Royal College of Anaesthetists

Accelerated Return to Training (ARTT) Call for Ideas

Trainees take time out of programme for a variety of reasons and as such their return requirements are very different. As such a return to work should be tailored to the individual and their requirements and agreed in advance.

Current Issues (1)
Maternity and family issues
These depend on the reason for the time off. Maternity leave is probably the best supported but has its issues. New parents with childcare concerns, new financial burden and extra commitments are just some of the issues faced by trainees. Also depending on whether they've experienced difficulties either physically or mentally following the birth there may be additional concerns when returning to work. Sleep deprivation and fatigue are a big problem and they are expected just to cope. The potential for the offer of arrangements for onsite crèche or nursery facilities or if mothers are still expressing milk if there are facilities for this to be done in private in hospital and deanery sites may be beneficial. Out of Programme time is also well supported and arranged for. One concern may be the clinical skills and knowledge on the return to work.

For trainees out of programme following child birth the option of paid keep in touch sessions should be provided/encouraged as it is in other professions. I have heard of this in medicine but it is often at the trainees request and unpaid.

Sickness and return to work
A note from an anaesthetist in training "I personally was off work on sick leave for 8 months and had a 6 week phased return to work. I had almost no contact from my deanery apart from when I sent in a sick note. I was continually put back onto the monthly rota and had to explain that I would not be back yet. I had to learn to walk again and cope with chronic pain, fatigue and depression. I got diagnosed with an acute adjustment disorder and had to undergo CBT and trauma counselling. The return to work process was haphazard and made up. My consultants locally were excellent but I got no support from the local training committee or postgraduate educational bodies. Occupational Health needed a referral from my line manager for me to access them and this never happened. I got seen by occupational physio who was great but the OH nurses were less than useless. They had no idea about my job, or my injury or how to help but I was sent there anyway because it was part of a process."

Sick leave needs more support in terms of mental and physical health, it is almost expected that doctors won't get sick. Keeping in Touch days are available for returning to work but trainees sometimes are not routinely offered these and sometimes expected to use accrued annual leave as part of a phased return.

Maintaining skills: communication skills
The Lay Committee at RCoA feels strongly about developing the communication skills for all doctors and we think this applies equally to doctors returning after time out. We would think it necessary for mandatory re-training on this, particularly as things may have moved on while returning doctors have been away.

At RCoA we have been looking at ways in which communication skills can be improved, for instance through extending the domains of the communication testing station in the FRCA Primary OSCE Exams, such new aspects to be tested in a pilot later this year. Such principles could be applied to some form of assessment for returning doctors.

Maintaining skills: Clinical and non-clinical skills
Most clinical skills (depending on the stage of training of the person involved) will return relatively quickly, though support may be required in some instances. In the case of maternity leave/OOPE the trainee will often return to the hospital that they were at before going on leave. Some processes of care/important local policies may have changed in this time. For example some trusts have moved completely away from paper based hand-over documents to electronic, incorporated into our electronic prescribing system. The usability of this system may be taught on an induction session but actually the clinically useful functions are better learnt through direct shadowing of colleagues. As such, a phased return to work involving a small number of mentoring consultants and "shadowing" peers would be useful. The duration of this will depend on circumstances and should be negotiated locally within a specified time-frame. i.e 2-4 weeks full time equivalents. Consultant mentorship will ensure readiness to return to work, alongside peer support through shadowing. This suggestion is not just applicable to anaesthesia.

Communication skills and other non-technical skills may need targeted induction, training and reorienting. There may be requirements for reviewing organisational policies, professional guidelines and good practice within the profession to integrate back into practice.

Simulation
The use of simulation could potentially be very useful as a training adjunct in return to work programmes. It would allow trainees to experience anaesthesia related critical incidents safely in a theatre environment. Its routine use in this instance should be strongly encouraged although it would there are multiple barriers to accessing high fidelity simulation facilities on a flexible basis. Making its use mandatory would help to overcome such obstacles and courses could be centralised to account for the relatively low numbers that might be expected.

Mitigations
It could be mitigated by more freely available and accessible information and formal return to work processes. The AAGBI have details of excellent resources on their website https://www.aagbi.org/professionals/wellbeing/return-work OH services should be more accessible and not require a referral from a line manager. trainees often don't know who that is and the line manager rarely knows who the trainee is. There should be an identified individual locally where people can go to for advice. A mentoring or buddy system would be a great service for people returning to work.

Role of College Tutor and Educational Supervisor
The College Tutor in a department should be the central point of access for trainees returning to work after a period of absence. They should be provided with specific guidance or training to ensure that they are aware of the processes and options available such as the use of OH services, KIT days, regional trainee support services and availability of courses such the College's GAS Again (Giving Anaesthesia Safely Again). The educational supervisor allocated to a trainee returning to work should also have received specific training in order to support such a situation. It would be preferable to have 1 or 2 educational supervisors within each department with specific expertise.

Occupational Health
Occupational health departments should play a central role in return to work after sickness absence. Anecdotal evidence would suggest that the services offered in trusts are sometimes inconsistent and difficult to access. The College would welcome a review of occupational health services nationally as part of a drive to raise awareness and ensure standards are consistent, appropriate and accessible.

Ways to improve return to work
Trainees take time out of programme for a variety of reasons and as such their return requirements are very different. As such a return to work should be tailored to the individual and their requirements and agreed in advance.

- Before leaving trainees should meet with Educational Supervisors and detail progress to date so that is available on return
- Plan a return to work strategy which is left flexible enough for change if required
- Before return consider a return to work package including practical e.g. simulation day (many schools now run these for anaesthetists)
- Return to Anaesthesia courses are generally one day long and include some practical simulation work which gets course members working together in a real life scenario.

There should be a concerted effort to limit any impact on training duration. People are put off from having supervised periods as they have already extended training by taking out of programme and are concerned about adding more time to a long training programme. With advance planning return to work can be provided without extending training. Conversely some trainees feel they need extra time and this is discouraged. Again there needs to be flexibility based on competence not on time.

Issues of returning to work (in anaesthesia and ICM – may apply to other acute specialties)
- Confidence - there is a risk of under confidence in own knowledge base or technical skills. This can be addressed through mentoring and peer support
- New working environment(s)- Change in local policies/working patterns: this will depend on each specific department but it would be helpful if any major policy changes/expected local practices were signposted to returning trainees and they were given time to review these policies. For example, in our trust a medical review function was introduced such that a button was clicked on an electronic programme every time a patient was seen by a medical clinician of any grade. If this was introduced while you were away, this would need signposting on your return.
- Poor recall of local policies re study leave/annual leave etc. Locally we have a Trainee handbook that contains all this information in it
- New colleagues
- Practical skills need refreshing
- Getting back up to speed, being able to think as quickly but safely as before leaving and spotting when things are going wrong – more important for those coming back to work solo or who are due to be supervising others
- Things change when you are away e.g. new drug information becomes available, new techniques are now routine, new evidence or guidance from RCoA/AAGBI/HEE etc.
- Arriving in new department
- Remember that if you are out of specialty e.g. doing ICM and coming back in e.g. to anaesthesia the same issues can apply as returning from a long leave

Issues for academic training
- Research council funded PhDs include funding for 1-2 clinical sessions per week. This should be encouraged and facilitated and should be an approach recommended to internal funding organisations. Universities tend not to offer or encourage this but if planned correctly should allow maintenance of skills without significant impact on research
- For those undertaking clinical sessions during out of programme research there needs to be more planning and clarity as to what the sessions involve. Medical specialties often staff clinics with trainees doing research and this prevents them doing acute or practical based sessions such as endoscopy. It may be sensible for a structured plan for clinical sessions to be submitted and agreed at the start of an OOPR and agreed with the trainee rather than letting the academic supervisors force them into a clinical environment that is not beneficial for maintaining skills.

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Use KIT days to work alongside others in the department where you are restarting (difficult to arrange if moving hospital).
Return to the same department you left – also has financial and leave benefits as these not always transferable between Trusts.
Work with same consultant for a few lists on return.
No on call initially – probably after two weeks.
Work with direct supervision until supervisor and trainee can sign off that they are happy for solo work/ work at current training level.

Innovative options
Develop more return to work courses for different sub-specialties.
Run them in workplace as better to get used to that again.
Refresh basics of most important topics especially those relating to patient safety eg emergency situations.
Use some carefully chosen e-learning e.g. units of e-LA.
Make KIT days more flexible – presently have to be in your previous hospital and cannot be taken during annual leave. Could have them in new hospital if necessary to change hospital after leave and could allow them interspersed with annual leave so that timing can be more appropriate.

Mentoring – a pastoral mentor scheme is delivered in Bristol so that the trainee has a mentor throughout their stay in the school (they choose the mentor and can change). This runs parallel to the training supervisors and offers another option for support which many have found useful.
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The challenge is that each individual trainee will have different requirements depending upon personal circumstances. Personally I think that these are best achieved by personalised mentoring by appropriate consultants and peers and a return to full duties when the individual feels ready to do so (within a pre-advised time frame. There should be advice on how to proceed for small minority who may need longer than this time-frame). This is particularly important in acute specialties with busy on call commitments – e.g. medical registrar, cardiology, ITU, Obstetrics, anaesthetics etc. I am aware of a textbook publication on return to work written by less than full time trainees in anaesthesia with a view to helping colleagues when they return to work (E.Plunkett, E.Johnson, APierson. Returning to work in anaesthesia. Back on the circuit). Such resources should be signposted.

Good practice
Mentoring – we run a pastoral mentor scheme in Bristol so that the trainee has a mentor throughout their stay in the school (they choose the mentor and can change). This runs parallel to the training supervisors and offers another option for support which many have found useful.

In Wessex there is a fairly robust guidance found below which is helpful for supporting return from maternity leave. Trainees have found that they were able to plan what they would do whilst off and was able to say if they do feel confident to resume all activities quickly after a return. This ensures that trainees do not feel pressurized into doing or practising anything that they feel uncomfortable with and it enables trainees to ask for more experience of something before going on call etc.

http://www.wessexdeanery.nhs.uk/policies__procedures/return_to_training_scheme.aspx

The key is allowing people to have some autonomy and regain some experience of whatever they are concerned about before having to go solo/on call.

There are a number of locally return to work programmes and courses designed to assist and prepare anaesthetists when returning to work. The RCoA also has an established national programme called Giving Anaesthesia Safely Again "GasAgain" which is an award winning programme which is structured to provide strategies for managing a return to work. Not only is there simulation scenarios to refresh an anaesthetist's skills, but there is also a series of workshops underpinned by short relevant lectures to update you on the latest in the world of anaesthesia. The course provides essential updates (i.e. resuscitation, WHO checks) whilst giving you the opportunity to build your confidence managing common and unusual emergency scenarios again. Currently the Gas Again programme is delivered and heavily subsidised by the College in order to maximise the opportunity for access for anaesthetists as there has been extensive research to suggest this is a critical issue within anaesthesia. The course is delivered 4 times a year across the UK.
www.rcoa.ac.uk/gasagain

It would be beneficial for central funding to be made available from HEE or Trusts to support this course in order to meet demand or for Trusts/ Deaneries to work with the RCoA to support the delivery of regional events. Funding is the principle restriction to

Concluding note
A number of LTFT trainees in anaesthesia have reported that they are not keen on an accelerated return to work as they thought this would reduce their training experience. In the HEE letter ARTT refers to the return only and not to accelerated training – this needs to be clear to trainees.
If trainees take several periods of maternity leave they accrue annual leave which is presently counted towards training time. Some consider that they are losing a significant period of training. Although training is competency based the element of time is important to the trainees who perceive that an ARCP resulting in an outcome 3 to give an extension is a bad thing as they have progressed well but been given less time than those who have not taken maternity leave. Would it be possible for this annual leave to be counted or not according to the TPD and trainee with the assessment panel? Or if the training is going to be assessed only by competence, remove the annual leave=training rule?

The language and nature of the attached document a bit managerial and missing the point. This is about planning, clarity and doing the basics well such as supporting trainees and thinking about return to work early, not about 'innovative ideas' and certainly not about prioritising innovation over substance.