Supported Return to Training in Emergency Medicine

Guideline for Emergency Medicine trainees returning to practice after a period of absence of 3-18 months.

Thames Valley Deanery
School of Emergency Medicine

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Purpose & Scope

This guideline provides a framework to support Emergency Medicine (EM) trainees who are returning to clinical practice after a period of absence, for any reason, of up to approximately 18 months. Trainees who have been out of practice for a longer period require a return to practice programme agreed on a case-by-case basis.

This guideline outlines the areas of support that a trainee may access as part of a phased supported return to practice. No part is compulsory and an individualised return to practice plan should be agreed with each trainee taking into account their requirements. However a uniform structured process for trainees returning to work across the deanery will help support both the trainees and the trainers.

The guideline has been agreed with Thames Valley EM Head of School and Thames Valley Return to Training Associate Dean. It will be in place across the Thames Valley Deanery from April 2019 with a review date of April 2020.

Model & precedent

The model for this return to clinical practice in EM guideline is taken from the Supported return to Training (**SuppoRRT**[1]) suggested process with reference to: Health Education Thames Valley (**HEETV**[2]); other specialties' developing policies on return to clinical practice - specifically Radiology and Anaesthetics; and the Academy of Medical Royal Colleges (AOMRC) Return to Practice Guideline (2017)[3].

[1] **SuppoRRT** https://www.hee.nhs.uk/our-work/supporting-doctors-returning-training-after-time-out

[2] **HEETV** http://www.oxforddeanery.nhs.uk/about_hee_oxford_local_office/medical_and_dental_policies/supported_return_to_training.aspx

[3] **AOMRC Return to Practice Guideline (2017)** https://www.aomrc.org.uk/wp-content/uploads/2017/06/Return_to_Practice_guidance_2017_Revison_0617-2.pdf

Background: National Overview & Progress

HEE, AOMRC, GMC, RCEM

Health Education England (HEE)

HEE has published a report on doctors in training returning after a period of absence: '**Supported Return to Training**'[4]. Summarised key points below:

- At any time there are approximately 10% of trainees out of training. This is a normal and expected part of many doctors' progression through training, and should be recognised as such.
- There is robust evidence indicating that time out of practice can impact on a clinician's competence and technical skills, as well as their confidence.
- Targeted support may be required to help doctors get back "up to speed" when they return to training.
- The 2016 Acas junior doctors' contract agreement committed Health Education England (HEE) to develop innovative, evidence-based initiatives to "remove as far as possible the disadvantage of those who take time out due to, for example, caring responsibilities."
- The Department of Health allocated £10 million recurrent annual funding from the 2017/18 financial year to support the delivery of this commitment.
- HEE conducted an evidence gathering process and received strong feedback that support for trainee returners is inconsistent across location and specialty and, in some places, lacking entirely. They heard that returning to training after time out of practice is a challenging process and that the associated impact on confidence poses the main concern to trainees and trainers alike.
- Stakeholders asserted that, as well as designated resource and structural enhancements, a cultural change is required to improve the return to training process consistently across the country.
- HEE propose making a resource available to all trainees who return to training to access a menu of options – such as refresher courses, coaching and supernumerary training status – to be agreed between a trainee and their educational supervisor as part of the trainee's individualised return to training package.
- Trainees will take a leading role in shaping HEE's Supported Return to Training (SuppoRTT) programme, and will be closely involved in its design, including the

[4] HEE Supported return to training https://www.hee.nhs.uk/sites/default/files/documents/Supported%20Return%20to%20Training.pdf

development of a menu of support available to returners and defining the generic and specialty-specific processes to follow. HEE are appointing trainee fellows to lead this process

Academy of Medical Royal Colleges Return to practice Guideline 2017

There is a lack of robust evidence as to the rate of attrition of skills and knowledge whilst away from clinical practice, however the AOMRC Guideline suggests any absence >3 months should result in a supported return to practice. This is in view of the understanding that skills drop off most in the first few months.

The AOMRC conducted a survey which highlighted 4 main concerns from doctors returning to clinical practice:

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

General Medical Council (GMC)

In 2014 the GMC published a literature review on how time out of practice affects skills, time and performance - 'Skills fade'[5]. This extensive review examined literature on doctors, other healthcare professions and other skilled professions. The conclusions were:

- With respect to doctors and other health professionals, this isn't a subject that has been extensively researched.
- In the wider literature, though, there is substantial evidence that time out of practice does impact on an individual's skills. Skills have been shown to decline over periods ranging from six to 18 months, according to a curve, with a steeper decline at the outset and a more gradual decline as time passes.
- Various factors, such as keeping in touch with peers and staying aware of developments, can mitigate skills fade. Further, the higher the level of learning and proficiency prior to any break from work, the higher the level of retained skill will be.
- There is evidence that self-assessment of competence doesn't necessarily match the findings of objective assessments.
- No consensus exists as to what time period out of practice ought to result in an assessment of competence.

[5] GMC literature review 'Skills fade' https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/research-and-insight-archive/skills-fade-literature-review

Royal College of Emergency Medicine (RCEM)

RCEM is in the process of developing a guideline on returning to practice in EM. The college does recognise the importance of sustainable careers. This is highlighted in their report '**Creating successful, satisfying and sustainable careers in EM**'[6] in which the college pledges to address issues of system design and appropriate resourcing to improve the working environment in the ED. The changing population of Emergency Medicine trainees means that there are increasing numbers of trainees taking time out for medical, personal or parental reasons[7]. Returning to work in emergency medicine after a period of absence presents challenges from clinical, leadership and communication perspectives: confidence in all these areas can be improved with appropriate focus, support and preparation.

[6] RCEM **Creating successful, satisfying and sustainable careers in EM**
https://www.rcem.ac.uk/docs/Workforce/Creating%20successful,%20satisfying,%20sustainable%20careers%20in%20Emergency%20Medicine.pdf

[7] British Journal of Hospital Medicine, September 2018, Vol 79, No 9

Unique to Emergency Medicine

Emergency Medicine is a stimulating, exciting and rewarding career but there is an acknowledgement that working in an Emergency Department is high pressured and challenging. This is with regards to time pressure - a rapid decision making environment and time-critical management decisions and interventions - and to high acuity illness and injury seen on a daily basis. This is paired with a high proportion of out-of-hours work and a significant emotional load. There is a wide scope of knowledge and skills expected of emergency doctors, including critical life support, airway, transfer and procedural skills. All these present challenges to supporting a doctor returning to clinical practice in EM. However, the Emergency Department has constant staffing and a strong approach to teamwork which should be used as an advantage in reintegrating an EM doctor to clinical practice.

Emergency Medicine is unusual among other medical specialities in not operating an 'on-call' system at trainee level. All shifts are 'on-call' essentially. Senior registrars are often expected to manage the Emergency Department overnight with remote supervision. Whilst other specialties suggest a phased return to clinical practice to not include on-calls, this is not applicable to EM with the exception of suggesting that during a phased return senior registrars are not expected to manage the department overnight.

There is a current chronic understaffing in most EDs in the UK. This may lead to pressure on a doctor returning to clinical practice to reintegrate to full clinical duties quickly in order to alleviate pressure on the department. This is not in the long-term best interest of the department or the doctor. It is recommended that to protect the doctor returning to clinical practice from this 'pressure to cope' an initial compulsory supernumerary period be utilised. This will need to be reviewed following a trial period - review date planned from April 2020.

In EM doctors are expected to have up-to-date expert skills in advanced life-support, trauma, paediatric life support, and (if applicable) airway skills. Following a prolonged time away from clinical practice it is sensible for doctors to refresh these skills in a learning environment prior to the resus room. This may be in the form of refresher / observer on ALS / APLS / ATLS, or in attending regional / departmental SIM / life-support training, or similar. Trainees should be encouraged to arrange appropriate training that best suits their learning needs. Their department should support them in allowing time (in supernumerary / SPA / study leave) for this refresher. It is suggested that this be mandatory.

Supported return to the ED including supernumerary shifts

The aim of a supported return to the ED is multifactorial. The trust aims to mitigate risk to patients and department by ensuring staff are appropriately up-to-date and competent. The Deanery, and HEE, aims to support trainees in their return to practice, improving confidence, facilitating training and reducing attrition. The trainee aims to improve both competence and confidence in order to provide safe patient care and develop as a doctor.

The Emergency Department is a high risk environment in which to work. A wide range of, often time critical, skills and knowledge is required. It is on this basis that EM doctors may well require more than the universal cross-speciality 3-day supernumerary period.

Summary of specific pressures of working in Emergency Medicine:

- High acuity workload: Severity of illness and complexity of patients
- High intensity environment: Potential reduced access to supervision and support
- Multiple undifferentiated presentations - greater time required to familiarise with key presentations
- Multiscope competencies: Wide spectrum across all subspecialities
- Time pressured decision making environment: Increased supported time to 'get up to speed'
- Multiple time critical skills (airway, life support, interventions) - often not time to 'call for help' - need to be up to speed prior to independent practice.

Individual needs & Review date

The individual needs of a trainee must remain the most important determinant of the rate & degree of support required during a phased return to clinical practice.

The deanery has agreed to support trainees in their application for funding based on the above suggestions and individual applications as a trial period to be reviewed in April 2020. The impact on trainees / departments will then be reassessed and the process adjusted accordingly.

Intermediate / HIgher tier EM trainees (ST3 - 6+, or equivalent)

We suggest the EM ST3+ returning to work would require 1 day supernumerary for each month out of clinical practice to enable safe reintegration and reskilling. It is recognised the need for supernumerary days will vary between individuals but it is stressed that this time should only be reduced in exceptional circumstances and only if both the doctor returning to training and their supervisor are both in agreement. These are given as guidance timeframes and may vary according to individual needs.

Entry tier EM doctors (ST1-2 or equivalent)

Entry tier EM doctors will also require supported reentry to clinical practice in EM. Although they work in the same environment as intermediate and higher level EM trainees there is less expectation for them to operate as independent practitioners. There is a pre-existing understanding that their patient care in the ED will be directly overseen by a senior doctor (registrar or consultant), including both decision-making and skills / interventions. Hence a doctor of this level returning to clinical practice already has good support mechanisms in place on the shop-floor. In view of this we would suggest application for a moderated supernumerary period a 1 day supernumerary for every 2 months out of clinical practice (with a minimum of 3 days supernumerary). It is also suggested that entry tier doctors do not be rota'd for night shifts for the first 2 weeks on rota after supernumerary period, or alternatively be doubled up on the rota. This is acknowledging that they may still be requiring increased support and that the reduced senior cover at night may be challenged to adequately provide this.

Foundation Year Doctors

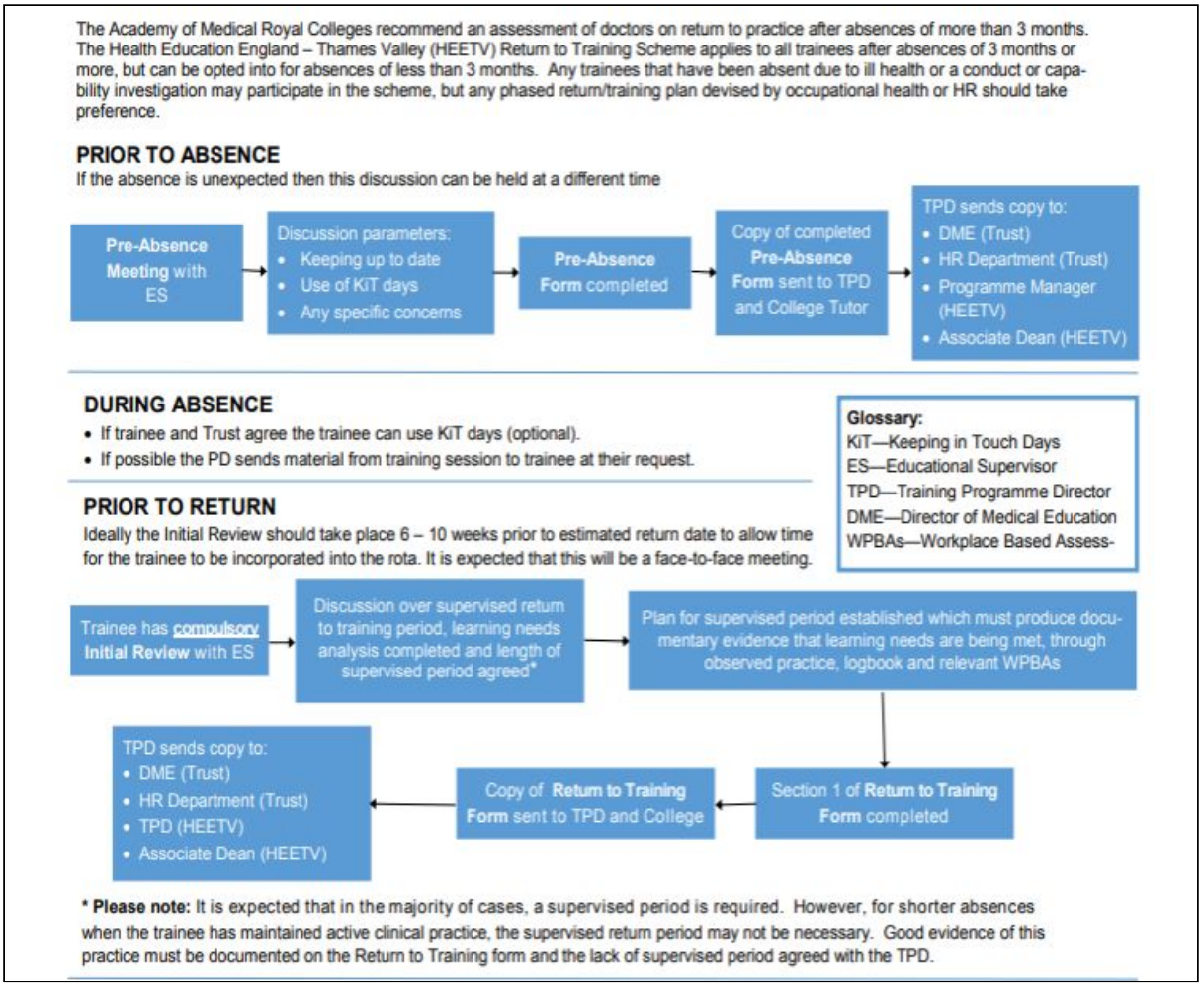
There is a developing return to practice guide for foundation doctors which should be adhered to as much as possible in their time in EM.

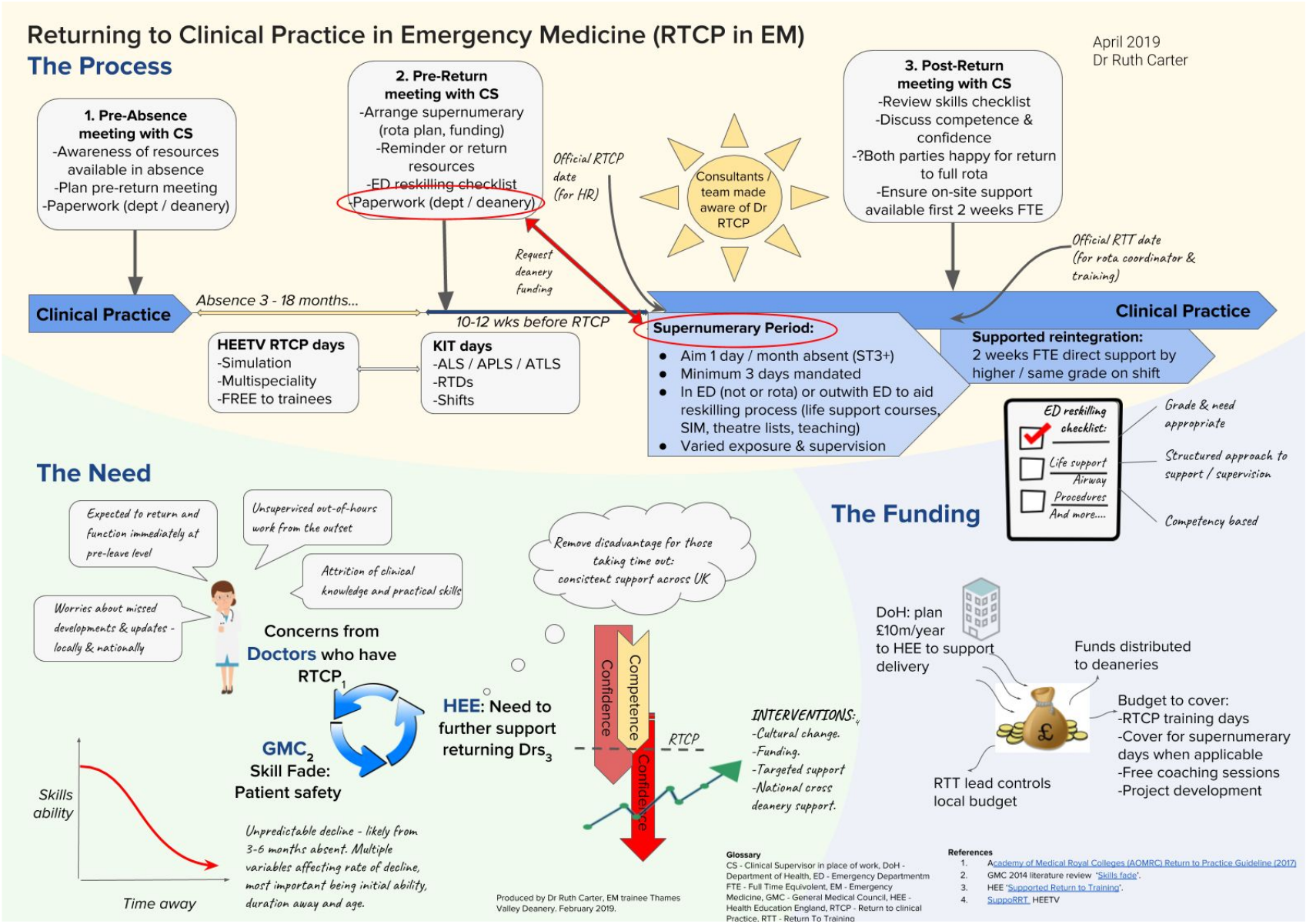
Funding

There is funding available to support trainees returning to clinical practice via HEETV & TV deanery. This is being used to support cross speciality training days, free to trainees, aimed at doctors returning to clinical practice. Trainees can also apply for funding to cover costs for a supernumerary period during a supported return to practice. This is specific to a trainee's needs and needs to be individually requested from srtt.tv@hee.nhs.uk. The funding is applied for and considered after completion of *pre-return to training* paperwork at the pre-return meeting. Forms available on the SuppoRRT website. The funding is transferred to the trainee's trust to finance additional cover whilst the trainee is supernumerary.

All TV deanery trainees are eligible to receive funding to cover 3 days supernumerary practice. Application for funding for further supernumerary cover - as would be suggested in the return to EM guidance - needs to be applied for on an individual basis with reasons given on the above forms. We strongly encourage EM trainees to do this. If funding is not secured from the deanery it is not the trust / department's responsibility to fund further supernumerary shifts.

Flowsheet from HEETV SuppoRRT:




Returning to Clinical Practice in Emergency Medicine (RTCP in EM)
April 2019
Dr Ruth Carter
The Process
1. Pre-Absence meeting with CS
-Awareness of resources available in absence
-Plan pre-return meeting
-Paperwork (dept / deanery)
2. Pre-Return meeting with CS
-Arrange supernumerary (rota plan, funding)
-Reminder or return resources
-ED reskilling checklist
-Paperwork (dept / deanery)
Official RTCP date (for HR)
Consultants / team made aware of Dr RTCP
3. Post-Return meeting with CS
-Review skills checklist
-Discuss competence & confidence
-?Both parties happy for return to full rota
-Ensure on-site support available first 2 weeks FTE
Official RTT date (for rota coordinator & training)
Request deanery funding
Clinical Practice
Absence 3 - 18 months...
10-12 wks before RTCP
Clinical Practice
HEETV RTCP days
-Simulation
-Multispeciality
-FREE to trainees
KIT days
-ALS / APLS / ATLS
-RTDs
-Shifts
Supernumerary Period:
Aim 1 day / month absent (ST3+)
Minimum 3 days mandated
In ED (not or rota) or outwith ED to aid reskilling process (life support courses, SIM, theatre lists, teaching)
Varied exposure & supervision
Supported reintegration:
2 weeks FTE direct support by higher / same grade on shift
ED reskilling checklist:
Life support
Airway
Procedures
And more....
Grade & need appropriate
Structured approach to support / supervision
Competency based
The Need
Expected to return and function immediately at pre-leave level
Unsupervised out-of-hours work from the outset
Attrition of clinical knowledge and practical skills
Worries about missed developments & updates - locally & nationally
Concerns from Doctors who have RTCP1
GMC2 Skill Fade: Patient safety
HEE: Need to further support returning Drs3
Skills ability
Time away
Unpredictable decline - likely from 3-6 months absent. Multiple variables affecting rate of decline, most important being initial ability, duration away and age.
Remove disadvantage for those taking time out: consistent support across UK
Confidence
Competence
Confidence
RTCP
INTERVENTIONS:
-Cultural change.
-Funding.
-Targeted support
-National cross deanery support.
The Funding
DoH: plan £10m/year to HEE to support delivery
Funds distributed to deaneries
Budget to cover:
-RTCP training days
-Cover for supernumerary days when applicable
-Free coaching sessions
-Project development
RTT lead controls local budget
Produced by Dr Ruth Carter, EM trainee Thames Valley Deanery. February 2019.
Glossary
CS - Clinical Supervisor in place of work, DoH - Department of Health, ED - Emergency Departmentm FTE - Full Time Equivolent, EM - Emergency Medicine, GMC - General Medical Council, HEE - Health Education England, RTCP - Return to clinical Practice. RTT - Return To Training
References
1. Academy of Medical Royal Colleges (AOMRC) Return to Practice Guideline (2017)
2. GMC 2014 literature review 'Skills fade'.
3. HEE 'Supported Return to Training'.
4. SuppoRRT HEETV

Process for EM Trainees returning to clinical practice

Pre-Absence meeting with Clinical Supervisor.

The purpose of this meeting is to ensure the trainee has information about resources available during absence including access to free return to training days. This can be found on the HEETV SuppoRRT website. It is also to complete paperwork and to highlight that trainee needs to arrange a pre-return meeting 10-12 weeks prior to return to clinical practice.

- ➢ Complete pre-absence form. Copy sent to TPD & Clinical tutor.
    - If likely to move trust whilst on maternity leave TPD needs to link with ongoing hospital & future CS.
- ➢ Discuss options for KIT days (including how to claim salary), courses to refresh skills, life support refreshers, plan for meeting prior to return (10-12 weeks prior to return).
- ➢ Make aware of SuppoRRT (website, contact details, free courses).
- ➢ Put in contact with EM rep for returning to clinical practice

During Absence

Trainee could consider the following options whilst out of clinical practice in order to aid skills retention & reintegration on return. These days are to reskill and therefore might be more beneficial towards the end rather than the start of an absence.

- ➢ Keeping in Touch (KIT) days. Days on shop floor / regional training days / national conferences. Your employer will pay for up to 10 days work during parental leave at normal daily pay rate without affecting maternity pay.
- ➢ HEETV training days (can also count as KIT days). No specific EM one at present but ICU / anaesthetics / medicine / paeds / cross speciality / core skills would all be applicable. They are free to TV trainees. Details are on the the HEETV SuppoRRT website.
- ➢ National RCEM return to clinical practice day (see RCEM.ac.uk for details)
- ➢ Life support courses prior to return - teaching / as a participant / as an observer.
- ➢ Regional training days

Pre-return meeting

Planned pre-return meeting with clinical supervisor (or equivalent) at 12-8 weeks prior to return to clinical practice, ideally in the department the trainee is planning on returning to work in. The purpose is to establish any concerns or needs the trainee or department might have regarding returning to work and form a strategy to help a safe and positive transition back into clinical practice.

- ➢ Complete learning needs summary and **pre-return form.** This needs to be returned to the deanery & TPD as it serves as funding application for the individual trainee.
- ➢ Reminder of pre-return resources available

- ➢ Reminder of 3 free coaching sessions available via TV deanery for trainees returning to clinical practice - access via the SuppoRRT website.
- ➢ Trainer to inform consultant body of trainee returning to clinical practice at return date.
- ➢ Plan for supernumerary period: See above for suggested number of days. It is recognised this will vary between individuals but it is stressed that this time should only be reduced in exceptional circumstances and if both the doctor returning to training and their supervisor are both in agreement. The timing of the pre-return meeting should allow for adequate rota planning. As detailed above, application can be made to the deanery for funding to cover the cost to the employer.
- ➢ The trainee's return to work date (ie day they start being paid from) will be their first day including the supported return. Their return to training date will be after the initial supernumerary period.
- ➢ The trainee may want to book onto training courses / theatre lists / SIM / life support refreshers during their supported return to clinical practice.
- ➢ Further 2 weeks (full time equivalent) with supervision on site (not remote via phone) - ie if on nights no expectation to run the department - senior / equivalent support on hand.

On return

Following a pre-return meeting the trainee should have a clear plan as to their supported return to clinical practice. The aim of this period is to refresh skills, competencies and knowledge in a safe environment that does not endanger patient care and helps to rebuild rather than further decrease the trainee's confidence.

- ➢ The first day of return should be non-clinical & in working hours to allow for re induction / orientation and completion of online training, allowing access to computer systems & HR documentation.
- ➢ Supernumerary period as above
    - ○ On the rota but clearly demarcated as supernumerary
    - ○ Should be at times when there is most senior cover to provide support, but can be flexible according to the trainee's own perceived needs.
    - ○ They should be allocated a buddy for each shift of higher / similar grade. This should not be the same person for all shifts
    - ○ Their area of work should be varied throughout the period (majors, resus, paeds, ambulatory, EAU) and focused on their perceived needs.
    - ○ The doctor may choose to spend some of these days out of the ED refreshing core skills (life support, airway, ultrasound etc)
    - ○ The doctor should keep a brief log of phased return to discuss with CS in secondary meeting,
- ➢ Use ED reskilling checklist (below) as a guide to focussed reskilling during this period.

Post-return meeting

The aim is to discuss and assess how the phased return has gone & if both parties are happy for the returning trainee to reintegrate into mainstream practice & responsibilities. Extension of the phased return period if needed, in discussion with the deanery. If both trainee and trainer are comfortable that the trainee is ready to return to clinical practice they will return to the full rota.

- ➢ For the 2 weeks (FTE) after return to normal shift pattern the doctor should have direct supervision on the shop floor should they require it. This does not include supervision by phone. If on nights during this period the doctor should have an equivalent or higher grade doctor to provide support if required. This may require doubling up, or delaying of night shifts until after this period.

Essential skills update

It is recognised that knowledge and skills attrition are variable according to many factors - the most important of which appear to be competence and ability prior to absence, duration of absence, and age. As such doctors will need variable amounts of support and skills refreshers. We suggest a skills list for refresher / supervision depending on baseline exposure. The following is a guideline but may need to be adapted according to the individual Dr's baseline experience level.

Certain critical skills and knowledge need to be instantly accessible and immediate supervision may not be possible - therefore formal refreshers on return to work are recommended. Otherwise skill / procedure supervision is suggested depending on pre-existing competence level, as detailed below.

It is suggested that all Drs refresh on critical skills (in bold) irrespective of overlearning prior to absence, if competency is grade appropriate. Otherwise aim for supported / supervised skills if able to independently perform prior to absence but not considered to be 'expert' in the procedure.

All critical skills should be refreshed during / prior to reentry to the ED rota. However the doctor returning to clinical practice may well not be able to complete the entire skills checklist prior to the end of their supernumerary period. It is then their responsibility to ask for supervision / support when they have opportunity to reskill as part of their ongoing clinical practice.

Suggest supervision for first 3 procedures if <10 performed prior to absence: (If both trainee and supervisor happy with competence can be reduced after first supervision)

Locum shifts

Whilst a doctor is participating in the supported return to work plan it is inappropriate for them to be simultaneously working extra shifts at locum rate. They may choose to reintroduce these when fully reintegrated into mainstream clinical work.

Responsibilities

Trainee	**Supervisor**
Engage with the supported return to training process	Engage with the supported return to training process as triggered by the trainee / department
Arrange meetings at the suggested intervals with CS / appropriate supervisor	Facilitate meetings as requested by the trainee
Complete deanery paperwork (on HEETV SuppoRRT website) & return to deanery - this will trigger access to funding for supernumerary return.	Review pre-absence & pre-return forms as provided by the trainee, discuss & support plan for return.
Be proactive in arranging opportunities to reskill	Make trainee aware of resources available prior to return to clinical practice. Highlight to consultant body the trainee is returning from absence and is undergoing a supported return to clinical practice as per protocol.
Be aware of reskilling needs, use checklist as a guide	Discuss anticipated needs on return. Discuss & facilite supernumerary period - make rota coordinator aware early
Be honest & responsible with acknowledging responsibilities to patients and departments: Ensuring they are practicing safely and raising concerns if needed	**Safeguard both trainee and patients in honest assessment of competence & consideration of extension of supported period if necessary.**

ED skills checklist on returning to clinical practice in EM

Refreshing skills will depend on the initial level of experience & duration of absence.

It is suggested that all doctors refresh on critical skills (in bold) irrespective of overlearning prior to absence, if competency is grade appropriate. Otherwise aim for supported / supervised skills if able to independently perform prior to absence but not considered to be 'expert' in the procedure.

Skill / competency	Required?	Performed / supervised 1	Performed / supervised 2	Performed / supervised 3
ILS				
ALS				
APLS				
ATLS / ETC				
Airway skills				
Intubation / ventilation				
Procedural Sedation				
Venepuncture				
Arterial line insertion				
Central line insertion				
Chest drain insertion				
Knee aspiration				
Nerve blocks				
Joint / fracture manipulation/ reduction				
DC cardioversion				
IO insertion				
Lumbar puncture				
Level 1 ultrasound				
Command & control				