in exercise of the powers conferred on it by section 31 of the Health and Social Care Professionals Act 2005 (as amended), with the approval of the Health and Social Care	4. (1) An applicant who has not practised the profession for any period of between 2 and 5 years must complete a period of updating which must consist of not less than 210 contact hours. (2) An applicant who has not practised the profession for any period greater than 5 years must complete a period of updating which must consist of not less than 420 contact hours.	No

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	Professionals Council, hereby makes the following bye-law: 1. (1) This bye-law may be cited as the Physiotherapists Registration Board Return to Practice Bye-Law 2016. (2) This bye-law comes into operation on 30 September 2016.	(3) An applicant must have completed his or her period of updating within the two year period prior to the date of submission of his or her application, unless the Board permits otherwise. (4) The period of updating shall consist of contact hours spent by the applicant engaging in supervised practice, formal study and private study and the period of updating shall meet the following minimum requirements: (a) At least 50% of the period shall consist of supervised practice; and (b) At least 15% of the period shall consist of formal study; and (c) No more than 35% of the period shall consist of private study. 6. (1) For the purposes of the period of updating, formal study shall, subject to paragraph 8, consist of the applicant undertaking and participating in educational courses, training or programmes of education and/or training (including structured educational courses or training delivered electronically and/or through distance learning) relevant to the practice of the profession. (2) Formal study may include group learning whether undertaken by means of a lecture, workshop, seminar, tutorial, video-conferenced lecture or tutorial or in such other manner as may be acceptable to the Board from time to time. 7. (1) For the purposes of the period of updating, private study may, subject to paragraph 8, consist of the applicant engaging in one or more of the following: (a) reading professional journals or publications relevant to his or her area of practice;	

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		(b) engaging in research relevant to the profession generally and/or his or her area of practice; (c) engaging in online study or e-learning consisting of education and/or training that is generated, communicated, processed, sent, received, recorded, stored and/or displayed by electronic means or in electronic form including that provided through the internet or other computer network connections, sound and/or visual formats provided through an electronic file, and/or provided through digital or other electronic means; (d) publishing written materials in relation to the profession and/or his or her area of practice; and (e) such other activities as may be acceptable to the Board from time to time.	
1. Physiotherapy Board of NZ RTP programme review[74] 2. Regulator 3. New Zealand 4. RED 5. Recency of practice information 6. Physiotherapy	Website detailing information about RTP	RECENCY OF PRACTICE CRITERIA (for overseas applicants) To meet the Board's recency of practice criteria, you must be able to answer 'Yes' to at least one of the questions below. Did you graduate from your primary physiotherapy qualification within the three years prior to the date of application for registration? Have you worked as a practising physiotherapist, whether full-time or part-time, for any period of time during the three years immediately prior to the date of application for registration? Are you able to provide evidence of successful completion of a formal course of university level physiotherapy study undertaken during the three years immediately prior to submitting your application for registration? This physiotherapy course of study is in addition to your primary physiotherapy qualification and must include clinical practice experience, i.e. a	PDP, CV and reflective practice template (https://www.physioboard.org.nz/application-to-return-to-practice)

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		Graduate Diploma, a Postgraduate Diploma or a Masters with a clinical component. the RTP information is the registration process: reflective practice statement, CV, PDP, CPD logbook <u>Physiotherapy Practice Thresholds:</u> The Physiotherapy Practice Thresholds, which were launched by the Physiotherapy Board of Australia and the Physiotherapy Board in May 2015, set out the entry-level requirements for initial and continuing registration as a physiotherapist in both Australia and New Zealand. This document should also be used for an applicant who has not practised the profession for three or more years immediately prior to their APC application (i.e. a return to practice applicant) to identify specific strengths and limitations to guide their professional development plan.	
1. AHPRA website - Podiatry Board [69] 2. Regulator 3. Australia 4. RED 5. Recency of practice standard 6. Podiatry	The Board's Recency of practice registration standard sets out the minimum hours that you must practise in your scope of practice to maintain your competence to practise safely. It also sets out what you must do if you change your scope of practice or wish to return to practice. These guidelines have been developed to support the registration standard and to help you understand its requirements. They also provide guidance on: · the information you are required	If you have not met the Board's Recency of practice registration standard, the Board will consider a number of factors when deciding whether or not to grant your application for registration or renewal of registration, including the following: • your registration and practice history, including when and where you last practised as a podiatrist or podiatric surgeon • the length of time since you last practised • your level of prior practice experience in your scope of practice • activities you have done related to the practice of podiatry or podiatric surgery during the period since you last practised, including any continuing professional development, education, or professional contact • additional relevant qualifications obtained since you last practised • your intended scope of practice, and • the level of risk associated with your practise.	Plan for professional development and re-entry to practice - template

1. Author (year of publication) 2. Author type 3. Country 4. Comprehensive judgement 5. Type of literature 6. Profession	Aim	Key findings (quote)	Useful resources?
	to submit with your application form if you don't meet the registration standard, and · planning and preparing for a return to practice.	If you are currently registered in any category other than 'non-practising', you need to: • explain why you have not met the Recency of practice registration standard • provide evidence of the CPD you have completed in the previous 12 months • provide evidence of any other specific education you have completed in the previous three years, and • provide any other relevant information to demonstrate your competence to practise the profession safely. If you have non-practising registration, or you are not currently registered and you wish to return to practice, you need to: • provide evidence of the CPD you have completed in the previous 12 months • if it has been more than three years since you last practised, provide a plan for professional development and re-entry to practice for the Board to consider and approve • provide evidence of any other specific education you have completed in the previous three years, and • provide any other relevant information to demonstrate your competence to practise podiatry or podiatric surgery safely. A plan for professional development and for re-entry to practice should: • nominate a proposed supervisor • define the terms of an agreement between you and the proposed supervisor • state your previous scope of practice and your intended scope of practice • identify any gaps in your knowledge and skills	

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		• identify any training or education requirements that will be done to meet your learning requirements • articulate goals, expected outcomes and clear timeframes to achieve your goals • propose the level of supervision, mentoring or peer review that may be required for a safe return to practice • describe the orientation process that you will undertake at the proposed employer's workplace • allocate time for regular formal feedback or performance reviews by the proposed supervisor, with this feedback or review recorded and signed by you and the supervisor • provide the anticipated completion date for the re-entry to practice plan, and • articulate the measures that will be put in place if the stated goals are not achieved in the stated timeframes.	
1. AHPRA website - Podiatry Board [69] 2. Regulator 3. Australia 4. RED 5. Guidelines (recency of practice) 6. Podiatry	This registration standard sets out the Podiatry Board of Australia's (the Board) minimum requirements for recency of practice for podiatrists and podiatric surgeons. This registration standard applies if you are: • currently registered or applying for registration as a podiatrist or podiatric surgeon (apart from non-practising registration) • applying for an endorsement • applying to change your type of	1. If you have at least two years prior clinical practice experience as a registered podiatrist or podiatric surgeon and you wish to return to practice one of the following will apply to you. a. If you have had non-practising registration or have not been registered for between one and three years: i. at a minimum you must complete at least one years' quota of continuing professional development (CPD) activities relevant to your intended scope of practice (during the 12 months prior to applying for a category of practising registration). The Board's Continuing professional development registration standard sets out the Board's CPD requirements, and ii. the Board may require you to provide additional information and may also impose additional requirements which may include requiring you to undertake: • an assessment or examination to assess your competence to practice, and/or • further specific education, and/or • a period of supervised practice. b. If you have had non-practising registration or have not been registered for more than three	No

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	registration from non-practising to another category of registration, or • changing your scope of practice. It does not apply if you are: • a student • a recent graduate (as defined in this registration standard), or • applying for or renewing non-practising registration.	years: i. at a minimum you must: • complete at least one years' quota of CPD activities relevant to your intended scope of practice (during the 12 months prior to applying for a category of practising registration), and • provide a plan for professional development and re-entry to practice to the Board for consideration and approval. Information to assist you in developing a plan for professional development and re-entry to practice is published on the Board's website, and ii. the Board may require you to provide additional information and may also impose additional requirements which may include requiring you to undertake: • an assessment or examination to assess your competence to practice, and/or • further specific education. 2. If you have less than two years prior clinical experience as a registered podiatrist or podiatric surgeon, and you have had non-practising registration or not been registered for more than 12 months: a. You must complete at least one years' quota of CPD activities relevant to your intended scope of practice (during the 12 months before applying for registration); and b. You will have conditions placed on your registration to facilitate your return to safe professional practice, which may include a requirement for you to undertake: • an assessment or examination to assess your competence to practice, and/or • further specific education, and/or • a period of supervised practice. You must retain records of your practice for at least five years in case you are audited. If you cannot provide evidence of practice, you may be required to undertake a competency assessment, further study or a supervised clinical placement to demonstrate your competence	

1. Author (year of publication) 2. Author type 3. Country 4. Comprehensive judgement 5. Type of literature 6. Profession	Aim	Key findings (quote)	Useful resources?
		to practice. The Board may also place conditions on your registration where necessary to ensure safe professional practice.	
1. Australian Podiatry Council Magazine (Australian Podiatrist) (2014) [75] 2. Professional body 3. Australia 4. RED 5. Commentary 6. Podiatry	Summary of Podiatry Board of Australia's Recency of practice registration standard	<u>As detailed in Podiatry Board of Australia's recency of practice standard:</u> • Practitioners with less than two years experience who have been absent from work for more than 12 months, will have conditions placed on their registration to facilitate their return to a safe professional practice. • Practitioners with two years or more prior experience who have been absent from work for between one and three years, will be required to complete a minimum of one year's quota of continuing professional development (CPD) activities in the 12 month period prior to returning to practice relevant to the intended scope of practice. • The CPD activities must be designed to maintain and update knowledge, clinical judgment and technical skills. The practitioner is required to provide evidence with their application of having met the minimum of one year's quota. • Practitioners with two years or more prior experience who have been absent from work for more than three years is required to provide the Board with a plan for professional development and for re-entry to practice. This may include a range of activities including working under supervision and completing specific education and/or assessment. • The purpose of a re-entry plan is to ensure that the practitioner is returning to safe practice with appropriate supports in place. This is for the safety of both patients and the	No

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		practitioner. • The plan for professional development and re-entry to practice will be different for each practitioner. It should be tailored to the practitioner's particular circumstances and their individual learning needs. It is therefore not appropriate for the Board to issue a standard re-entry to practice plan with set tasks or supervision levels. However, the Board has developed a re-entry plan template to assist practitioners. Professional associations, prospective or past supervisors and prospective employers/colleagues and mentor may also assist in developing a plan. A plan should take into consideration the practitioner's specific learning needs and past education, experience and training and the requirements of the specific position that the practitioner is proposing to work in.	
1. College of Podiatry RTP page [76] 2. Professional body 3. UK 4. RED 5. Re-entry to practice website 6. Podiatry	The Society frequently assists podiatrists wishing to return to practice and resume HCPC registration. Although some are able to rely on previous networks or colleagues and peers, others find themselves unable to locate a system that is designed to support their needs.	<u>Society Mentored Membership</u> Until you regain HCPC registration, you are encouraged to become a Mentored Member before you commence any supervised clinical practice as this will ensure that you are suitably covered to practice under insurance. Mentored Membership recognises that you are practicing under supervision towards the ultimate goal of resuming your HCPC registration and this way, any worries of implications onto your mentor or supervisor's insurance should be limited as you would be working under your own. Mentored Membership is generally for a period of 12 months during which time, we will contact you to see how you are progressing with your update and whether there is anything we can do to help. Of course, you are most welcome to contact us at any time throughout your update for support and advice. <u>Need help finding a Mentor?</u> When applying for Mentored Membership, you are required to nominate a fellow Society member as your return to practice mentor for verification purposes. If you are experiencing	No

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		some difficulty in finding someone available or willing to help, our 'List of Return to Practice Mentors' may be able to help.	
1. Podiatrists Board of NZ site [77] 2. Regulator 3. New Zealand 4. RED 5. Policy for re-entry to practice 6. Podiatry	Application for an Annual Practising Certificate (APC)also involves undertaking Board recertification requirements. Before you apply for your APC you are advised to read the following information.	<u>Not practice for 3+ years:</u> 1. CPR certificate (including AED and anaphylaxis) required prior to starting work. 2. Self-directed return to work practice plan. (i.e. PBRCF form 1 “Self-directed professional development needs analysis” page in APC application form) 3. Police check for every country lived in for past 5 years 4. Certificate of Good Standing from every registration authority practiced under since last practiced in NZ. Two character references if practiced in an unregulated country. 5. Initial 40 hours of planned clinical supervision* prior to full APC being granted. A supervisor agreement must be completed and sent to the Registrar 6. Audit in 1st year returning to practice. (See Podiatrists Board Recertification Framework) <u>Not practice for 5+years:</u> Requirements 1 to 6 plus 7. Complete Board’s Cultural Competence Open Book Exam. 8. Supervision* - decided on a case by case basis. (See criteria) <u>Not practice 7+ years</u>: Requirements 1 to 8 plus	No

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		9. Sit and pass ANZPAC Examination, both stage 1 & 2. (To be conducted by Auckland University of Technology) <u>Criteria for establishing supervision hours:</u> a. Length of previous experience before ceasing practice. b. Health related professional involvement during period of non-practice. c. Feedback from the initial supervision. Areas of weakness or risk identified.	
1. British Association of Prosthetists and Orthotists [78] 2. Professional body 3. UK 4. RED 5. Standards of best practice 6. Prosthetists and Orthotists	This Standard explains the role and scope of practice of the Prosthetist/Orthotist as he/she delivers treatment. As well as the practicing clinician it should also be of particular interest to the service user, prosthetic/orthotic student, other healthcare professionals and service commissioners	In cases where the Prosthetist/Orthotist is returning to practice they will follow the standards stated in the HCPC document - Returning to Practice	No

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1. Australian Health Practitioner Regulation Agency (AHPRA) website - Psychology Board of Australia [69] 2. Regulator 3. Australia 4. RED 5. Policy for recency of practice 6. Psychologists	This policy applies to individuals who do not meet the requirements of the Board's registration standard for recency of practice who: 1) were previously registered with the Psychology Board of Australia, or a prior state or territory board of Australia, whose registration has lapsed and who are applying for general registration, or 2) currently hold general registration with the Psychology Board of Australia and who are applying to renew their registration, or 3) are applying to change registration status from non-practising registration to general registration, or 4) are applying for registration in Australia for the first time.	<u>Re-entry plan requirements</u> All re-entry plans must include the following minimum inputs: • Psychological practice – hours as specified in approved work role/s • Supervision with a Board-approved supervisor – the usual requirement is 2 hours per week or 1 hour per 17 hours of practice, which may be varied as appropriate but should be no less than 1 hour per week or 1 hour per 38 hours of practice • Direct observation of practice by a Board-approved supervisor – at least two observation sessions every six months and minimum of two observation sessions for supervision programs of less than six months, and • CPD – the standard requirement is between 40 – 60 hours per year which may be undertaken pro-rata if working part-time provided the minimum requirements of the CPD standard are still met. <u>All re-entry plans must include the following minimum outputs:</u> • Progress report/s – one every six months and at least one for programs that are shorter than six months • Satisfactory final assessment of competence report • Pass the national psychology exam • Case report – at least one and usually one for every six months of FTE practice.	Recency of practice policy Supervision program for re-entry to practice - Progress report Plan for professional development and re-entry to practice Progress report for professional development and RTP Fact sheet recency of practice FAQ recency of practice Overseas applicants registration information

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1. Australian Health Practitioner Regulation Agency (AHPRA) website - Psychology Board of Australia [69] 2. Regulator 3. Australia 4. RED 5. Recency of practice standard 6. Psychologists	This registration standard sets out the Psychology Board of Australia's (the Board) requirements for recency of practice for psychologists. This registration standard applies to all applicants for provisional or general registration and all registered general psychologists and provisional psychologists. It does not apply to applicants for non-practising registration and psychologists who are applying to renew non-practising registration.	The National Board may grant an exemption to this standard for individuals who: • successfully completed a Board-approved four-year sequence of study more than five years ago and have been approved by a tertiary institution to enrol in an accredited program of study that requires provisional registration in the higher degree or 5+1 internship pathway, or • successfully completed a Board approved four or five year sequence of study between five and 10 years ago and apply for provisional registration to undertake a Board approved internship program of at least one year full-time equivalent (FTE).	No
1. New Zealand Psychologists board RTP site [79] 2. Regulator 3. New Zealand 4. RED 5. Re-entry to practice website including RTP policy 6. Psychologists	The Boards 'Return to Practice' (RTP) framework is a set of guidelines rather than firm rules. There are many variables to consider when assessing a returner's application.	<u>What information will be requested?</u> Before the Board considers an APC application, it will request that a returner who has been away from practice for longer than three years provides: A letter stating their return to practice intentions, including the nature of the intended work and, if possible, the intended practice setting. An up-to-date Curriculum Vitae, including professional development and professionally relevant activities undertaken since an APC was last held. Evidence of any relevant practise in another country. This may include registration documents and a reference from a supervisor in that setting. <u>Factors considered and possible outcomes</u>	

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		The information submitted will be considered to help us decide which of three optional outcomes best applies: Option 1: APC issued with no further restrictions. (No additional information will be requested, other than the normal complete application for an APC.) Option 2: APC issued once revision and supervision plans (based on the Board's Continuing Competence Programme (CCP), see below) are submitted and approved. A condition is likely to be placed on the returner's scope of practice that they must only practise with Board-approved supervision, and the supervisor will be requested to provide three-monthly reports for one year. Option 3: APC issued only once further training or retraining is successfully completed. While each individual application will be considered on its merits, the threshold for Option 3 is approximately ten year's absence from active practice. <u>Competence enhancing factors:</u> • The degree to which knowledge and skills were consolidated after completing professional training. • Any relevant experience in a related field of endeavour during the break from holding an APC in New Zealand. • Activity which is likely to maintain knowledge and familiarity with current research in psychology. • Resuming practice in a field similar to that practised in prior to the break from holding an APC.	

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		<u>Factors which are perceived as increasing the risk of loss of competence:</u> • An extended period of time away from practice with little or no engagement in activity relevant to professional psychology. • Little consolidation of professional training prior to having a break away from the psychology profession. • Greater duration of time away from practice as compared to the time spent in practice. • An intention to resume practice in a different field of psychology than that practised in previously. <u>Supervision plan:</u> The reinstatement of regular supervision with a senior and respected member of the profession is regarded by the Board as a key component of ensuring competence and a safe return to practice. If approved by the Board, the supervisor will be asked to provide oversight on our behalf by completing brief reports at 3-monthly intervals over the first year of returning to practice. <u>Revision plan</u> The Board's CCP is used to provide a structure to the development of the revision plans. The revision plan is expected to include the CCP "starter" documents for the coming year; that is, to include a self-reflective review of current competence, strengths and weaknesses, learning goals, and learning plans to indicate how these goals will be progressed. It is expected that supervision will offer the platform for returners to complete their CCP structured revision plans to review their training needs and to develop plans for any extra reading, revision, and/or professional development activities. It is likely that returners will need to undertake	

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		extra professional development activities (as compared to the ordinary or routine development activities expected of all active psychologists) to support their revision. <u>Continuing Competence Programme</u> The CCP must be completed each year by every psychologist who holds a current APC. The CCP steps provide the structure for a self-directed professional development programme for each practitioner. For returners, the CCP provides a RTP plan which will detail intended remedial action to address any perceived weaknesses, based on an up-to-date appraisal of skills and knowledge as related to the intended area of practice. Your CCP should be developed in conjunction with and will need to be countersigned by your supervisor.	
1. Society of Radiographers RTP site [80] 2. Professional body 3. UK 4. RED 5. RTP information 6. Radiographers	Information in this section is for diagnostic and therapeutic radiographers seeking to return to practice and employers seeking to support a returnee.	The Health and Care Professions Council set and assess the standards that registrants must achieve before being readmitted to the register. Potential returnees should read the HCPC 'Returning to Practice' pages and follow the links as well as reading the SoR pages. For individual advice, as either a potential returnee or an employer looking to support a returnee please contact the Society of Radiographers professional officer responsible. Return to practice update Potential radiographer returnees need to attend clinical departments for supervised practice to help them achieve the standards and regain entry onto the register. Please note that the readmission route for returners is only available for UK qualified radiographers. Return to Practice in Ultrasound The SCoR has produced useful information about ultrasonographers returning to practice, which can be found here.	Return to Registration Supervised Practice Framework

1. Author (year of publication) 2. Author type 3. Country 4. Comprehensive judgement 5. Type of literature 6. Profession	Aim	Key findings (quote)	Useful resources?
		Useful Resources • E learning for health modules An NHS e-mail address allows free access to these excellent resources, relevant for both diagnostic and therapeutic radiographers.	
1. British Association of Social Workers [81] 2. Professional body 3. UK 4. RED 5. RTP guidance 6. Social workers	Refers to HCPC RTP document	As per HCPC RTP document	No
1. Bogg 2013 and Coventry Return to Social Work Activity pack [82] 2. Education 3. UK - England 4. AMBER 5. Learning materials 6. Social Workers	The 'return to social work' learning materials are designed as an open-learning resource that can be used flexibly to meet the learning needs of individual returners to the field of children and families social work. Whether you are a social worker looking to return and unsure of what to do next, or an employer looking to provide learning opportunities for your returning staff, you will find a range of useful information, guidance and learning activities to help.	The return to social work materials are underpinned by the PCF domains and by completing modules you will come to understand how it relates to professional development and quality in practice. How you use these materials is up to you, although we recommend that wherever possible the materials should be used in conjunction with practice supervision. Materials detail the reform of social work over recent years following death of Baby Peter. This includes the following areas of reform: • professional capabilities framework, standards for employers and supervision framework, CPD, Strengthening the calibre of entrants to social work education and training, social care degree, practice learning, assessed and supported year in employment, workforce model, partnership principles, and career framework. <u>Activity pack:</u> Reflective log template, reflective activities, learning activities, SWOT analysis template, critical incident analysis template relating to each of the 10 modules • returning to social work practice,	The resources detailed in Appendix 1 relate to materials for carrying out the modules rather than the process of RTP itself. (include a stand alone pack for each of the 10 modules, a shadowing

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	Activity pack: Throughout the return to social work materials you will find a range of exercises and activities designed to help you to embed your learning and apply it to practice. This activity pack collects all of the activities included across the ten modules into one place. It can be used to dip into and refresh learning at any point, or exercises can be taken out and used to support taught courses in conjunction with the slides included in the return to learn presentations material. Some of the activities within this pack include suggested answers, but in many cases you will need to refer to the relevant module information to check your answers. A degree of prior knowledge and understanding is required by trainers using these materials in the delivery of taught programmes.	• understanding the PCF, • reflective self, • law, • equality and diversity, • social policy, • communication and partnership, • safeguarding and corporate parenting, • children in need, • working in organisation	guidance pack, a resource pack, an activity pack, and a slide pack) - details of the activity pack is included in key findings here in data extraction sheet

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1. Care Council for Wales (2016) [83] 2. Professional body 3. UK - Wales 4. AMBER 5. RTP guide 6. Social Workers	How to Return to Social Work Practice in Wales A Guide for Social Workers	The Care Council for Wales (Care Council) is introducing specific registration requirements for social workers who are not currently registered as a social worker and who have not been practising as a social worker for a period of time. <u>Why the Requirements are being introduced</u> The Care Council wants to enable social workers who are not currently registered to be able to apply for registration and enter the social work workforce with up to date knowledge and understanding of contemporary practice. In doing so it wants to ensure applicants meet the Care Council standards required for registration. Employers will also want to be confident of an applicant's suitability for a post before making an appointment. Whenever a social worker decides to return to professional registration and social work practice after a break, they are going to face changes in the workplace and in social work practice. Social work draws on a wide range of knowledge and skills which may change as a result of research or changes in legislation or policy. The requirements set out below aim to ensure social workers have a framework through which to update their knowledge and understanding of contemporary social work. Employers find it harder to recruit experienced rather than newly qualified social workers. By providing a broad framework for updating knowledge and understanding, employers may find experienced social workers not currently in employment more keen to return to practice and should enable applicants to feel more confident about their abilities when they decide to return. Return to practice requirements can also support the further professionalisation of social work by ensuring registration requirements reflect standards of fitness to practise. Setting requirements for social workers returning to the Register and social work practice can therefore have an impact on the quality of social work practice for individuals using services. <u>The Requirements for social workers' return to practice</u> This section describes the registration requirements for social workers who have not	Care Council Wales portfolio of evidence

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		maintained their professional registration in the UK and wish to apply for registration onto Part 1 of the Care Council's' Register to practise as a social worker. The requirements apply to situations where: • a social worker has post-qualifying experience of social work practice but is no longer registered and has been out of practice for a period of time; • a social worker has never practised as a social worker since qualifying. <u>The Requirements</u> 1 All applicants to the Register of Social Care Workers must provide evidence of the following: · good character, as it relates to their fitness to practise in a way expected of a social worker; · their good conduct; · physical and mental fitness to practise in social work; · competence in social work practice. 2 All applications will need to be endorsed in accordance with Care Council guidance, details of which are available on the Care Council website. 3 To return to Part 1 of the Register of Social Care Workers after a period of absence, applications must be made as set out on the Care Council website at Returning to social work practice and must demonstrate the following: · If you are applying for registration or to return to the register following a period of less than three years in which you have not been registered in the social worker part of the register or an equivalent register, you must provide evidence of updating your knowledge and understanding that would meet the normal Post-Registration Training and Learning requirement (PRTL). This is currently 90 hours or 15 days in the three years prior to the application. See PRTL requirements for social workers; · If you are applying for registration or to return to the register following a period of between three and six years in which you have not been registered in the social worker part of the register or an equivalent register, you will need to be able to demonstrate through a portfolio	

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		of evidence, 30 days or 180 hours of updating your professional knowledge and understanding within the three years prior to the application; · If you are applying to return to the register following a period of over six years since your previous registration lapsed and you have not been on an equivalent register during that period, you will need to demonstrate through a portfolio of evidence, 60 days or 360 hours of updating of professional knowledge and understanding within the three years prior to the application; · If you have never been registered on Part 1 of the Register or an equivalent register and you qualified as a social worker over six years before the date of application, you will need to demonstrate 60 days or 360 hours of updating of professional knowledge and understanding within the three years prior to the application. In such situations the application will be referred to the Care Council's Registration Committee. · If your social work qualification was gained outside of the UK, the Care Council will assess the qualification gained using the procedure outlined at Register as a social worker qualified outside the UK You must contact the Care Council before starting the application process to ensure that you meet the criteria to apply. Any additional requirements relating to a Return to Practice under this guidance will then be considered. 4 In updating your knowledge and understanding in social work, you can draw on study, training, courses, seminars, reading, teaching or such other activities which could reasonably be expected to advance the professional development of the social worker or contribute to the development of the profession as a whole. These may include: · Formal study through courses or accredited programmes; · Private study which may include for example research, relevant reading; · Supervised or shadow practice which may include project work, shadowing social work, relevant voluntary work and reflection and analysis of social work practice1. 5 Applicants will need to provide evidence of fitness to practise in the form of a portfolio. The	

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		portfolio will be assessed by a panel of at least two people drawn from appropriate Care Council officers and social workers involved in social work education or leadership of practice. All panels will include a registered social worker. The portfolio will need to demonstrate the following: · That the applicant completed the requisite period of updating in the period specified; · That the applicant has reflected on the period of updating and how the learning and practice relates to the Social Work National Occupational Standards and related knowledge and skills (see appendix 1); · That where the applicant has experience of working as a qualified social worker, that private study accounted for no more than 50 per cent the required period of updating; · That where the applicant has no experience of working as a qualified social worker, no more than 25 per cent of the updating is drawn from private study; · That the updating appears to be relevant to current social work practice; · That the evidence indicates knowledge of current legislation, policy and social work practice and indicates competence in social work to the standard expected of a registered practitioner; · Any other information relevant to considering the person's application for registration. 6 Portfolios will need to include · Certificates of completion or attendance for any courses attended · Testimonies or brief evaluations from shadow practice or other practice · Bibliography of your reading 7 The applicant will need to pay a fee of £1252 for assessment of the portfolio of evidence in addition to the ordinary registration fee.	
1. One Stop Social RTP site 2. Professional services hub 3. UK 4. RED 5. RTP information	Do you want to return to Social Work? Are you finding the process confusing with little or no support available?	<u>Timeframe/requirements for returners:</u> In order to return to practice, the first step is to identify how long you have been out of practice. Once identified, you will need to complete and meet the following requirements, depending on how long they have been out of practice:	No

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6. Social Workers	Below you will find the relevant guidance on what is required and the process you need to follow in getting re-registered with the HCPC. For clarification purposes, we have also provided links to the HCPC website for further information and have been in active discussions with them so as the information presented below is accurate.	0-2 years – no requirements 2-5 years – 30 days of updating their skills and knowledge 5 years or over – 60 days of updating their skills and knowledge What does "updating their skills and knowledge" mean? To put it simply, in order for you to return to Social Work, the HCPC require that you complete a readmissions form which details that you have updated your skills and knowledge in three ways: Supervised practice Formal study Private study <u>Supervised practice</u>: 'Supervised practice' is practising under the supervision of a registered professional. During a period of supervised practice, you may have the option of being employed as an assistant in your profession. However, employment is not essential (includes relevant voluntary work). In order to complete a period of supervised practice, you will need to identify a supervisor. Your supervisor must: • be HCPC Registered; • have been in regulated practice for at least the previous three years; and • not subject to any fitness to practise proceedings or orders, (i.e. they must not be cautioned, or subject to 'conditions of practice'). Note: The registered professional (HCPC registered Social Worker) does not need to be based at the placement setting on a full-time basis. This can be completed in an off-site role/capacity – see it like an off-site Practice Educator role.	

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		However, it is expected that the registered professional will assist in your development and will determine how regularly you are required to meet and what areas of work (skills and knowledge) you need to develop. <u>Formal study:</u> 'Formal study' is a period of structured study which is provided by a person or organisation. This can include distance learning or e-learning, or any other type of course or programme that is relevant to your practice. Types of formal study that you might choose to take could include: 'return to practice' programmes run by educational institutions or other bodies; relevant 'continuing professional development' courses; relevant modules or elements currently included in programmes run by educational institutions; or programmes offered by professional bodies. Note: The HCPC do not approve return to practice courses, which is different to return to practice programmes run by educational institutions etc. <u>Private study:</u> 'Private study' is a period of study which you structure yourself. If you choose to use private study as part of your updating, you could use resources including: websites; library books; and	

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		Journals <u>How many days should I do each section for?</u> There is no one formula in terms of establishing how many days you are required to demonstrate supervised practice, formal study or private study. The only requirement is that any private study makes up a maximum of half the period. For example: you could choose 50% private study, 25% formal study and 25% supervised practice. As long as it makes up the total number of days you are required to demonstrate. Once completed, the registered professional will be required to sign off the Returners to Practice application which is completed the returning Social Worker. This is then processed by the HCPC and (once passed) full Social Work Registration status is achieved. <u>Registered Professional Service:</u> We have recently developed a Registered Professional Service to assist returning Social Workers. We offer support in finding a suitable placement, conducting the Registered Professional Role and in supervising the returning Social Worker.	

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1. RTP Social Workers New Zealand Wellington site 2. Regulator 3. New Zealand 4. RED 5. RTP guidance 6. Social Workers	This page is to assist you with returning to social work and having your Annual Practising Certificate (APC) in place before you start work.	Returning to Practice Many social workers return to practice under different circumstances, it may be after some time on parental leave or after returning from overseas. This page is to assist you with returning to social work and having your Annual Practising Certificate (APC) in place before you start work. Competence Certificate expiry date Check that your competence certificate is still valid. Not sure of the expiry date, you can check the public register by clicking here. If your competence has expired, you may need to complete a competence assessment, please email us on apc@swrb.govt.nz or call 0508 797 269 to discuss which path you'll need to take. Been Living Overseas Have you been living outside of New Zealand for the past 12 months or more? If yes, then you will need to submit a police certificate from the country you have been living in, even if you have lived in more than one country. You will also need to check your competence certificate expiry date. Please email us on apc@swrb.govt.nz or call 0508 797 269 to discuss which path you'll need to take. No APC for 3 years or more If you are a registered social worker who has not held an Annual Practising Certificate (APC) for the previous three years you will need Board approval for the secretariat to issue you with an APC. Section 30 (1) (a) (iv) of the Social Workers Registration Act states that: The Registrar must	No

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		refer an application for a practising certificate to the Board if he or she believes on reasonable grounds that the applicant has previously held a practising certificate, but has not held a practising certificate within the 3 years immediately before the date of the application. You will also require a current competence certificate before an APC can be issued.	
1. Alberta College of Speech and Language Pathologist and Audiologists (2018) [84] 2. Regulator 3. Canada 4. RED 5. Registration and standards guidelines 6. Dual professions – SLT and Audiology	Registration and standards guidelines for speech and language therapists in Alberta including re-entry information	Demonstrate that your professional practice is current by showing you have one of the following: a) Graduated from an approved program within the three years before applying or b) Practiced as a speech-language pathologist or audiologist for at least 1250 hours in the five years immediately before applying or c) Successfully completed approved, refresher education courses in your profession within the three years before applying. Practiced less than 1250 hours in previous 5 years need to follow re-entry process also, if you have not practiced professionally for a period of five years or more, you will need to successfully complete the Speech-Language & Audiology Canada (SAC) Certification Examination, and then also a period of supervised practice as described below. Re-entry process: • You will receive a temporary practice permit with the condition that you must practice under supervision for a minimum of 450 hours (roughly equivalent to 3 months of full-time work). There may also be additional conditions on the practice permit (these will be clearly outlined as required). • Your re-entry process will include supervision of a minimum of 150 direct contact speech-language pathology/audiology clinical hours; of the 150 hours, for SLPs, at least 60 hours	Supervised practice plan and agreement - re-entry to practice for SLPs p.59 plus mid point report and final report Supervised practice plan and agreement - re-entry to practice for Audiologists p. 71 plus mid point report

1. Author (year of publication) 2. Author type 3. Country 4. Comprehensive judgement 5. Type of literature 6. Profession	Aim	Key findings (quote)	Useful resources?
		must be related to diagnostics/assessment/testing and at least 60 hours must be related to intervention/treatment/counselling.	and final report
1. RCSLT (2013) overseas [85] 2. Professional body 3. UK 4. RED 5. RTP guidance and FAQ 6. SLT	The RCSLT has set standards for the SLT workforce that may exceed the threshold standards set by the regulator (HCPC).	Under current arrangements, overseas qualified practitioners (OQPs) are entered into the supervised category of RCSLT membership when they first join when entering the UK. These entrants to the profession are expected to complete up to one year in a clinical setting under supervision before being given certified RCSLT membership. This timeframe is given as a guide and may vary according to the individual. This competency-based transitional framework for OQPs sets out a balanced set of clear expectations and standards, the framework can be used to support learning and development specific to practice in the UK context. It will also support you with your continuing professional development (CPD) by informing you about the competency framework that underpins the RCSLT CPD requirements. You can use the RCSLT CPD diary to record your CPD and your progress through the competency framework.	No

1. Author (year of publication) 2. Author type 3. Country 4. Comprehensive judgement 5. Type of literature 6. Profession	Aim	Key findings (quote)	Useful resources?
1. Royal College of Speech and Language Therapy (RCSLT) [86] 2. Professional body 3. UK 4. RED 5. RTP guidance and FAQ 6. SLT	Important news for SLT Returners	RCSLT is also advising supervisors and returners to use either the competency-based framework for newly qualified practitioners (NQPs) development by RCSLT as a guide or, if they are undertaking the distance learning course, to use the Action Plan on the HPC's Standards of Proficiency. Both of these will provide a framework for reviewing competencies and helping returner and supervisor to decide whether or not the competencies have been met. For further information on current HPC requirements, see their website update http://www.hpc-uk.org/registrants/readmission/	No

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