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Decision making process and workplace experiences of Return to Practice AHPs with protected characteristics

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Executive Summary

This is a timely report as it meets the objectives of the NHS Work Force Plan (2023). Return to Practice enables talented AHPs back into the workforce. Return to Practice could and should make an increased contribution to this NHS Work Force Plan if its scope were to be extended and the recommendation of this research actioned.

Return to Practice needs to be seen as a potential work force solution that starts as soon as the AHP leave the workforce and or an AHP is unable to find employment. Whilst we acknowledge the small sample size the mixed methods approach does give some robustness to the findings What the report has uncovered is thar some AHPs have failed to be successful in gaining employment which means Return to Practice is their only hope of re-joining the register.

To date there are many barriers and challenges to enable the successful return of AHPs with protected characteristics back into the workforce. The community needs to be front and centre of Return to Practice making is fair, visible, and accessible. Investment in the programme will result in a speedier and fairer return to practice. However, to do this, returners need to have available to them access to funded placements, access to work support, fully funded full time childcare provisions and educators that welcome them back into the workforce.

The key to successful and sustainable Return to Practice for persons with protected characteristics is flexible working. Employers need to adopt an innovative problem-solving approach to the workforce solution that is fair and equitable regardless of the person's band. Return to Practice must be seen by managers and leaders as an opportunity to nurture and grow the workforce. There needs to be a reflection and or consultation as to whether self-assessment is a safe method of assessment for all returners in relation to the risk of skills fade.

Background

Significant National Health Service (NHS) workforce issues are impacting on the recruitment and retention of Allied Health Professionals (AHPs). In England there are 124 000 vacancies across the NHS (NHS Digital 2023). There are geographical variances with the highest percentage of full-time equivalent vacancies in London (10.9%) and the lowest in the Northeast and Yorkshire (6.1%). An NHS survey found that a fifth of NHS employees had thought about leaving their jobs with over a third of the NHS workforce planning to leave their employment by 2027 (NHS 2022, Weyman et al 2023). Similarly, a workforce survey of occupational therapists found that over a third of occupational therapists were planning to leave their role within the next two years (RCOT 2023).

There has been a negative trend regarding people wanting to work in the NHS. According to Weyman et al (2023), personal recommendations have decreased from 61% to 51% since 2021. A person's attitude towards working for the NHS is strongly associated with their intention to do so (Coombs et al 2007). Factors impacting on job satisfaction are staffing levels and increased workloads (Bimbong et al 2020, Weyman et al 2023). Indeed, a national workforce survey found that 63% of occupational therapists reported being too busy to provide the level of care that they would like to give (RCOT 2023).

New graduates into the Allied Health Professions are also difficult to retain, despite efforts to implement preceptorship, to support newly registered professionals. One in eighteen newly qualified persons left an Allied Health Profession during the first four years of practice. Although, there are notable differences between the professions. For example, 1 in 8 prosthetists and orthotists left the register whilst fewer paramedics left the register (HCPC Insight & Analytics Team 2023). This suggests that preceptorship as an intervention may not have a positive outcome on retention and or counterbalance factors such as staffing and workloads.

There is a complex interplay of factors that contribute to the retention of professional staff in the NHS. These factors may be different for professionals with protected characteristics as identified by the Equality Act (2010). There are nine protected characteristics namely age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation. The Equality Act legally protects professionals with these characteristics from discrimination and harassment. Nevertheless, there are visible inequalities within the NHS related to protected characteristics and carers are only protected by association with someone who is protected by the Act. And yet, a considerable number of NHS employees are unpaid carers (NHS Survey 2022). Unfortunately, there is a paucity of research on the recruitment and retention of staff with protected characteristics. There is even less data on carers as hitherto there has been no requirement to collect data on carers. However, a paper published by the NHS Assembly, 'The NHS in England at 75: priorities for the future' (2023) recognises the role of unpaid carers as essential partners in the future of the NHS. It upholds the need to create inclusive environments for those who are traditionally marginalised. The paper goes on to state that staff need to consider whether changes to their practice will improve patient and carer experiences noting an inability to tackle workforce inequality without promoting safety and inclusivity. There is clearly a need to consider the lived experiences of professionals with protected characteristics, direct or by association as data suggests that workers with protected characteristics can encounter discrimination. For example, a worker with a disability may not be confident to report it and or disclose such information in surveys.

The NHS People Plan (2019) acknowledges that, as an employer, the NHS must be fair, inclusive, and compassionate. Yet, the NHS has been accused of not actioning reasonable adjustment recommendations to enable professionals to remain in the

workforce (Hemmings et al 2022). Black and Minority Ethnic staff are more likely than other staff to experience harassment, bullying or abuse and enter a formal disciplinary process (NHS England 2022). Pay inequalities exist between different ethnic groups. There are religious inequalities too with Sikhs, Muslims, and Hindus less likely to be shortlisted or appointed from a shortlist (Hemmings et al 2021).

In the NHS there is a pay disparity between men and women. Data found in around nine out of 10 NHS organisations the median hourly pay gap favoured men within most ethnic groups, to a sum equivalent to £207 per month. The gender pay gap within the highest pay bands in the NHS also favoured men, with an even wider pay gap experienced by women in older age groups. (Appleby and Schlepper 2019).

There is concern that existing recruitment and retention strategies are not having a positive impact on workforce retention and recruitment. (Health and Social Care Committee 2021). Current strategies to address workforce issues include international recruitment, changing the skill mix of staff and changes to work roles. Workforce re-entry strategies include Return to Work Programmes for AHPs. These are known as 'Return to Practice' programmes and have the aim of enabling AHPs who are no longer registered by the regulator to re-engage with their professions, re-register with the Health and Care Professions Council (HCPC) and hopefully gain employment. A person who has been out of practice for more than two years is required to undergo a Return to Practice programme (National Health Service Employers 2022). Data from a Return to Practice evaluation found that 37% had been away for between 5 and 10 years and a further 44% had been away from practice for over ten years (Thom et al 2019)

Return to practice programmes are flexible in that they allow returners to manage their own process which means that can have work-life balance, consider childcare as well as adopt diverse working styles. AHPs can design their own personalised programme too. This may include supervised practice and or formal study and or private study. In the UK there are two fully funded AHP return to practice courses available from Coventry and Birmingham City universities, both of which are geographically located in the Midlands. Not all returnees register for these courses but rather, design their own bespoke programme.

A systematic review of return to practice found limited research specific to AHPs returning to practice (Campbell et al 2019). More than half of the studies (15/28) focussed on return to practice of doctors. A rapid review by Edward et al (2022) included pharmacists within the review who are not one of the fourteen AHPs an failed to comment on equality and diversity issues and or that the evidence for Return to Practice was not UK focused.

To date the need to ensure diversity, inclusion and belonging is legalised for persons with a protected characteristic but it does not directly protect carers (Equality Act 2010). We are aware that many AHPs are carers, and our approach is one of inclusion not exclusion as an intersectionality approach allows us to capture a more person-centred understanding of the nuances of protected characteristics. This means we can have a more in depth understanding of

compounding factors intrinsic to decision making and the lived experience of the return to practice process.

The aim of this study is to ascertain the decision-making process of persons with protected characteristics, who are eligible to be registered by the HCPC or who register to return to practice; and to understand the barriers and enablers that facilitate the decision to return to the workforce.

Ethical Approval for this Study was obtained from London South Bank University.

Methodology

This was a mixed methods study within an overarching qualitative paradigm that used interviews and focus groups. This is referred to as intra-paradigm research as, both aspects of the study are drawn from within the same paradigm (O'Reilly et al 2022). We analysed each set of data independently without reference to each other. We did two separate analyses which were then combined to answer our research question.

Co-production

The focus of this project was co designed and co-managed by two return to practice AHPs with intersecting protected characteristics. The views of AHPs with lived experience shaped and influenced the inclusion of carers, who are protected by association, as well as the drive for the lived experience to be front and centre of this research proposal. We also held an online webinar to discuss some of the issues around protected characteristics and the workplace to help with community looping. We conducted 2 pilot interviews which allowed us to modify some of the prompts used in the interview.

Critical Incident Process

The critical incident technique (CIT) is a systematic procedure for obtaining rich, qualitative information about significant incidents which in turn helps researchers understand the critical requirements for individuals, processes, or systems. In this instance the significant incident was return to practice with a specific focus on AHPs with a protected characteristic. The critical incident approach (Flanagan 1954) is unique in that the focus is on obtaining a rich description from AHPs as to events and actions that influenced their return to practice decision making. Flanagan advocated five steps: (1) determine the general aim of the activity; (2) develop plans and specifications for collecting factual incidents regarding the activity; (3) collect the data (either through interview or written up by the observer); (4) analyse, as objectively as possible, and (5) interpret and report on the requirements.

General Aims

We aimed to explore the decision-making process of AHPs with protected characteristics, either direct or by association, who were eligible to be registered by the HCPC, who register to return to practice; and to understand the barriers and enablers that facilitate the decision to return to the workforce.

Develop Plans and Specifications

Health Education England acted as a gate keeper to recruit participants and posted the research poster on their share drive and Return to Practice closed face book page. If a Return to Practice was interested in the study, they were then asked to email the principal investigator. In total 16 AHPs contacted the researcher of which 12 agreed to participate in the study, From the 12 AHPs 5 were occupational therapists, 2 were Speech and Language Therapists, 3 Physiotherapists, 1 Paramedic, 1 radiographer.

Inclusion Criteria

1. AHPs with protected characteristics, either direct or & by association, who are in the process of returning to practice
2. AHPs with protected characteristics, either direct or & by association, who have retuned back to practice
3. Previous HCPC registrants with protected characteristics, either direct or & by association, who are currently not registered with the HCPC but are considering returning to practice.

Participants received written information and a consent form electronically before the interview which were returned to the researchers.

Data Collection

During the interview we used probing questions to help us understand more how decisions were made and or barriers and enables that were encountered during the decision-making process. In our study we asked for situations and examples of good and bad practices in relation to retaining the AHP prior to leaving; decision making activities as regards not returning to practice; decisions related to return to practice (what were the motivating factors); And barriers and enables for return to practice related to their protected characteristic.

Data Analysis

Inductive analysis was used to analyse critical incident data using Strauss and Corbin's (1998) description. Indictive data analysis enables researchers to explore multiple perspectives and viewpoints as well as to discover themes that may not have been considered initially. To achieve this aim, we used the constant comparative method. As soon as one interview was completed, we compared and contrasted thoughts and reflections from the data. As patterns started to emerge,

we began the process of data filing. This is the process of categorising and coding as well and examining and comparing data. After which we began the process of axial coding in which we tried to make connections between codes as well as relating it to other categories. From the categories the themes started to emerge

Focus Groups

Focus groups enable researchers to gain a rich understanding of the perspectives of a particular group of people by capitalising on the interaction that occurs within the group setting (Côté-Arsenault and Morrison-Beedy 2005). Online focus groups enable inclusivity since they remove barriers to travel and are cost effective both in relation to finance and time (Reid and Reid 2005). Online focus groups allowed us to recruit from wide geographical areas which allowed us to gain a UK wide view of Return to practice, As the focus group may discuss sensitive topics, we had two facilitators and an observer. To ensure psychological safety of participants post focus group support was available and offered. All focus groups were held over Microsoft Teams and were recorded with consent to enable transcription of focus group discussions.

In total 4 focus groups were scheduled but we could only recruit to 2 of them. Returners who agree to be interviewed were asked to self-select as to whether they would participate in focus groups. We also invited return to practice leads and or work force leads via social media. Focus groups occurred via teams and were recorded. The aim of the focus groups was to explore themes from the critical incident interviews. The topic guide focused on key themes that emerged from the critical incident interview.

Analysis

Template Analysis is not inextricably bound to any one epistemology; rather, it can be used in qualitative psychology research from a range of epistemological positions. We used template analysis to analyse the data generated from the focus groups. We formulate the prior themes template using the findings from the individual interviews. This approach is flexible, and we added additional themes to the template after reflecting on focus groups and re reading the transcripts. We then modified the data and then applied it to the focus groups transcripts.

Findings from interviews

Decision to Leave Practice

Participants decided to leave practice/not practice due to ill health and life events (HA), service closures(JB, R), reasons associated with maternity leave (JM) and child care (JB, R, ET, KB) with no financial incentives to remain in work due to the costs of child care (KB), a lack of flexible working with no availability of term time &

school hours only contracts (ET), and the demands of caring for child with SEND(JB).

Decision to Return to Practice.

There were two types of returners.

1. Returners with experience of working in health and social care.
2. Returners who were registered with the HCPC but had never secured employment in the UK (JL, C, SB)

Two out of the three AHPs who had never secured employment in the UK were overseas recruits and HCPC registered; whilst one AHP who had never obtained employment was trained in the UK. All three AHPs used the return to practice programme to re-energise their career.

No Work Available

Despite huge workforce shortages in the NHS some Return to Practice AHPs could not obtain employment in their professional field

> *'It's hard to get into the NHS. I am still a nursing assistant. Could not get a post. I went for apprenticeship post- they told me I was not eligible and then told me about Return to Practice'* (SB)

> *'I am a very unusual case, I studied occupational therapy at university in South Korea. I moved to here in 2011 and I was registered with HCPC in 2016. I sometimes consider myself as returning to practice OT and or sometimes as an international OT. I don't know. But I could not find work at the time. Then I found out I was having a baby, so I put my family as my priority. My boy is now six years old and now I'm Returning to Practice. I never had experience in the UK and or in the NHS*.' (C)

One Physiotherapist, who was UK, trained could not find a HCPC role and or assistant role after moving to a different part of the UK. What was evident was the lack of networks to help her. In 2021 she was offered Band 3 post after 9 years. The rationale being is that she did not have the needed experience for a Band 5 post (JW)

Factors influencing Decision Making after a Career Break

There were mixed experiences, hopes and expectations that influenced participants decisions to return to practice.

Mixed emotions

For one participant, the failure to RETURN TO PRACTICE was related to contextual & social factors plus a lack of knowledge regarding the expectations of return to practice.

> '*My first attempt at return to practice, I had been very unwell. My son was in nursery but coincided with daughter being unwell. I sort of bumbled along for a little while, shuffling paperwork and not really knowing what to do. And then things got more complicated at home, and I realised I just had to stop doing that for a while. I left my husband and then decided to start again. It was very difficult to find a place when someone that could facilitate my return to practice hours' (R)*

One AHP was looking forward to becoming part of the NHS community and was excited by the prospects of returning to practice.

> *'Looking forward to contributing to the NHS again or contributing to health or whatever shape that may be. It excites me to know that I'll be part of that machine again.'* (JW)

Only one AHP reported that they missed patient contact (HA).

Pragmatism

In contrast other AHPs were coming back to practice for pragmatic reasons such as finance (KB, ET, V)

> '*My husband said to me, maybe you should think about going back to work now. My oldest son will be going to university in about a year. And from talking to friends the cost really kind of scared me and my husband. And I'm like, where's this extra money coming from*?' (V)

For another AHP the pressures influencing return to practice were both financial and childcare focused.

> *'Surrounded by a lot of people who to return to practice, who have been in the very lovely position of being able to have five or ten years off with their kids and not have to work. And they're coming back because they haven't got anything else to do and their kids have grown up. I'm not in that position unfortunately, so I must work. There is a constant balancing act'* (ET)

For one AHP she used the opportunity '*getting her foot in the door*' to gain experience and be supported to Return to Practice. She got '*stuck in'* It was an opportunity for her to extend networks as well as to understand the required experience needed for a Band 5 post such as on call. However, this was only after the trust agreed to support her and more importantly for her was the motivation to wear a '*blue unform*.' (JW)

Shadowing

For other AHPs it was a mixture of conversation with friends and shadowing that facilitated the decision to return

> ‘*The shadowing that I did was the best thing because it made me realise that I wanted to do it.’ (ET).*

For another AHP who was looking for another career the shadowing convinced her to return

> ‘Kids grown up and just wanted to do something ‘*Was looking at brand new degree but not sure if it was worth the investment*.’(N).

Identity

In contrast another AHPs decision to return to practice focused on regaining her own identity

> ‘*So really what happened to bring me back was I just though Oh my God this is my life with him. This is my life now. There's no me left. I'm not doing any of the leisure things I used to do, like going to the gym, going canoeing, or the wine club’* (J)

Pandemic

The pandemic also influenced decision making and the opening of a temporary register.

> ‘*I’ve been wanting to do it ever since I was deregistered. I have made several attempts. When I heard about the COVID register, I put myself on that thinking that maybe I could pick up the odd shift. but I had not worked on wards’ (R)*

> *‘Well, it was during the pandemic I thought. Oh well, I could probably do a few hours here and there’* (HA)

Barriers and Enables of Returning to Practice

It's not retraining. It's refreshing your knowledge (JW)

There was confusion as to the roles and responsibilities of a return to practice AHP

> *‘I don't know what I am. What I would call myself because I can't call myself a student, but sort of a trainee. That was the biggest hurdle.*’ (P)

Due to the lack of clarity surrounding roles there was some frustration in relation to the teaching and supervision that occurred in practice. Issues were raised about the lack of structure (JB, C, R, EW) and the facts Returnees had to chase for AHPs to sign notes and or to discuss issues on placement (C). Another returnee was no aware of how much autonomy she had (P). There was also a view that you don't want to appear '*clueless'* particularly if you may apply for a job in the trust (V). One AHP was grateful that her supervisor was not '*breathing down her neck* but perceived she needed to see more patients as she was too slow (ET). Another returner perceived supervisors did not understand how to supervise returners.

> '*So, my manager let me join in with them. There is a lack of insight about people who are returning to practice because they don't have any former training*.'

One AHP perceived that she was not welcome on placement.

> *This had been sprung on her and she was very clear she did not want to take part in this, but she had been told she should*.' (EW)

One AHP could not achieve her goals as she '*can't really just follow them around because I'm not even a student.*' (SW). For the returner with no knowledge of health and social care there was a disconnect between online learning and application in the real world

> 'It's all online, they give us a supervisor and then they have case studies. I get stuck when I don't know how to answer things I haven't seen.' (SW)

One AHP perceived that the 60 days was not needed, and she could have returned after 30 (V). Another AHP perceived that the online learning material could be done in half the time allocated to each activity (HB). IN contrast one AHP managed to complete her hours within a year after securing a Band 3 post (JW)

Varied experiences of Return to Practice programme

The experience of registering for a programme varied.

> *'Yes, it took a while. I did find this out by myself, but I also phoned up. I read the Royal College website and then I called and spoke to somebody at the college and he kind of went through stuff with me. And then, like I said, I emailed the lady at Birmingham City. She emailed me right back.'(JB)*

> *'And the only thing that took a while was getting registered on the course. I had done, everything I had to do. I was just literally waiting for somebody to click the button to accept me. I did have to phone about four times to see what's going on,' (V)*

Information about the requirements of what was needed was perceived by one AHP to be not clear but acknowledged '*it is meant to be quite broad'* (JM). There was a

lack of understanding from the course provider on contextual issues associated with pensions and benefits (NHS England)

> '*Yeah, but it would only be six weeks full time. Would that not average itself out? And I said, I cannot physically work full time. And if I work over 16 hours it would totally mess my benefits and pension*.' (HA)

It's not what you know- it's who you know

AHPs used existing friends and networks to help with supervised placements (JB, JW, V). For one AHP her old boss was still in the trust which made the whole process more manageable (ET). AHPs with no networks found placement opportunities difficult to find (C, JW) another felt detached from friends from work (R). One AHP had not kept in touch with her profession which she left 9 years ago (JM)Findings a placement was viewed as *'potluck*' (HA) whilst another commented on the wait just to find a placement (SB). One AHP suggested that there should be a central list of placements that were available for Return to Practice (EW).

Flexibility

What attracted Return to Practice AHPs was the flexibility of the programme and that it was online (JM, JB) which gave AHP control and autonomy. This flexibility fitted into the busy schedules usually around family and childcare. Employers were more likely to be flexible on honorary contracts and if no costs were incurred. One AHP was working Bank as she wanted the flexibility which was not available via her employer (J),

> *'I said I could only do one day a week and they were quite happy with that. They're happy for me to have an honorary contract as it is not costing them anything.'' (ET)*

There was also the view that flexibility was good for patients.

> '*I think for a lot of patients would find evenings appealing, people work as well. I would like to hope the NHS is recognising that not just from the professional side, but also from the patient side*.' (JW)

For disabled AHPs there are additional environmental factors that mean flexibility is needed in relation to transport to work and or placement

> '*You can't use your disabled bus pass till after 9:30. So if you want to work and you are disabled, you can't use your bus pass. You must pay. Coming back will be alright. However, if there's more than one disabled person on the bus, like a wheelchair user, I can't use that bus.*' (HA)

Equity

Inequitable support mechanisms and experiences

One AHP perceived that Return to Practice was isolating and '*a bit overwhelming* (KB, JW). Self-management strategies included to overcome isolation and sense of disconnect included WhatsApp groups of friends (JW, V). Another AHP has paired up with another returnee and are supporting each other (JW) whilst other joined online communities or action learning sets (ET).

> *'I'm using my OT skills all the time. A big part of my getting better has been being in an online community of other people with the same conditions.' (R)*

> *'I joined Twitter because I'm very isolated, very out of date on things. I suddenly realised there was a community out there. I've been in contact with some of my old colleagues and friends and we're still supportive of one another.' (JB)*

> *'So, without that actual learning set group, I'm not sure I would have carried on. There were moments when I thought this is just impossible.'* (ET)

Some returners complimented the team in practice for their support (ET, P). Other returners emphasised difficulty in relation to balancing family responsibility and the importance of support from partners (V, C, P, JW). Other AHPs had to balance childcare without any support (JB, R,). One AHP was only able to do one day a week as she needed the money via child minding business (EC), another was working as a nursing assistant (SB). One AHP was offered a paid placement, but the placement team were disorganised which frustrated the returnee (R).

> *I am only doing one day a week at the hospital, so it's going to take me quite a long time. I'm halfway through now, I'd be able to do more than one day a week. I might have finished it (ET)*

Costs

Barriers to placement and or study were related to the fact that AHPs could not claim full time nursery fees unless they were in full time employment (EW, R, KB, SB).

> *It's more of the time when you have a family and juggling it with the work and juggling it with doing placement. That's the that's a difficult part of it (SB)*

There were significant financial costs related to childcare and costs associated with living which prevented AHPs from completing Return to Practice in a timelier manner.

‘*Only doing 1 day a week as need money via child minding business, otherwise I would have completed much quicker. So, it's going to take me quite a long time. I'm halfway through now. If I had been able to do more than one day a week, I might have finished it’* (ET)

‘*Placement is not paid so still having to work as nursing assistant.’ (SB)*

One AHP was offered a paid placement, but the placement team were unorganised which frustrated the returnee (R).

I am only doing one day a week at the hospital, so it's going to take me quite a long time. I'm halfway through now, I’d be able to do more than one day a week. I might have finished it (ET)

Work was available that she was desperate for people's interview for… we will pay you … Because she'd say, yes, this is amazing. And then she'd disappear. And I didn't have very many contact details for her (R)

The returner was working as a nursing assistant found it difficult to switch roles.

‘*That's the difficult part because I'm working as a nursing assistant and then I have to think as an OT’* (SW)

An AHP, who was a carer highlighted the impact of financial sanctions on claimants.

‘*Completely isolated, run down, blamed. Living in poverty on benefits and you always live in fear that you might be sanctioned and so on. Having gone from Band 7 OT to assistant OT. I have been sanctioned and threatened by security at the unemployment Benefits Office. My self-esteem and confidence just went. Then they said to me you can work in physical now. I said, I’m not very good on physical. I really am not.’* (JS)

There was also concern about inequalities in relation to accessing the CPD fund. Some AHPs went over the allocated funds, others were concerned about sanctions and or simply did not have the funds to pay upfront so did not use the available monies. Some AHPs found the system of reclaiming money to be too complex.

‘*Not easy to get money back from CPD allowance. It was a four or five stage process to get that money back*.’ (R)

Direct Discrimination

Flexibility into employment was viewed as important by most AHPs but it was not always offered and or asked for (JB)

> *'I can see from the employees' point of view that it's not easy to employ somebody part time, but it's not easy for me to work full time.' (P)*

> *'I kind of know that you are allowed to ask for the flexible working. I don't really know in what scope, and I don't know anything about what you are entitled to'* (R)

> *'I don't think I would feel comfortable asking for (special seating) if I was just going in as a placement'(V)*

Some employees appeared to understand and value the importance of flexibility in the workforce.

> *'I've already mentioned to her that I only wanted to work three days a week and would that be an issue? And she's basically like, we'll take anything we can get. So no, it's not an issue.' (V)*

Some AHPs were clear what they wanted in relation to workforce hours.

> *'I'm going in there with an agenda too. I'll be quite happy to stick to my agenda and I will be open to ideas. But equally is that agenda is not met then this isn't for me.'(JW)*

> *'I want to work as a band six and three days a week, because then I can manage holidays.'* (ET)

One AHP who was not afraid to ask for modifications needs were not met.

> *'I've spoken to them and they're like, it's a six-week training course. I was like, OK, so do you offer that part time? What? You don't offer it part time, I said. You're offering part time jobs. but the training isn't offered part time. I then spoke to a mentor on my course. He worked somewhere completely different in the country. He said I've known people that have done the course part time like 16 hours a week or done it just at the weekends... He said it's whether the service decide that they want to deliver it part time. I can't do a placement that would be of benefit to me, and I can't get a job with you because you won't make a reasonable adaption to provide the training part time.'* (HA)

Similar one AHP was acutely aware of her own physical limitation and knew how her own capabilities which influenced were she would work (J).

Exclusion

Return to Practice AHPs were excluded from local courses available to local AHPs (C, JB). AHPs, particularly those who trained abroad and who had not worked in the NHS spoke of exclusion.

> *'I want to be in that meeting. I'm less confident about MDT meeting because in South Korea I used to work with Physio but not doctors, nurses and speech and language therapists. We have an MDT meeting every Wednesday and I have never been in the meeting. English is not my first language. I have a different culture background. When I work with nursing staff, I am more comfortable and confident because there are a lot of international nurses.' (C)*

Mental and Physical Health

The employers did not ask about occupational health needs of Return to Practice AHPs. Health issues could make return to practice 'trickier'.

> *'So, I've got my new hearing aid. I miss things. And obviously, although you can have text on a phone if it's moving quickly, it's hard to focus because it's so small and my computer's not set up and I can't get access to work (JB).*

For another AHP return to practice and or work was dependent on factors that she could not control

> *'I can't turn up at 8:00 o'clock. I can only turn up about 9.30, depending on what time the carers can come. Well, to be honest, being disabled is a bit of a daily challenge. It is a fight.'* (HA)

> 'I did 2 very short days because that's what I could fit in around my home balance, my home, work life balance.' (P)

One AHP discussed the menopause and its effect on work.

> *'Menopause, you know, it affects your sleep, and you can get early morning wakening.' (C)*

Another AHP *was concerned about the physical demands of her role.*

> '*You've got to do so many hours before you can go back. And I was thinking that meant I'd have to go back physically on an ambulance to do the hours. I was thinking, well, I can't do that. And then realised that, oh, if I could do it all the 100% online, then that must mean that I don't have physically go back onto an ambulance'* (HA)

Another AHP commented on issues with her back.

> *'I do have some back issues. So that is slightly worrying, and you know carrying and all the equipment around again. They are they doing things a lot differently nowadays.*' (V

Skills Fade

Some returners were clear as to what skills they need to develop and or observe and that the process was about 'learning what's changed' (HA)

> '*I have not done quite a lot of stuff in 16 years. So, for example, I haven't done a speech sound assessment for a child in at least 16 years'* (V)

Another returner perceived that supervisor(s) did not have time to help them with skills development.

> *'There's not always the opportunity to go through things obviously at the end of the day'(P)*

Most of the AHP perceived the biggest skills they were lacking was confidence.

> *'I don't feel fully confident to return to practice yet because sometimes I feel overwhelmed by new environment and new things. '*

Age was viewed as a factor that impacted on learning. One AHP perceived that young people learn quicker (P) whilst another noticed she was more tired (JM)

> *'I think approaching that sort of time of your life where your brain's quite full of stuff, isn't it? Your thirst for learnings is not what it was. When you're in your late 20s, early 30s you're really sort of driven to advance your career.'(C)*

The learning most returners found most difficult was not associated with clinical skills but technology such as computers. One returner even suggested a manual '*laptop for dummies*.' (R). On a positive note, one returner was able to support junior AHPs and offer reassurance and confidence (J).

There were concerns about applying for jobs from all the AHPs who participated in this research study. One AHP stated she was *'Overwhelmed. So, I think I'm not ready to apply for a job'* (C). In contrast one AHP used her experience as a Band 3 to practice interview questions with other Band 5s. She realised she had an advantage as she was known to the trust (JW).

> *'Probably getting a job and going for an interview if I'm honest. That's probably the scariest bit of it. 2008 was my last interview because I stayed in my last job for about 7 years.' (JM)*

> *'I'm in my 50s and I'm going to be competing against graduates fresh out of university. They are fresh in terms of their theory and knowledge and current experience.' (C)*

> *If you didn't say the keyword, you won't get the points. And they know that I don't have the experience here, but they're not flexible. Then she said the one who got the job is a gym instructor. I applied twice for an OT assistant*

post. For some reason, I didn't get it. I applied for every single vacancy. I still can't get it." (SW)

Findings from focus groups

Return to Practice. Its Hazy

In both focus groups there is limited clarity as to the role of supervisors in relation to assessment of competence. There was also a view that supervisors were used to supervising students but not Return to Practice AHPs

'*Generally, AHPs are the type who will not want to go into practice if you don't feel that you know what you're doing, I felt that I didn't have a clue what I was doing or didn't know how to do the assessment, I would say that I was not fit to go back myself*' (V0)

'I think if you're having an assessment, it might cause a load of anxiety and stop people from even doing the course and returning to practice' (B)

'If *you're used to doing something, you become more confident and competent. I don't think our staff are confident to be supervised for returners to practice because I don't think they do it often enough. I would agree with what everybody else has said. I think I think that's a definite issue. I don't think the supervisors feel confident in that role, which can have a knock-on effect to the person undergoing that return to practice experience.'* (JG FG2)

*'So, I think people are understanding that they are working at an assistant role. But they also need to be doing more of what a Band 5 would be doing. They need to understand that they're not assessing competency, but they are supporting with confidence building and somebody's self-declaration or competency. It is quite hazy. We have had teams who have refused to sign off objectives because they're saying that they are based around competencies, and they don't want to sign the competencies off.' (*FG2 RG)

There was a view that AHPs could self-assess their own competences but one AHP perceived there should be a baseline of what '*you should know to do your job, to be competent in your job'* (FG1, AB)

I *don't even know what to call myself (FG2, BJ)*

There was also a view that Return to Practice Supervisors and or AHPs did not know their role in professional practice.

> ‘*Sometimes the feel like they're in the student role. You're not a student. You were qualified occupational therapies. You've got all this knowledge and experience. And then sometimes the supervisor would treat them like a student*.’ (FG2, AK

It was perceived that placement could spend time getting to know the student first and adopting a strengths-based approach and adopt an approach that was focused on reciprocity.

> *‘I'm just about to start a placement I've been to meet them a couple of times and it's a GP surgery and they said, well, oh right, you've got these skills. Oh, brilliant and we can learn from you about, telephone triage. And I thought that was quite a good introduction. They saw me as being an asset rather than a student or somebody to teach. So, I think it's going to be quite a positive placement from the way they seem to be talking about it.’* (FG2 HA)

Who knows about Return to Practice?

In FG1 there was view and agreement about the role of a student and a returner

> *‘When you know that you have the experience, you know what to do. You're not a student. As a student that you need to prove to them that you can do it’*. (FG1 SW)

> *So, what am I? Am I an associate OT? Am I an OT? Am I a student? I don't know what I am because there's no category* (FG1 B)

Likewise in Focus Group 2 there was a view that no one really knew and or understood Return to Practice. Consequently, numbers accessing the programme were low (FG2, RG)

> ‘*We've had to have meetings with managers around the return to practice process because no one knows anything about it’* (FG2, RG)

One participant was aware that it was not always known who the return to practice lead in the trust and they were acutely aware of the need for better sign posting (FG2 BJ) Strategies used to promote Return to Practice include money from ICBs to promote Return to Practice in local newspaper and media which was not successful. A strategy perceived may be useful would be a multifaceted approach which would include access to schools and more assistance form regional teams (FG2, JL). Other strategies including adverts in libraries, pharmacist, and places where there was high public footfall. All these strategies were viewed as

unsuccessful and queried whether cost effective. A potential: solution from a participant was to advertise on GP websites which are accessible by most of the public (FG2 HB)

Paid or unpaid placement

In focus group one there was a view that placement should be paid however one AHP perceived that this would not be plausible for persons on benefits (FG1 B). Another participant perceiving it may be more difficult to find a placement if they had to pay you as well (FG1 VO) whilst another participant perceived that returners were 'as cheap pair of pants' (FG1 AM)

> *'When I first phoned up, she was clear I wouldn't be paid. I would have loved to have been paid at least at an assistant level. I'm probably only going to do three days a week. It's going to mean 10 to 12 weeks with no money to be able to do it*.' (FG1 VO)

In FG2 that Return to Practice AHPs perceived they should be asked their preference. If there was no vacancy in area of interest and whether they wanted a paid placement (FG1 JB)

> *'We've lost somebody who said that there were happy with her honorary contract placement. They then pulled out last minute when they said no, I can't afford it right now. And so, we've lost a returnee (FG1 JB)*

Return to Practice advertisements attracted international recruits who have HCPC registration but also Returners who have not worked in the UK as an AHP

> *'We get a lot of applicants who got their qualification abroad and have have never worked in the NHS. I'm struggling to get their HCPC registration. We also have people who are internationally trained, haven't worked for 10 years, are in this country as rehab assistance and must register through the international recruitment process. But they have also been not practicing their profession for 10 years. So, we have struggled. We have quite a few different groups of people applying for a return to practice process. There's lots more people out there that don't necessarily fit within that sort of stream (FG2, RG).*

Another participant agreed with RG views.

> *'I've come across people who apply for return to practice, have never worked but who qualified in the UK. And the longer it goes on, the less confidence*

they become. They're the ones that I've come into contact mostly… people who've never actually practiced their profession.' (FG2, AK)

Another participation perceived mentorship may help with language issues (FG2, BJ). Another participant perceived that we had a responsibility to be '*compassionate and to nurture each other'* (FG2, AH)

Flexibility – 'Just words in an advert' (FG2, JG)

Flexibility was acknowledged to be important but, this was not always actioned.

'*Have one great example of a job advert that was saying about how they're flexible. How they're a great place to work for families etc. They offer part time working and there's a little clause that you must be able to work six weeks full time to start with. I thought, well, that's not very flexible*.' (FG2, AH)

'*It's one thing advertising part time, flexible working but the reality is, I think all our band fives are full time. It's still very much the band 5 the juniors… They're usually the younger members of staff and then it's still sort of follows that sort of hierarch. I'm not saying it should, but that's just seems to be the way that I've observed it*.' (FG2, RG)

'Flexibility it's not as commonplace as perhaps I think it should be. There are obviously policies drivers behind all those things that you see in adverts. It's a real shame when it's just words that's in that advert and it's not followed through with actions and conversations.' (FG2, JG)

One participant was going to take challenge of flexibility back to their service.

'I think we need to put that challenge back to services. So, this is useful for me to make sure that I can take that back to my own organisation So, we need to make sure that we're aware of what the obstacles might be and make sure that we are removing some of those barriers that people have got.' (FG2, RG)

One participant emphasised the need for the NHS needed to change quicker.

'I only actually work with organisations that were genuinely empathetic to the worker. What I find is I work harder because I'm glad that I can work for them, whereas with the NHS they need to catch up with everyone else. Everyone else is changing. The NHS needs to change quicker.' (FG1 AM)

Is return to practice inclusive?

There was a view in FG1 that if the NHS was more inclusive, they would not have left. This AHP left practice due to lack of support for her neurodiversity and have small, children.

> *‘I did like a few months and I as basic rotation and then bailed out. One of the things that I made me bail out was because I'm just dyslexic and I had small children. I've got a good degree. Why am I doing that? So, I just thought I can't be bothered with it. (*FG1 AM)

There was evidence of inclusion from a placement due to language issues.

> ‘*I'm just giving another example of a lady that we had who has physio who trained in Romania. She got her HCPC registration and then never worked. So, she doesn't have that NHS experience. She fits the return to practice requirements because she was officially HCPC registered. There is a significant language issue, so we wanted to interview her for a supervised practice placement. The team didn't feel that they would be happy to support that because there were significant language issues. There were confidence issues. And so, we're offering shadowing, but at the same time, it's not quite the same*.’ (FG2, RG)

One trust had been reflecting on how to be more inclusive when interviewing.

> *We've been trying to think about the way that we interview people. Are we using too much NHS jargon? Is it suited to people whom English is not their first language and things like that*.’? (FG2, RG

Support

There was a view that there was lack of structure and the need for more formalised networks such as peer support and a view that Band 5 competencies may not be appropriate (FG2 BJ)

> *‘We need a workbook or something that we can work through with core competencies per profession and expectations. And there's such a broad range, we can't just be matched with band 5 competencies*.’ (FG2, BJ)

Participant in focus group 1 agreed with each other in relation to support and the different type of support that was available.

> ‘*It would be good to make it a bit more formal and to f have that in place for returners so they of pair up people of the same profession. I think the same profession is good because then you can have a much more in-depth discussion. II like having somebody around to talk to and think about things*.’ (FG1, VO)

One participant questioned whether the courses to enable Return to Practice

> '*I don't need a supervision to go back to return to practice because I have the Coventry University course. I still they still don't understand. I want to see what OTs are doing in the hospital. You still need to acquire all these skills. I just want to experience what they do. Coventry University said that if you finish the whole thing then you can return to practice.*' (FG1 SW)

Another AHP in FG1 (SW) also perceived that key to success was support from within your trust as well as connections for placements.

> '*From my experience, I think it's more of the support. If there's no support from anyone in your trust. I'm doing my placements and I am still doing my nursing assistant role because I still need the money, I can't get an OT assistant job. I tried I twice and I can't even get through to interview. If you don't have the link Who will do it for you? Who will supervise you? And then every time I'm there, it's as if they don't know what to do with me. That's the problem they don't have a set pathway. It's taking longer because first you're not confident enough to show that you can do it There's no support available, even though they said there is, but there's none That's what I think*.' (FG1 SW)

One AHP gave an example of support from her supervisor.

> '*She's updating my knowledge basically. I'm doing a lot of things anyway, but they just need to be tweaked to the role of an OT. And I found that useful because things have changed a lot and it's good to have something that says well, no, this is the updated thing. And then have someone say you do know that.'* (FG1 AM).

Discussion

This is the first study to explore Return to Practice for AHPs with protected characteristics. We identified two types of Return to Practice AHPs (1) those with experience who are returning, (2) AHPs who have never worked after registering with the regulator (HCPC) and or have registered with the HCPC after gaining qualification outside the UK. Both groups have different needs and experiences that suggest a different approach needs to be reflected on but there are some common shared experiences.

Reasons for de-registering were complex and reasons cited were related to childcare ill health and or caring responsibilities. Another reason why AHPs de-registered was if they could not find employment as an AHP. The findings support Sheppard et al (2010) who found that child-care were the main reason returners and potential returners took a break from physiotherapy. What drives returners back appears to be focused on pragmatic issues. This is focused on financial issues and

or a desire to see return to practice kick start careers. Our findings contradict those of Sheppard et al (2010) who found that physiotherapy return to practice was not driven by financial reasons.

Our findings suggest for that return to practice AHPs will have different needs on supervised placement, particularly if they have never worked returnees should be managed in placement, particularly as they have already completed a period of training and they are not a student needing to prove competencies. Whilst AHP self-assess their competence even though self-assessment of competence doesn't necessarily match the findings of objective assessments (GMC 2014). We found no studies related to AHPs or skill fade and we do not know whether returners are a risk to the public. The issue is whether CPD activities and current Return to Practice safeguards do mitigate against skill fade. To date, there is no evidence that completing the required number of hours ensures competence (Campbell et al 2019). Work conducted with pharmacy returnees found that returners experience ad-hoc training by employers (which was more in line with CPD) and not specifically return to practice training from a pharmacy perspective (Phipps et al 2013).

The findings from our study found inequalities in relation to the type and amount of supervision available for Return to Practice AHPs. There was also a view that trusts and supervisors did not know and or understand the process. The findings from our study found there was lack of clarity about roles and what was expected from a return to practice AHP. AHPs did not perceive they were a student and or a registered professional. Moreover, there was concerns about appearing to be incompetent as well as confidence issues. Similar findings are reported by Coates and MacFadyen (2021). Most returnees were cautious, nervous, and lacked confidence and some returnees were anxious about appearing inept and inadequate, fearing that clinical staff and patients would be critical of their performance. Our findings support the work of Jamieson and Taua (2009) who found that nurses need committed mentors and supervisor to enable the returner to feel more confident. It appears that there may be inequality across the different AHPs and trusts as there is no standardisation and or quality mechanisms. In addition are findings are consistent with the findings of Manriquez (2012) for a physician re-entry programs in obstetrics and gynaecology that occurred in the US. Moreover, there is need to see Return to Practice AHPs as assets, many of whom have had careers outside of their profession. Return to Practice AHPs could and should have a greater role in supporting newly qualified AHPs on their career journeys.

Access to Return to Practice was not equitable in relation to access to placements. There was also considerable variation in relation to whether placements or paid and to what band. Moreover, our research found many AHPs had difficulty finding both paid placements which resulted in them having to maintain jobs and delayed completion. Other studies have found lack of access to clinical placement for nursing and midwifery students (McMurtrie et al 2014) In addition, AHPs with protected characteristics are limited by childcare and financial factors. The Returners in this study were unable to access full time nursery care and or access to work if they were not working full time and or on benefits.

Our study found that friends and or sponsors played a significant role in opening doors to opportunities and placements. Many AHPs developed and found their own supportive networks but wanted more formal arrangements. Thus, support mechanism for those without networks are important. Generally, those who have support from peers and employers, and who are proactive in developing themselves, are most likely to succeed (Phipps et al 2013). Springboard events that involve dedicated training courses tailored to the needs of physicians. Return to Practice provide an opportunity for improving confidence relating to many areas of clinical and non-clinical practice as well as providing an environment for networking and sharing experiences (Mullender et al 2021)

We do not know why AHPs were unable to find work as an AHP and or a support worker and this requires further investigation. We would suggest that some AHPs could be making decisions based on personal biases which is viewed as discrimination. Moreover, there is a lack of consistency and or indeed inequity between paid placements and banding levels. If Returners are to be retained in the workforce, it is evident that the NHS needs to change in relation to being a flexible employer. This was also a key finding for successful Return to Practice for nurses (Barriball et al 2007).

What attracted Returners back was the flexibility arrangements. Such arrangements need to be transferred into the workforce. It is evident that without flexibility returners are unable to go back into the workforce. A study examining speech and language therapists return to practice found that returners returned because of flexible hours; work location; professional development; and pension provision (Loan-Clarke et al 2009). The data from our study strong suggests flexibility is to key to AHPs returning to practice and that AHPs with protected characteristics need to achieve a work-life balance. Feeling valued by management and colleagues helped occupational therapists returning from maternity leave feel comfortable and confident with compromises that were made (Parcsi and Curtin 2013). Our own analysis of flexibility on job recruitment adverts for Band 5 physiotherapists and Occupational therapists suggests that employers expect AHPs to be flexible. Holcombe et al (2020) found that AHP managers are implementing part-time work for AHPs returning after maternity leave because it is a regulatory requirement without complementary changes to established workplace practices or adequate organisational support. We did not find a sense of moral obligation to contribute to the NHS as suggested by Coombs et al (2010).

Limitations

Whilst a mixed method study does enhance the robustness of this study, we need to acknowledge its limitations. The first is (1) in relation to small sample size (2) the recruitment process which recruited from AHPs who used the Return to Practice support networks. Thus, we may not have reached all AHPs.

Recommendations

For Integrated Care Boards (ICBs)

AHPs need to become Ally for Return to Practice AHPs with protected characteristics which means adopting and implementing the principles of Allyship.

Return to Practice AHPs have many strengths are numerous should be utilised creatively within practice for example supporting new graduates.

Local communities should appoint Return to Practice Champions in collaboration with Professional Bodies. Return to Practice Champions should help navigate systems as well as perceived biases in collaboration with EDIB leads,

Local communities and ICBs should conduct long term analysis of Return to Practice to ascertain whether AHPs with protected characteristics remain in work.

ICBs should conduct an audit to ascertain whether AHPs are currently working as support workers and offer paid route to Return to Practice if this is the case.

If a Return to Practice Returnees preference is for a placement, they are paid at a Band 5

All job advertisements should offer flexible working with no additional catches such as expectation that work weekends, Flexible working should be available to all grades.

AHPs who leave a post should be given details about return to practice and offered keep in touch days.

Commission regional Return to Practice courses with links to NHS AHP leaders in each area who can oversee localised training opportunities and placement provision.

Employers need to identify persons with protected characteristics, direct and by association when they take career breaks and when they return. They can develop further keep in touch days and minimal standards to help the retention of staff and prevent professionals having to leave the HCPC register.

Recruitment advertisements need to consider Return to Practice professionals as well as newly qualified persons.

Department for Work and Pension

All job centres should be informed about Return to Practice and make the appropriate referral if AHP is looking to go back to work and or currently on benefits.

AHPs on Return to Practice programmes need to have access to full time childcare provision so they can complete placements and or Return to Practice competencies in a timely manner with no additional financial burden.

Return to Practice Workforce Leads

Prior to commencing Return to Work Programme all AHP should access carer passports and or my health care passport to ensure that health and carer needs are met within the work environment

Growing awareness of Return to Practice should occur via local advertisements in GP surgeries and more forward-facing community events.

Develop a mentoring & peer support system that is both unprofessional and multi-professional so that Return to Practice AHPs have a sense of belonging and connectivity.

Provision of training on technology and use of social media.

NHS England AHP International Workforce Leads

International recruits who have not worked in the NHS need an alternative type of Return to Practice that should involve a rotational placement as well as introduction to health and social care policy and structure of health and social care.

Have quarterly reviews of the Return to Practice process with regional AHP leads, NHSE, Universities and persons with lived experience to problem solve issues and barriers to Return to Practice

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