

‘Welcome Back’: Return to Practice for Doctors in Wales

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Proposal

Problem

There is a lack of understanding of the nature and scale of problems in Wales surrounding doctors returning to clinical practice (RTP) after a career break ('returners'), with seemingly no reliable process in place.

Aims

The aims are to understand the current landscape for returners and the complexity of issues with respect to the workforce. Depending on findings, there will be discussions where potential areas for improvement are explored.

Background

Following on from the sad, complex case of Dr Bawa-Garba and Jack Adcock (Cohen, 2018), there was an escalation of focus on system pressures and their involvement in cases with unfavourable outcomes. One pressure is returning to regular clinical practice after a career break for three months or more (AoMRC, 2017). Anecdotally there is poor/lack of induction, with great variability. There is an unreliable reliance on word-of-mouth and doctors instigating induction. This often leads to defaulting to no support/induction. Where there is guidance, e.g. from Royal Colleges, it is anecdotally not always adhered to.

The effect on returners is a feeling of vulnerability, fear, less clinical confidence and skills fade (General Medical Council (GMC), 2014). The GMC's National Training Survey (NTS) showed that 24.9% of doctors are feeling a high/very high level of burnout (24.9%) (GMC, 2019a, p. 12). This can negatively affect wellbeing, consequentially leading to poor practice, morale and therefore poorer patient care and reduced patient safety: e.g. Hall et al commented that "poor wellbeing and moderate to high levels of burnout are associated...with poor patient safety outcomes such as medical errors" (2016, p.9).

Doctors have a higher propensity of flexible career paths with more unenforced career breaks e.g. research, fellowships: 23% of consultants and 15% of trainees in medicine working less than full time (Trudgill, 2018). Recruitment and retention issues are prevalent throughout Wales and UK, with an increased focus on workforce strategy locally (The Welsh NHS Confederation, 2017). The need to maintain a stronger, happier workforce for the safest patient care is imperative.

Induction, for any doctor, whether a returner or not, can be complex and happens at different levels – corporate, directorate, hospital and departmental. Induction for returners may need to involve doctors becoming refamiliarised with practical procedures, clinical updates, life support skills and graduated RTP with enhanced supervision. To add to the complexity for returners, these needs may differ between individuals.

GMC emphasise the importance of an effective induction (GMC, 2015). Health Education England (HEE) in 2018 suggested that what is needed are “standardised guidelines with flexibility...and individual requirements but provide a process, menu of initiatives and clarification of responsibilities of trainee, employer and HEE”. (p. 16)

Impact

To have a better understanding of the processes and nature of problems creates a stronger position to make positive changes. This vision includes a reliable and fair process for returners in Wales.

For the GMC, addressing this healthcare system issue is a step towards rebuilding trust between them and the profession. This workstream lies under the umbrella of projects in the ‘Supporting a Profession Under Pressure’ (SAPUP) programme (GMC, 2018b) and correlates to core organisational values of ‘excellence’ and ‘collaboration’. (GMC, 2017)

For the Welsh Health Boards (HBs) and Responsible Officers, this is an opportunity to improve the employer/employee relationship and provide clarity and evidence of induction for both parties.

For Health Education and Improvement Wales (HEIW) and the National Health Service (NHS) Wales, the potential that this leads to a stronger, safer and happier workforce could consequentially increase recruitment, retention, and financial benefits e.g. reduced locum doctor costs to fill rota gaps. This could also drive registered doctors without a licence to practice to return to clinical work. This area of work is linked with current Welsh Government strategies and policies around workforce and ties in with all the core principles of NHS Wales, in particular ‘wellbeing and prevention’ and ‘value all’. (NHS Wales, 2016)

For the profession, this could positively impact morale and wellbeing, with an increased sense of being a valued employee. The impact this could have on the above organisations, as well as the direct effect on the profession, is a positive step for maximising patient safety.

Deliverable Goals and Plan

The short-term goal is to explore current practice for Welsh returners, from employer and employee aspects. This involves seeking information on current processes and resources and looking into non-healthcare-related processes, e.g. critical industries, for comparison. A survey/interviews of doctors in Wales will explore reasons behind career breaks, RTP induction, thoughts on what a safe and effective induction looks like, the value and awareness of available resources, and delving into welfare and wellbeing aspects.

The medium-term goal is collating the above, with the long-term goal to discuss with stakeholders regarding areas for further work or improvement e.g. signposting tool for returners in Wales or HBs mandating an effective RTP induction. This project would feed into UK-wide GMC work into induction.

Success Criteria

Understand the landscape in Wales for returners would be a success. To have an informed, engaging discussion with stakeholders where clear areas for improvement are agreed upon and recommendations actioned would be the next step. If any interventions are made, success is a measurable outcome of having created a safer, happier workforce, with a consistent, effective approach.

Personal Goals

Along this project's journey, development of leadership skills and their application, including team engagement, influencing, inspiring, sharing visions and strategies would be valuable for my personal and professional development. (NHS Leadership Academy, 2014)

Stakeholders

The primary stakeholders are doctors, GMC, HEIW, HBs and Welsh Government. Other contacts are British Medical Association (BMA), Academy of Medical Royal Colleges in Wales (AMRCW), NHS Wales Employers and UK-wide organisations involved in providing support for returners.

Considerations and Barriers

Consideration must be given that potential recommendations released relating to this project or UK-wide work does not supersede employment legislation or occupational health processes.

Potential barriers include findings not reflecting practice, poor stakeholder engagement and resource/financial implications for employers.

Ethical Approval

This project does not require ethical approval. (Appendix 1)

Report

The Story

The appetite behind this patient impact project lies within a story. A trainee in Wales was coming to the end of parental leave. She had spoken to the HB she was returning to about an induction and supported RTP programme: yet her need for induction was questioned. This engaged trainee had attended a RTP conference external to Wales and 'Keeping in Touch' (KIT) days (GOV.UK, 2019). Despite this, she felt vulnerable, scared and clinically anxious returning to practice, saying "I will end up like Dr Bawa-Garba: I might make a mistake and I will end up in jail". **REF**

My Interest

This story resonates on a personal level as an upcoming returner and because it affects many of my colleagues. Through initial conversations, I realised, despite personal experience of induction, I was unaware of many problems surrounding RTP. I practised 'listening to understand' and reflected on the importance of having awareness and appreciation of a wide range of perspectives. I hope that in developing and applying leadership and management skills, I can improve the healthcare system for those doctors returning to clinical practice.

Jack Adcock and Dr Hadiza Bawa-Garba

To most working in healthcare, the sad and complex landmark case of Jack Adcock and Dr Hadiza Bawa-Garba needs no introduction (Cohen, 2018). The emotions – solidarity, anger and fear will be remembered by doctors for years. The sentiment "It could have been me" resonates with much of the profession.

There were many elements that contributed to that case, one was that Dr Bawa-Garba had recently returned to clinical practice after parental leave without a proper induction or RTP programme.

Definitions

BMA defines induction as:

A Workplace-specific process that ensures new employees understand the employers' local policies, both clinical and non-clinical...should help a doctor become familiar with new working environment...so they can provide excellent care (2018)

The Academy of Medical Royal Colleges (AoMRC) defines career breaks as breaks “from regular clinical practice for three months or more” (2017, p. 3).

There are many reasons for doctors taking career breaks. These can be categorised broadly into:

- Forced – long-term sickness, after resolution of fitness to practise (FtP) cases
- Unenforced – Parental leave, career opportunities, time out of programme (OOP). The Gold Guide describes these as additional clinical experience (OOPE), research (OOPR) or a planned career break (OOPC) (COPMED, 2016, p. 40)

For this project, a ‘returner’ is a doctor that is about to, or in the process of, a RTP induction following a career break.

A proposed name and branding for this project and further work is ‘Welcome Back’ as it embodies the philosophy and spirit of doctors returning to clinical practice.

Methods

Relation to Aims

To understand the current landscape and complexity of issues surrounding induction for returners in Wales, the current processes in Wales needs reviewing. This involves not just exploring this area with the profession, but the providers of induction as well, i.e. employers. This exploratory work will provide a stronger position from which to guide discussions with relevant stakeholders to determine what action could be taken to address areas of improvement. This will ideally create a more reliable and fair process for doctors returning to clinical practice and guide changes in culture and policy. This also avoid duplication of work in the future and shape the rest of the project and guide analysis. For this to happen, there needs to be engagement from stakeholders and a relevant review process for evaluating and measuring whether any intervention has had a positive outcome for the workforce and employers.

The GMC: The Bigger Picture

Following the case of Jack Adcock and Dr Bawa-Garba, the GMC escalated several workstreams, structuring them under the umbrella of SAPUP (GMC, 2018b). (Appendix 2) The focus of this programme is supportive rather than statutory and includes projects looking at seven elements

of the case where the healthcare system could be improved to prevent these issues arising again. This patient impact project sits within the 'Induction and Returners' arm of this programme.

Review of Current Practice for Returners in Wales

This focused review involves seeking information on current processes for RTP for doctors in Wales. The following areas will be covered:

- Numbers of doctors on a career break in Wales with, if possible, a breakdown by speciality and reason for break
- Welsh HBs (including Trusts), specifically looking at the following areas:
 - Process or standards for returners
 - What support is offered
 - Whether the standards are adhered to in practice
 - Barriers identified in this process
- Wales-wide policies used
- Organisations providing support e.g. GMC, HEIW, BMA, Defence unions, AoMRC, NHS Wales Employers etc
- UK-wide resources e.g. Royal College toolkits, conferences, seminars, workshops, peer-to-peer networks – specifically reviewing what is available in Wales and evaluation of this support.

Comparative Review of the Landscape of Return to Work

It is also worthwhile reviewing processes for non-doctor healthcare professionals that return to clinical work in Wales for comparison and to enable sharing of good practice. These would potentially include:

- Nursing staff
- Other healthcare professionals e.g. Paramedics

Historically, many similarities are often drawn between medicine and critical industries as the level of risk is comparable. Therefore, it is sensible to briefly review their processes in place for those returning to work:

- Civil aviation
- Military

Exploratory Themes

When exploring the views of doctors, the questions can be grouped into themes. The experiential learning model of Kolb was used as a basis for establishing these themes with regards to the doctor's RTP induction (Kolb, 1984):

- 1. Facts**
- 2. Feelings**
- 3. Learning from induction**
 - a. Awareness of raising concerns
- 4. Thoughts on a safe and effective induction**

It is predicted that, especially during focused interviews, there will be time for other comments to be made in relation to the subject. The themes and questions were tested for clarity on a few clinical and non-clinical colleagues.

Survey of Doctors in Wales

This will provide evidence, mainly quantitative, exploring the themes as above, with extra information exploring whether the doctor was aware of how to raise a concern and whether they felt discouraged from taking an unenforced career break due to the anticipated RTP.

This survey would engage with all doctors in Wales of all grades and specialities and be distributed using the HEIW and health board networks. It is worthwhile to boost the distribution via my own network of doctors.

Focused Interviews

These interviews will provide rich qualitative data delving deeper into the reflections doctors have on their experiences and perceptions of induction on returning to clinical practice. These will be semi-structured interviews (either face to face or over the telephone to allow for greater geographical spread) and will enable a comprehensive exploration. The interviews will last 30-45 minutes each and open and honest conversation will be encouraged. Confidentiality will be assured, and verbal informed consent taken. Timings will be flexible to increase recruitment, which will be via personal networks, and aim for a wider scope of grades, locations, specialities and types of careers breaks.

There will be a thematic analysis, using Microsoft Excel and not qualitative data analysis software, due to the small amount of data and wanting to ensure the richness of the comments are fully recognised. After familiarisation with data, the comments will be coded and main themes drawn. The aim will be 10-12 interviews as more after this is unlikely to provide new information. If agreed from the interviewee, one to two cases will be drawn out to provide an extra layer of

context to the data in the form of a case study. It should be noted that RTP for other disciplines in healthcare and following FtP career breaks is out of scope for this work for reasons of limited resources and sensitivity respectively.

Collation, Coalition and Beyond

It is planned that the information gathered from focused review of literature and practice, the doctors' survey and interviews will be collated to paint a picture of the current landscape and its complexities. This information will be used to guide discussions with stakeholders in this area and a joint agreement made for actions moving forward. The approach taken will follow the ethos behind #newpower, with an emphasis on transparency, sharing and collaboration; a "distributed process" when seeking solutions and any implementations being "actionable, connected and extensible" (Timms and Heimans, 2019). Following implementation of this intervention or agreement, it is important to review whether this has had a positive impact in terms of workforce wellbeing and patient safety. This would be in the form of repeat surveys/interviews and reviews of practices with a focus on those that have experienced a 'Welcome Back'.

Change Model

It became evident that to achieve the aims of this project in service improvement, there would need to be an organisational change, not just in process but in culture and behaviours with regards to RTP and doctors. I chose to follow the framework of Kotter's Eight Steps for Change Model alongside effective leadership and management skills to evoke this change (Kotter, 2012).

Figure 1: Kotter's Eight Steps for Change Model (Kotter, 2019)



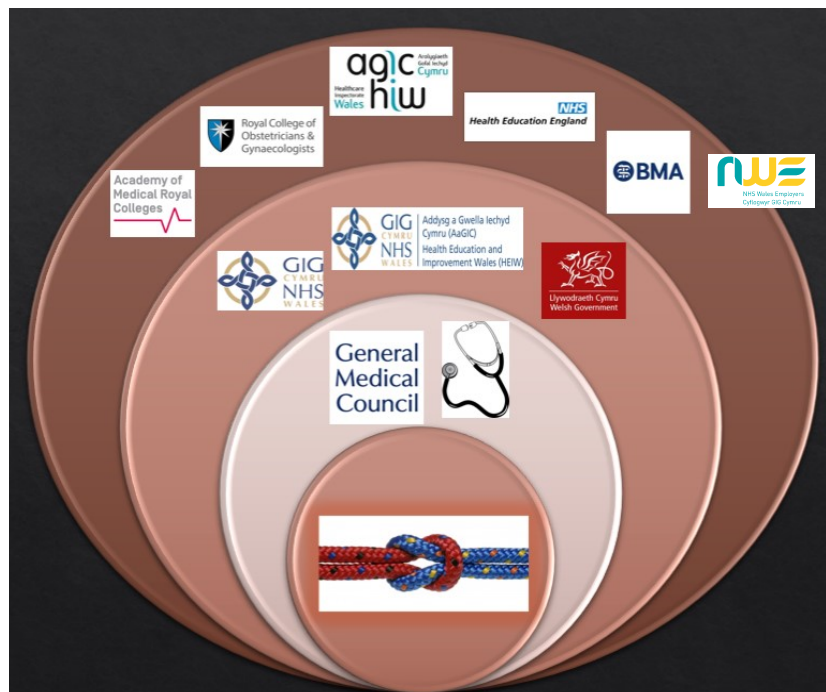
The review of the landscape for returners in Wales should create a sense of urgency, with the qualitative data from interviews providing a deeper, personal poignancy to the need for change. The stakeholders, especially the primary ones, will form the coalition and help build and communicate a collaborative vision. Many of the stakeholders will be vital in removing barriers and instituting change.

Stakeholder analysis

As mentioned above, stakeholder engagement, throughout the patient impact project, is crucial. When using Kotter's Change Model, discussions with stakeholders are essential for all steps but especially the following: build, form, enlist, enable and institute. To achieve the aims, the GMC internal key teams include SAPUP, employer liaison advisors, regional liaison advisors and the NTS team. The next crucial group of stakeholders is Welsh Government, HEIW and NHS Wales (i.e. Welsh HBs and Medical Directors/Responsible Officers) with HEIW and HBs being directly involved from an education and workforce point of view. Outside of these groups, contact with various other healthcare-related organisations is important, such as NHS Wales Employers, Healthcare Inspectorate Wales (HIW), BMA and AoMRC. Either with regards to available

resources or collaborative discussions about future action. English-based organisations such as HEE and speciality-specific bodies, such as the Royal College of Obstetrics & Gynaecology (RCOG), are valuable to note when looking for good practice. This stakeholder analysis is depicted below in Figure 2 below, with primary stakeholders being the profession itself, GMC teams as mentioned earlier, HEIW, Welsh Government and Welsh HBs.

Figure 2: Stakeholder Analysis



Resources

No separate funding from the GMC or other organisations was required for this work. My role as Welsh Clinical Leadership Fellow from August 2018 to August 2019 was funded by GMC and HEIW. No financial incentives were used for interview participation.

Risks

The potential negative impact on wellbeing and ultimately on patient safety if no action is taken is the most notable risk. Conversely, risks of the project itself include poor stakeholder engagement, lack of prioritisation of this work within GMC, timeframes not being met and increasing employer workload/cost. Also, potential interventions may not have a positive outcome for patient safety or the workforce. These can be mitigated by gaining a comprehensive

view of the landscape to ensure that work moving forward is evidence-based. Consideration must be given that any potential recommendations released relating to this project or further UK-wide work do not supersede employment legislation or occupational health processes.

Results

There is, in general, less literature which refers specifically to induction for doctors who are returning to clinical practice compared to doctors' induction in general.

Related Guidance and Work within the GMC

GMC guidance states that:

Organisations must make sure learners have an induction...for each placement that clearly sets out:

- a. Their duties and supervision arrangements
- b. Their role in the team
- c. How to gain support from senior colleagues
- d. The clinical or medical guidelines and workplace policies they must follow
- e. How to access clinical and learning resources (2015, p. 13)

Further guidance states that doctors have a duty to take “part in the induction offered by your employer” and “contribute to the induction of colleagues when asked”, whilst doctors with leadership or management roles “must make sure that any new doctor...is offered relevant induction” (GMC, 2012, p. 23)

NTS results this year showed 27.54% of Welsh trainees felt induction was ‘neither good nor poor’/‘poor’/‘very poor’. In addition, the overall positivity surrounding induction decreased from 83.36/100 to 76.93/100 between 2012 to 2019. (GMC, 2019b)

It is informally reported from the GMC's regional liaison service that induction is raised as an issue by doctors at engagement sessions. The employer liaison service report less talk of RTP induction from an employer point of view.

This year, the GMC published two high profile reports with emerging recommendations relating to the importance of doctors' induction, including RTP. (Appendices 3&4) The Mental Health and Wellbeing review will soon be published: all the emerging themes directly relate to the wellbeing of the workforce. These themes are subject to change as the final report has not been published yet.

Related Guidance External to the GMC

Many Royal Colleges refer to the AoMRC 'Return to Practice Guidance' (2017). The BMA have resources to support returners (BMA, no year). The Royal College of Physicians (RCP) has guidance on induction, which focuses on local guidelines, team roles and medical engagement. (RCP, 2016, p. 13, 26, 33)

There is, anecdotally, poor awareness of these documents and no apparent evaluation for whether these resources are effective.

HEIW: Workforce Strategy

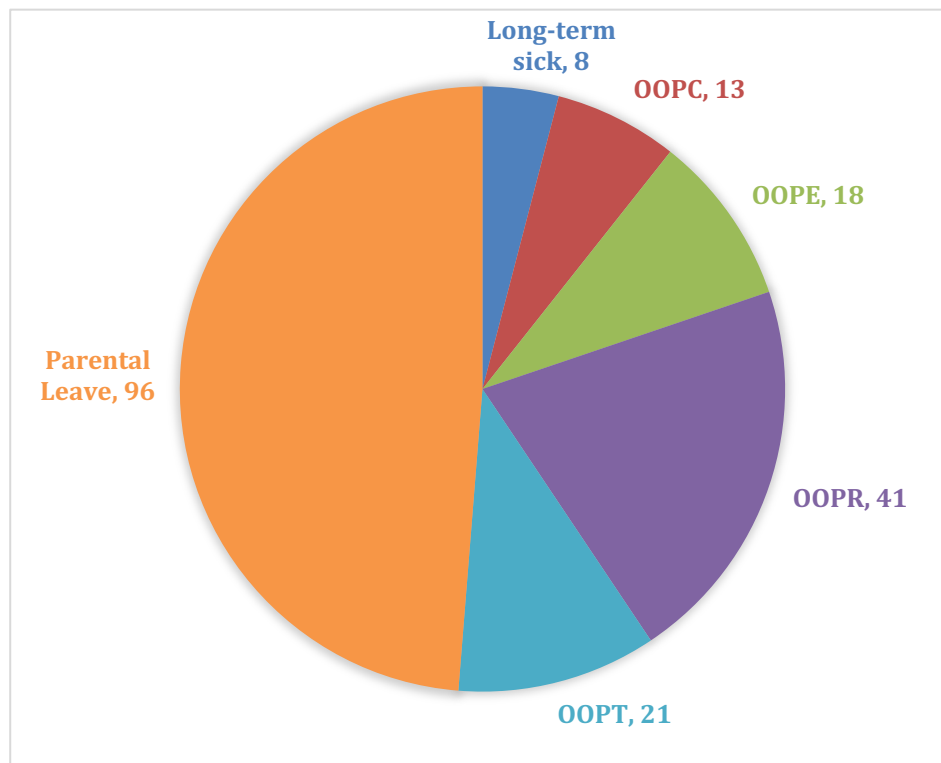
The themes of HEIW and Social Care Wales's (SCW) workforce strategy relate to wellbeing of the workforce and induction is mentioned:

Provide a values based, common induction programme for all of our workforce, who deliver health and social care in primary and community settings. (HEIW/SCW, 2019, p. 9)

Numbers in Wales

A snapshot view on 17th July 2019 showed that 197 doctors in training in Wales were on a career break. This represents **7.89%** (197/2495) **of trainees in Wales** (Roper, 2019). There are 11100 registered doctors in Wales (GMC, 2018a, p. 4). The proportion of all doctors in Wales who are currently on a career break is not known.

The main reason for a trainee in Wales taking a career break is parental leave, followed by time out of programme for research:

Figure 3: Breakdown of Career Break Reasons of Trainees in Wales on 17th July 2019

All specialities have between one and ten trainees on a career break, except for General Surgery and Obstetrics & Gynaecology with 14 trainees and Paediatrics with 15 trainees.

Welsh Health Boards

Discussions or email correspondence with each health board/NHS trust in Wales revealed the processes in place for returners. There is not a standardised process across Wales. Often induction is the responsibility of the returner or the local department and is highly dependent on the length and reason for the break. Some doctors benefit from a structured speciality-specific programme, e.g. Induction & Refresher Scheme (HEIW, No Year) or peer-to-peer support networks. Many HBs stated KIT days were officially for returning from maternity leave only. The whole RTP induction process is not routinely evaluated from human resources (HR) or workforce perspective for whether it is safe or effective and has a reactive, rather than proactive, approach. Many stated they followed the 'All Wales Policy' which provides guidance on returning to work after a period of sickness. (NHS Wales, 2018)

Other Healthcare Professions in Wales

Processes in place for nurses and paramedics returning to work were reviewed:

- Nurses
 - Nursing and Midwifery Council (NMC) approved RTP programmes to re-register
 - Bursary funded with mentorship and childcare included
- Paramedics
 - The Welsh Ambulance Service NHS Trust (WAST) provides a standard two-three week induction with mandatory competencies if returning to work after one year

Returners Outside of Wales

In 2016, HEE began to invest in the 'Supported Return to Training' (SuppoRTT) programme (HEE, 2018), releasing commitments to English trainees and providing resources including signposting, legal advice, peer-to-peer mentoring, knowledge refresher courses.

The RCOG released a toolkit for all their doctors to use as a guide to ensure a smooth return to clinical practice. There is no evaluation on the use of this resource but anecdotally it has been effective.

The Leicester Royal Infirmary, following the Jack Adcock/Dr Bawa-Garba case, appointed a 'return to work' lead for the hospital to support doctors after a career break.

Professions Outside of Healthcare

Civil aviation and the Royal Air Force have standard processes for returning to work, taking into consideration the length of time off and level of experience. The return programme is individualised with pastoral support incorporated.

Educational Events Supporting Returners

There are courses for returners but the majority are based external to Wales or aimed at specialities, such as Anaesthetics, Obstetrics & Gynaecology or Emergency Medicine. A few examples are as follows:

- Return to Training Medical Conference – Salisbury (Peninsula Postgraduate Medical Education, 2019)
- Giving Anaesthesia Safely Again – London (Royal College of Anaesthetists, No Year)
- Return to Clinical Anaesthesia – Bristol (Welsh School of Anaesthesia, No Year)
- Emergency Medicine Doctors Return to Work Course – Cardiff (Farrow, 2019)

Change of Plan

During the year, many changes took place within the organisation, resulting in the immediate project supervisor (who had also become a trusted mentor) and administrative assistant leaving the project team I was leading, without replacement. Quickly realising that this seemed to be normal and expected in large organisations, I adapted to my new situation, having already been out-of-my-comfort-zone, to ensure the project could continue.

Johnson (1999) describes how moving with change and learning to adapt will lead to something better, as change is inevitable. However, it took a while to realise that the departure of my project supervisor and mentor had an unexpected negative effect on my work, so began to apply the Kübler-Ross grief model (1969) to these changes. In addition, local office fluxes meant I was interacting with fewer colleagues on a day-to-day basis. Showing strong extraversion in my Myers-Briggs Type Indicator® Step II™ (Quenk and Kummerow, 2019, p. 3), I was not surprised that this was contributing to my despondency. Bridges (2004) helped me to understand how to cope with times of transition and focus on new activities.

Whilst reflecting on this, other factors influencing slow progress became apparent. UK-wide research into doctors' induction began and it became apparent the most efficient way of surveying all doctors in Wales was via the GMC list of registered medical practitioners. There were complications with this due to timing of other GMC surveys.

One of my weaknesses is often attempting to manage on my own. As per my first preference Belbin® team role being 'Completer-Finisher' (Belbin Team Role Report, 2019, p. 3), I understood there were elements out of my circle of control/influence and I had to innovate to find help, as my immediate team had been disbanded. Seeking help and advice from mentors, colleagues and my action learning set, a project revaluation allowed a shift of focus towards what would be of most value to the patient impact project - the rich, qualitative data from the focused interviews. The survey would provide results which hopefully backed up the emerging themes.

Focused Interviews

Ten semi-structure focused interviews with doctors were completed with a mixture of open and closed questions and time allowed to widen the scope of conversation. All discussions were open and honest, with confidentiality assured. They were either face-to-face or via telephone. The interviewees spanned North/South Wales, male/female, trainees/consultants from a range of

specialities. The length of career break ranged from six to 24 months and reasons included research, parental leave, sickness and out-of-programme experience. This is the breakdown of the main feedback:

- Facts
 - Unplanned
 - Disorganised
- Feelings
 - Vulnerable
 - Lonely
 - Exposed
 - Nervous
 - Imposter syndrome
 - Fine – just need my password and badge
 - De-skilled
 - Decision-making capability fatigue
 - Doing patients a disservice as not functioning at the level I should be
 - Did not want to admit how I felt as it would be frowned upon
- Learning from induction
 - Unaware of how to raise concerns
 - Pleased with support from Speciality Training Committee and pastoral help post sickness absence
- Thoughts on a safe and effective induction
 - Treat me like a human
 - Enhanced supervision with assessments
 - Reduce uncertainty
 - Pre-planning meeting
 - Easier process
 - Point of contact
 - Prioritise facilities
 - Reassurance

Influencing

When approaching discussions with stakeholders, I considered which influencing styles would be effective. I learnt I am more 'pull' than 'push' in my approach to influencing and persuading (Dent, 2009), scoring highly on bridging. I used impactful stories to create a sense of urgency, describe my vision and persuade stakeholders to support. In this setting, my natural preference is towards the facilitative rather than authoritative styles of influencing (Heron, 1989). These styles have benefits in this exploratory work, as the primary stakeholders will need to buy-in to the vision unreservedly. A more authoritative approach may not be received well or support the collaboration required for any potential interventions, especially considering the current political landscape of the GMC and the profession/other healthcare-related organisations.

Stakeholder Engagement

The primary stakeholders (Welsh Government, HEIW and NHS Wales) have shown a great deal of support for this work. The Chief Medical Officer for Wales has stated that in principle, employers of doctors should support RTP in any way needed and the Welsh Minister for Health and Social Services is interested in how this field will develop. The workforce team in HEIW are now collaborating on this piece of work with full support from their Medical Director. The Medical Directors that have interacted with this project have given it their support to progress in Wales.

GMC = Apollo

Handy describes models of organisational structures (2009); the realisation that the GMC and NHS Wales are examples of predominantly 'Apollo' organisations, guided a change in my framework for discussions. Being mindful of their risk averse and inflexible nature, I focused on small changes and discussed risk with a focus on shared values, e.g. how much of a risk does poor/lack of induction for returners pose on the workforce and patient safety? I explored ways of mitigating bureaucracy e.g. finding the right person with the right roles and responsibilities to achieve my goals.

Analysis

What are the Elements of an Induction for Returners?

Following discussions and literature reviews regarding doctors' induction, these are the components for a RTP induction:

- Pastoral
 - mentoring/supervisor contact
 - mental health and wellbeing
- Facilities and Human Resources
 - Information technology - passwords
 - Security – identification badges
 - Familiarisation/orientation with environment
 - Finances
- Corporate
 - Health Board values
- Knowledge and Skills
 - Knowledge refreshment
 - Local clinical policies
 - Practical skills
 - Resuscitation skills (where relevant)
- Enhanced supervision/supernumerary

Any doctors' induction can also be broken down into:

- Hospital or health board induction
- Directorate induction
- Local/departmental induction

Focused Review of the Landscape for Returners

There is a significant number of trainees currently on a career break. Despite not having the number for all types of doctors, even extrapolating the trainee figure leaves us with a large proportion of the workforce requiring a safe and effective return to clinical practice.

There is a great deal of variation across hospitals and specialities, with no standard process being offered to returners. Much of the time there is a heavy reliance on the doctor self-directing

induction as per their needs, encouraging even more variation in the process. This reliance on self-direction may be because the process requires such individualisation, or because workforce departments are unaware of doctors returning from a career break. Compared to other healthcare professions and comparable critical industries, processes for doctors seem less well established.

There are many bodies with guidance and toolkits available, but little is known of how effective they are and whether they are being utilised. Of the resources available, especially courses, there are few with a Wales focus. However, the topic of induction and returners has only recently gained traction in England with HEE's work and awareness of the impact this has on patient safety is generally underappreciated at present.

Thematic Analysis of Qualitative Data from Focused Interviews

The qualitative data from these interviews with doctors exposed multiple themes for discussion and further work. The three broad categories of culture, induction and innovation can be used to draw out the main themes. After thematic analysis, the emerging themes are as follows:

- ❖ *Cultures: Psychological safety*
- ❖ *Induction: Facilities and Human Resources*
- ❖ *Innovation: Point of contact for Returners - 'Welcome Back' Lead*

Cultures: Psychological Safety

The phrase "I did not want to admit how I felt as it would be frowned upon" is rather impactful. The healthcare system seems to have created a 'psychologically unsafe' environment where it is not okay to not be okay. There is an expectation that a doctor has the same competence level as when they left for their career break. The loneliness aspect was mentioned a few times – perhaps this is since returners are often out of sync with 'standard' doctors' induction at the beginning of rotations e.g. August. This psychological impact could cause stress and anxiety, affect morale and wellbeing and therefore clinical practice and patient safety.

Induction: Facilities and Human Resources

Many interviewees stated that the facilities aspect of induction was in their top two most important and that more focus should be given to getting this right. This is likely a reflection of the fact that without a security badge and computer system passwords, a doctor cannot function

in clinical practice. There was a clear message that the corporate element of induction, whilst important to be included, should be time limited and perhaps in the form of an e-learning package.

Innovation: 'Welcome Back' Lead

Many said that the department they were returning to were unaware they were returning after a career break. During the process, there were many logistical complications e.g. finance, rotas, tax codes etc, in addition to the psychological aspect of returning to clinical work with often having recently gone through a major life event e.g. birth of a child. Many suggested that a person (clinical or non-clinical) who had empathy, compassion and knowledge of their situation would be highly valuable at what is a stressful time of life.

Discussion

Induction for Returners

This is a complex, multi-faceted process which requires the need for an individualised approach, highly dependent on the length and reason for the career break: it is implausible be completely standardised across all specialities, grades and locations. There is dissatisfaction with the current process and a need for improvement with issues being comparable to the themes that emerged from HEE's work: psychological safety, facilities, pastoral support, skills fade and uncertainty (2018). For doctors in Wales, support available is variable and poorly evaluated, with pockets of good practice.

Other areas highlighted which need to be addressed by employers are the timing of inductions as returners are often 'out of sync' and the appropriateness/focus of the content i.e. could some of the less effective elements be delivered via e-learning.

Responsibility and Expectations of Induction

Whose responsibility is RTP induction? The responsibility lies with several parties – doctors, employers, educators, regulators, Royal colleges etc, but also colleagues and other healthcare workers, as one main theme emerging is the lack of psychological safety. Some may argue that the onus is on doctors to ensure they are safe to RTP. However, they need to be provided with a safe environment, resources, time and the mandate to do so. There will always be a substantive value-conflict between employer, employee and educators when considering induction and emotional value-conflict when doctors feel insecure and have poor morale. A question yet to be answered is

what is the expectation about RTP induction and if there are expectations, are they valid in the absence of such poor awareness/self-perception and a paucity of standardisation?

Impact

Since early 2018, the awareness of the issues surrounding the Jack Adcock/Dr Bawa-Garba case have been high on the healthcare agenda but RTP induction has not been a priority. Recently, there has been an increase in awareness and discussions in Wales about the importance of doctors' induction in general, including those returning to practice. This may be due to the renewed focus on workforce in the HEIW/SCW strategy (2019).

Patient Safety

In Wales in July 2019, 7.89% of trainees were on a career break, therefore requiring RTP induction. Extrapolating this figure to all doctors in Wales means a significant cohort are potentially feeling vulnerable and clinically less confident: therefore impacting on their professional development, mental health and wellbeing leading to poor morale and poor clinical practice. This theoretically negatively impacting on patient safety means that the potential impact work in this area could have for patients, the public and the profession is vast.

Drawbacks Faced

The main obstacles have been time resource, organisational changes and navigating through a bureaucratic system with conflicting priorities. Although some were done in this fashion, maybe all interviews should have been conducted over the telephone as perhaps some would have been more likely to disclose sensitive information. over.

Further work

The survey of Welsh doctors will be sent next month, with results likely to support themes already emerged from qualitative data. There are other elements that could be explored, such as the financial burden of induction and including specific questions in GMC NTS 2020.

Another aspect to deliberate is clear communication and raising awareness to the healthcare sector about the importance of induction for returners.

UK-Wide Work and Extrapolation to Doctors' Induction

This exploratory work will guide GMC UK-wide research: "Understanding the Nature and Scale of the Issues Associated with Doctors' Induction (Including those Returning to Practice)" which sits

within SAPUP. To doctors, induction is induction – many of the themes that have emerged here are relevant to induction in general.

Long term, there is scope for the 'Welcome Back' Programme to be extrapolated to other devolved nations.

New Role

My new role within the GMC is 'Clinical Lead for Induction & Returners'. With this new role, I feel I can utilise my experience, credibility, leadership and influencing skills to ensure that the research retains a clinical focus with emphasis on the wellbeing of the workforce and patient safety.

Welcome Back

Work with HEIW is ongoing, with stakeholder discussions (in particular, with the All Wales Workforce Group) in the next month, where a plan of action moving forward with the 'Welcome Back' Programme will be laid out. It is not in the remit of the GMC to mandate change but it has close professional relationships and influence amongst healthcare-related organisations that can enable this change.

Collaborative discussions will be Wales focused but duplication of work will be avoided and lessons learnt from good practice elsewhere. It would be imperative not to enforce new rules or policies which may not create positive change but increase workload and add bureaucracy where it is not needed. A 'standard offer' from HBs that it will support any individual RTP induction. This agreement could enhance the relationship between employer/employee and provide clarity to the process which is more evidence-based, robust, reliable and valuable – for HBs, the profession and ultimately, for patients.

Culture Change

The most important aspect is promoting a change in culture and behaviours surrounding doctors returning to clinical practice, which is likely to require a multi-angle approach – employers, doctors, educators etc, to improve how we treat our workforce and the consequential impact on patient safety. Is a safe enough environment is being created? Where a doctor feels they can raise a concern and have the time to reflect on their needs. Are doctors not voicing their needs for fear it would be frowned upon? Are employers not making changes due to tradition? The hope is that raised awareness help change culture.

Back to Kotter's

Reviewing the use of Kotter's change model (2012) in this project, I believe it provided a suitable framework. The project is at the enabling action stage and there is still work to be done: change in a vast setting like healthcare, will take time. On reflection, the delays and obstacles faced, were opportunistic, as the current climate is likely to be more valuable in relation to building momentum and instituting change together with stakeholders.

Conclusions

Professor Michael West, talking of compassionate and collective leadership, states:

“Good people management...and employee engagement”...are part of the “leading cultures for high quality care” (2013)

Leadership

Through my experiential learning and roles as clinician, clinical lead, project lead, project sponsor and clinical leadership fellow, I have appreciated the need to draw upon various leadership skills and styles, balancing and adapting to the situation and those around me. I have a deeper understanding of myself and my actions and exercised my MBTI-II type: ‘enthusiastic improviser’ (Quenk and Kummerow, 2019, p. 3), my Belbin® team roles of: ‘complete-finisher’ and ‘resource investigator’ (Belbin Team Role Report, 2019, p. 3) and a repertoire of leadership styles: affiliative, visionary and participative. I have learnt and implemented strategies to cope with change to ensure that the project continued.

My MBTI-II type shows I am strongly ‘feeling’ rather than ‘thinking’. I am compassionate and people-orientated but can often bring emotion into my work, sometimes being unsatisfied when my passion or vision is not shared. I strongly value inclusivity, diplomacy and co-operation and can often concentrate unnecessarily on the finer detail. In a setting where I am out-of-my-comfort-zone, my assertive skills and confidence tend to diminish. These weaknesses could have contributed to elements of the obstacles faced in this project, but my self-awareness and personal development thus far will ensure that I have an improved approach in the future.

Induction, for any doctor, in any context, is the foundation of not only safe clinical practice, but providing a sense of belonging and wellbeing to a team or organisation. It encourages positive engagement between the workforce and the system and ultimately leads to better patient care: maximising patient safety. A significant cohort of our doctors are feeling vulnerable, clinically less confident and therefore has an impact on mental health and wellbeing leading to poor morale and poor clinical practice and negatively impact on patient safety. The potential impact that work in this area could have for patients, the public and the profession is vast.

This patient impact project has reviewed the landscape and complexities of induction for returners in Wales, resulting in a better understanding of these processes. Examples of good practice, within Wales and external and within other aspects of healthcare, have been identified

and areas for improvement deliberated upon. Current work is encouraging a move towards culture change and implementing agreements whereby our workforce is valued and supported in their return to clinical practice.

Our NHS may collapse and patient safety is at risk if we do not look after our workforce. People matter: whether that be patients, colleagues or staff. A system does not work without the people within it. If the NHS and other healthcare related organisations invest in our workforce, like with the 'Welcome Back' programme – our NHS and our patients will reap the reward.

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Appendices

Appendix 1: Ethical Approval Consideration (Loasby, 2019)

Madhu Kannan (02920 495 363 ext 5120)

From: Steve Loasby (0161 923 6459)
Sent: 11 September 2019 13:28
To: Madhu Kannan (02920 495 363 ext 5120)
Subject: Ethical approval

Dear Madhu,

Based on the intended aims and objectives of the research and its chosen methodology, it would not be necessary to apply for any sort of external ethical approval.

Kind regards
Steve

Steve Loasby
Research Manager
General Medical Council
3 Hardman Street, Manchester M3 3AW

Email: Steve.Loasby@gmc-uk.org
Website: www.gmc-uk.org
Telephone: 0161 923 6459

Appendix 2: Supporting a Profession Under Pressure (SAPUP, 2018)



Appendix 3: The Gross Negligence Manslaughter/Culpable Homicide (GNM/CH) Review: Relevant Recommendations

Recommendation 5: The GMC should work with healthcare service providers, national bodies and representatives of overseas doctors to develop a suite of support for doctors new to UK practice. This should include information about cultural and social issues, the structures of the NHS, contracts and organisation of training, induction, appraisal and revalidation, professional development plans and mentoring. (Hamilton, 2019, p. 28)

And:

Recommendation 28: Healthcare service providers should provide induction and support for all doctors returning to clinical practice after a period of significant absence. These doctors should have a return to work meeting and appropriate supervision and support during the induction period tailored to the needs of the individual. (Hamilton, 2019, p. 69)

Appendix 4: The Fair to Refer Report: Relevant Recommendations

Recommendation 1: Support for Doctors: Employers should provide every doctor with effective induction and ongoing support that reflects national standards with enhanced induction for doctors who are new to the UK, new to the NHS or at risk of isolation in their roles (including overseas qualified doctors, locums and SAS doctors). Enhanced induction should include allocating a mentor (who will also sign off their induction). (Atewologun and Kline, 2019, p. 7)

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