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Return to Practice for Allied Health Professionals with protected characteristics: a mixed method study.

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Abstract

Introduction:

Return to Practice is one mechanism for recruiting and retaining Allied Health Professionals within the health and care workforce in England. Bringing back trained professionals, who may have left the workforce due to different circumstances with a programme of support to register with the professional regulator is in place, but it is not known how this affects persons with protected characteristics.

Aim:

To understand experiences of Allied Health Professionals with protected characteristics of returning to the workforce through a Return to Practice Programme.

Method:

A QUAL (semi structured interviews) + qual (focus-group interviews) mixed methods study. 12 online semi structured interviews with Return to Practice AHPs who had a protected characteristic, followed by 2 online focus groups with Return to Practice AHPs and workforce leads to further explore themes from interviews.

Results:

Our research identifies a new type of returner who are having to use Return to Practice programme as a vehicle to step into health and social care as they have not been able to find employment. A main driver to return to practice was financial reasons and not a sense of moral obligation to contribute to the health and care workforce needs.

Conclusion:

There is a need for organisational cultural changes to support return to practice for AHPs with protected characteristics. There needs to be a greater focus by AHP leaders on flexible working to retain workers. To date there is little evidence of leaders understanding the complexities of AHPs in a return to practice programme, the considerable contribution they can make to the workplace and the current inequities that exist.

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What we know

- Previous studies had identified return to practice AHPs as experienced health care workers.
- Drivers to return to are a moral obligation to support the wider health and social care workforce.
- AHP leaders may not actually be committed to flexible working.
- Barriers to Return to Practice programme are quality of supervision and fair access to paid placements.

What this study adds

- Some AHPs have never worked after registering with the regulator. This group of AHPs are having to use the Return to Practice programme as a vehicle to step into health and social care.
- A main driver to return to practice for individuals is financial reasons.
- Lack of flexible working is why AHPs leave the workforce. This also influences whether they join the workforce after completing a Return to Practice programme.
- The absence of paid placements and limited free childcare places financial burden on return to practice AHPs and delays entry into the workforce.

How this study might affect research, practice, or policy

- AHPs who have not worked in the NHS need a bespoke Return to Practice programme that needs to be co-produced with them.
- Flexible working should be available to all grades with no additional catches, such as the expectation that AHPs must work weekends.
- AHP leaders need to proactively identify persons with protected characteristics, directly and by association, when they take career breaks and when they return.

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Introduction

Allied Health Professionals (AHPs) comprise of 14 different professional groups in England [1] and work in diverse settings in health, social care, independent and the voluntary sector. All AHPs in the United Kingdom are regulated by the Health and Care Professions Council (HCPC). AHPs have a critical role in recovery, rehabilitation and prevention aspects across health and social care. Recruitment and retention of AHPs continue to be a priority for AHP leaders since one out of eighteen AHPs left their jobs during the first four years of practice [2]. Some trusts have instigated preceptorship for AHPs to facilitate transition from student to practice but there is limited evidence to show effectiveness of preceptorship on workforce outcomes [3]. There are notable differences between the Allied Health professions, for example, 1 in 8 prosthetists and orthotists left the register whilst just 1 in 56 paramedics [2]. There is a clear relationship between job satisfaction and retention [4]. Key determinants for retention are job satisfaction, career development and work-life balance [5].

Current strategies to address AHP workforce issues can include several approaches tailored to the local geography and employer needs and include international recruitment, changing the skill mix of staff and workforce re-entry strategies. Work force re-entry strategies are economically attractive as the cost to up-skill an AHP is relatively inexpensive compared to re-training. Work force re-entry strategies include programmes such as Return to Practice. Return to Practice (RtP) programmes enable AHPs to re-register with the regulator. Registration, which may have lapsed due to a variety of reasons including personal circumstances. Typically, the RtP programme would involve updating skills with an equivalent of 30 days (if 2-5 years out of the profession) and 60 days (if over 5 years out of the profession) with a day equivalent to seven hours [6]. Updating of skills can happen at Higher Education Institutions (HEIs), health, non-profit making, or social care organisations. Some funding (approx. £800) is available to everyone for out-of-pocket expenses and eligible organisations can claim £500 for supporting someone who wishes to return to practice [7]. The RtP programme is designed to be flexible and self-led by the returners, with AHPs identifying gaps in their own knowledge and skills and expected to come up with an action plan. Currently two Universities in England offer a formal RtP programme, including distance learning methods.

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A number of AHPs identify as having a protected characteristic. The Equality Act (2010) [8] identifies nine protected characteristics – age, disability gender reassignment, marriage and civil partnership, pregnancy, maternity, race, religion or belief, sex and sexual orientation. AHPs are the third largest clinical workforce in health and care in the UK [1], where data is available, 18% identify as being from a non-white background, a gender divide of 73% female to 27% male, 0.1% of the workforce preferring to self-describe their gender identity, 4% of the AHP workforce identifying as gay, bisexual or queer. Only 5% of the workforce report considering themselves as having a disability and around 52% are over 40 years of age [9]. Organisational culture can have a negative effect on the workplace, consequently AHP leaders need to create inclusive safe cultures for AHPs with protected characteristics [10]. Negative workforce cultures include not actioning reasonable adjustment recommendations to enable professionals to remain in the workforce [11]. Black and Minoritised Ethnic staff are more likely than other staff to experience harassment, bullying or abuse and enter a formal disciplinary process [12]. Pay inequalities exist between males and females as well as ethnic groups [11,13]. There is a paucity of research that has examined the impact of flexible working on retention and recruitment as outlined in the NHS Plan [14].

There is very little research on the impact of RtP programmes specific to AHPs, with existing research focussed on medical professionals [15]. A report on AHP RtP [16] did not evaluate whether this program is viable for persons with protected characteristics as identified by the Equality Act 2010. We need to understand whether there are barriers to RtP for AHPs with protected characteristics and whether AHP leaders can enable system changes to occur. This work is particularly important in relation to the number of AHPs identifying as having a protected characteristic [9].

The aim of this QUAL (semi structured interviews) + qual (focus-group interviews) mixed methods study [17–19] is to understand Allied Health Professionals' (with protected characteristics) decisions and experiences of returning to the workforce.

Methods

We chose a QUAL (semi structured interviews) + qual (focus-group interviews) mixed methods study as it was best served to answer the research question since we know little and or understand RtP for AHPs with protected characteristics [20,21]. This

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enabled us to have a dual perspective of the research question thus making the study richer by combining data from a different level of analysis, enabling us to hear voices that have not been heard previously in Allied Health professions [18]. In this study the core component is semi structured interviews and the supplementary component provided by the focus groups. Standards for Reporting Qualitative Research (SRQR) [22] were adhered to and provided as additional file1.

Participants:

Allied health professionals, who self-identified as belonging to a protected characteristic group, were currently on a RtP programme or had recently completed a programme were recruited for the interviews; in addition to the participant criteria for interviews, workforce and AHP leads involved in RtP programmes or were considering supporting returnees were recruited for the focus groups. NHS England acted as a gate keeper to recruit participants for the interview study using a closed RtP group that was hosted by Health Education England.

Data Collection:

Online Semi structured interviews with AHPs between the months of January and March 2023. The interview topic guide (appendix 1) was co-produced with two return to practice AHPs with intersecting protected characteristics. We then conducted 2 pilot interviews with a separate set of RtP AHPs, which allowed us to modify some of the prompts used in the interview. Participants received written information regarding the study before agreeing to participate. At the start of each interview verbal consent was recorded. To ensure psychological safety of participants support was available to all participants in case they expressed distress. The interviews were conducted over MS Teams and lasted approximately 45 minutes.

Online focus groups were then conducted to explore the interview findings in more depth between April-May. The focus group schedule (appendix 2) was informed by the qualitative interviews. For the focus groups, we used social media to recruit AHP leaders and work force leads. The focus groups were conducted on MS teams and lasted around 90 minutes.

Data Analysis:

Interviews and focus groups were audio recorded and transcripts were downloaded and checked for accuracy.

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Interviews: Inductive data analysis [23] enables researchers to explore multiple perspectives and viewpoints as well as to discover themes that may not have been considered initially. We used the constant comparative method [24] for inductive data analysis. Immediately after each interview, 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 as examining and comparing data. Following this, we began axial coding in which we tried to make connections between codes as well as relating it to other categories. From the categories, we created themes. During the analysis we held regular meetings with Return to Practice AHPs to discuss conflicting interpretation until we reached agreement. Guest et al [25] suggest that saturation of themes is reached by the twelfth interview, however we are confident that the themes captured most of the experience of RtP AHPs without having to conduct additional individual interviews. Focus groups: We used template analysis [26,27] to analyse the data generated from the focus groups. We formulated a themes template using the findings from the individual interviews. We added additional themes to the template after reflecting and discussing the focus groups and re-reading the transcripts.

Synthesis of data from two sources:

In a QUAL (semi structured interviews) + qual (focus-group interviews) mixed methods study data is analysed separately until the findings from each component can be incorporated into the results [18]. Data from the interviews and focus groups were compared in a side-by-side comparison, to allow a further analysis through comparing themes and meaning of responses.

Reflexivity [28] and integrity of the research process was maintained by all authors. The authors are from a BME heritage. In addition, the authors' experience as occupational therapists and health services researchers working with Black and Minoritised ethnicity AHPs [29–31] provided expertise necessary for this research. The interview and focus group question topic guide was informed by RtP AHPs, checking of results, as well as active participation from the participants during the interview and focus group discussions, assisted with triangulation. The authors' personal and past experiences enabled us to conduct a qualitative study of this nature. It is acknowledged that authors' previous experience may have influenced the coding and interpretation of the themes. Both authors met regularly to discuss and agree data

collection, analyses, and interpretation. Ethical approval for this study was obtained from London Southbank University Ethics Committee (ETH 2223-0100).

Results

For the interviews, 16 AHPs contacted the researcher AA, of which 12 agreed to participate in the study. Of the 12 AHPs 5, were occupational therapists, 2 were Speech and Language Therapists, 3 Physiotherapists, 1 Paramedic and 1 radiographer. Four AHPs chose not to participate as they did not self-identify as having a protected characteristic.

Focus groups: Four focus groups were planned for and scheduled but we could only recruit to 2 of them. RtP AHPs, who had agreed to be interviewed were asked to self-select as to whether they would participate in focus groups, but few consented. To ensure that all voices were heard we purposefully recruited between 5-6 persons in each group.

All collected data have been pseudonymised. Individuals have been pseudonymised to initials and focus groups 1 and 2 have been labelled FG1 and FG2 respectively, and to further protect the anonymity of participants we have not given additional demographic data apart from providing context to some of our findings. This is presented in appendix 3.

Motivating Factors to Return to Practice

Life events influenced decisions to leave their career which included '*health issues*' (HA), childcare issues including '*childcare costs'* (JB, RK, ET, KB) work force issues such as service closures (JB, RK), maternity leave issues (JM) and limited flexible working options (ET). For RtP, AHPs, it was a mixture of conversation with friends and or shadowing that facilitated the decision to RtP (ET, NA). The COVID-19 pandemic also influenced decision making as AHPs perceived that they needed to help (RA, HH).

For some AHPs financial reasons drove the process (KB, ET, VV JM) and we did not find that return to practice was motivated by a sense of moral obligation to support the health and care system.

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> *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. From talking to friends, the cost really kind of scared me and my husband*' (VV)

Some AHPs had never found an AHP role despite being registered. (JW, LT, CC, SB). These AHPs used the opportunity of return to practice to '*get their foot in the door'* (JW).

> *I studied occupational therapy at university in South Korea and registered with HCPC in 2016. I sometimes consider myself as a returning to practice OT and or sometimes as an international OT. I could not find work at the time. I have never had experience in the UK and or [sic] in the NHS*.' (CC)

One trust had been reflecting on how to be more inclusive when interviewing for RtP AHPs and was focusing on limiting NHS jargon (FG2, RG). From the focus groups it was perceived RtP could be more widely promoted by going out into the community for example in schools where mums and dads were often present.

Personal Sacrifice

Returning to Practice involved personal financial costs specifically related to childcare and loss of income whilst on placement for some. AHPs were unable to claim full time nursery fees unless they were in full time employment (EW, RK, KB, SB). For one AHP who self-identified as disabled there were additional financial costs

> '*You can't use your disabled bus pass till after 9:30. Coming back will be alright. However, if there's more than one disabled person on the bus, I can't use that bus [as using a wheelchair].*' (HA)

An AHP, highlighted the impact of financial sanctions if they were paid (ET), whilst others were only able to do limited hours as they still needed an income (EC, SB). Some were offered a paid placement, but trusts were unorganised, which frustrated the returnee (RA, ET). Other returners emphasised difficulty balancing family responsibility and hence importance of support from partners (VV, CC, PA JW). In the focus groups, AHPs had different thoughts about whether returners should be paid on placement. Barriers to payment included benefit and pensions sanctions (FG1 HB) and a view that healthcare NHS Trusts were not willing to give you a placement if it involved payment (FG1 V0, JB).

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Process for Return to Work

Employers offering flexibility were viewed as important by AHPs, but it was not always offered (JB, PA, RA, VV). Likewise in the focus groups AHPs perceived that flexibility was not visible within job adverts and often only available to senior staff (FG 2, RG, JG, AH). There was a view in FG1 that if the NHS was more inclusive, they would not have left. One AHP perceived that the 60 days to complete RtP was not needed, and she could have returned after 30 days (VV). Another AHP perceived that the online learning material could be done in half the time allocated to each activity (HB). AHPs value the flexibility of RtP (JM, JB) but it was also perceived that it was 'isolating' (KB) and '*a bit overwhelming* (JW). Self-management strategies included creating or joining WhatsApp groups (JW, VV) or other online communities (ET)

AHPs used existing friends and networks to help with supervised placements (JB, JW, VV, ET). Support from peers was viewed as important in focus groups 1 and 2.

AHPs without existing professional networks found placement opportunities difficult to find (CT, JW), another felt detached from friends from work (RA). One AHP had not kept in touch with her profession which she left 9 years ago (JM). Finding 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). Not all return to practice participants had a successful outcome.

> '*My first attempt at return to practice, I had been very unwell. My son was in nursery but coincided with my daughter being unwell. I realised I just had to stop doing that for a while. It was very difficult to find a place that could facilitate my return to practice hours'* (RA)

In Focus Group 2 one AHP from Romania was excluded from a placement due to language concerns despite being HCPC registered

> *'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)'

Retraining vs refreshing knowledge and skills:

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AHPs felt that RtP was '*not retraining. It's refreshing your knowledge*' (JW)There was confusion as to the roles and responsibilities of a RtP 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.*' (PA)

This was key theme from the focus groups (FG1 SW, BV; FG 2 AK). One AHP was not sure of her role *'[I] don't even know what to call myself'* (FG2, BJ). Due to the lack of clarity surrounding roles there was some frustration in relation to the teaching and supervision that occurred in practice. In both focus groups there was 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 (FG1 VX, BJ; FG2 JG). This view was shared by an AHP in the interview (EW) as well as by AHP leads in the focus groups.

> '*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 that's a definite issue. It can have a knock-on effect to the person undergoing that return to practice experience.'* (FG2 JG)

One participant perceived she did not require supervision to Return to Practice (FG1 SW) whereas another perceived they needed a workbook which clearly outlined core competencies and expectations. (FG2, BJ).

> *'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)

From the interviews there were issues related to the lack of structure (JB, CC, RA, EW) and RtP AHPs reported having to chase supervisors to sign notes and or to discuss issues on placement (CT). Another AHP perceived that supervisor(s) did not have time to help them with skills development (PA). From the focus group here was a view that AHPs could self-assess their own competences but two AHPs felt there should be a baseline of what '*you should know to do your job*,' (FG1, AB, BJ). One AHP was grateful that her supervisor was not '*breathing down her neck* (ET).

From the interviews some AHPs were acutely aware of the ageing process and the physical skills needed to be an AHP (CC, HA, VV). This contrasted with the knowledge

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of RtP AHPs to changes in the way of working over the years in process and procedures within a health or care setting. 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 limited knowledge of the health and social care system in England there was a disconnect between online learning and application in the real world (SW). One AHP even suggested a manual on information technology use ' [a] *laptop for dummies*.' (RA).

Inclusive return to practice:

One participant described how one NHS Trust had been reflecting on how to be more inclusive when interviewing for RtP AHPs and was focusing on reducing 'NHS jargon' (FG2, RG).

AHPs had different thoughts about whether returners should be paid on placement. Barriers to payment included benefit and pensions sanctions (FG1 BJ), Healthcare NHS Trusts not willing to give you a placement if it involved payment (FG1 V0, JB). One AHP perceived that they were '*just a cheap pair of hands*'. (JW)

> '*I would have loved to have been paid. It's going to mean 10 to 12 weeks with no money to be able to do the placement' (FG1, VO)*

Flexible working was acknowledged to be an important factor but was not visible within adverts and often only available to senior staff (FG 2, RG, JG, AH). There was a view in FG1 that if the NHS was more inclusive, they would not have left.

> *'I did like a few months on a basic rotation and then bailed out [left the job]. One of the things that 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)*

Current strategies used to access Return to Practice include money from Integrated Care Boards to promote Return to Practice in local newspaper and social media which had not been successful. Some participants suggested strategies that may be useful, such as advertisements in schools where mums and dads were often present (FG1), and more assistance from local regional teams (FG2, JL). Other suggestions included adverts in libraries, pharmacies, and similar places where there was high public footfall and GP websites which are accessible by most of the public (FG2 HB, JL).

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Discussion

This is the first study to explore RtP for AHPs with protected characteristics. Previous studies had identified returners as experienced workers [16]. Our research identifies a new type of returner who have never worked after registering with the regulator, this group of AHPs are having to use RtP as a vehicle to step into the health and social care workforce. We do not know why AHPs were unable to find work and this needs to be carefully unpacked but there is a lack of research in this area. There is limited literature on how AHP leaders respond and adapt to change, but leadership behaviours enhance employee well-being and satisfaction [32]. We would suggest RtP is particularly more complex if the returner has not worked in the UK, particularly in relation to skills fade [15,33]. We found no studies related specifically to AHPs' skills fade and we do not know whether returners are a risk to the public. To date, there is no evidence that completing the required number of RtP hours means that the AHP is competent [15].

Return to Practice AHPs are looking for flexibility to return to practice as well as when they are completing the RtP programme. One study found that AHP leaders may not actually be committed to flexible working but implement it because it is a regulatory requirement [4,34]. A study on RtP programmes found that from the 268 who had completed the programme, 50% were still looking for employment [16]. We found RtP AHPs wanted flexibility to have a work-life balance, and this was particularly important to complete RtP placements. A study examining speech and language therapists return to practice also found that returners returned because of flexible hours, work location, and professional development [35]. Our findings found that a main driver to RtP was financial reasons. Our findings contradict those of Sheppard et al., [36] who found that physiotherapists returning to practice was not driven by financial reasons. We did not find a sense of moral obligation to contribute to the NHS as suggested by Coombs et al., [34]. Money was important to ensure completion of RtP with placements enabling returners to complete practice quicker and not worry about finances. There was an inequality between the availability of paid and unpaid placements which varied amongst individual employers. This has been found to be an issue in nursing and midwifery RtP programmes [37].

Leaders can buffer teams against the negative effects of work conditions and reduce stress and burnout [38]. Negative factors impact on RtP and were associated with

supervision on placement, access to placements, quality of placement and role and awareness of supervisor. This is similar to, pharmacy returnees who found that returners experience ad-hoc training by employers (which was more in line with CPD) and not specifically RtP training from a pharmacy perspective [39]. Our findings support the work of Jamieson and Taua [40] who found that nurses needed committed mentors and supervisors to enable the returners to feel more confident. It appears that there may be inequality across the different AHP professions and trusts as there is no standardisation and or quality mechanisms in place for the RtP process. AHP leaders need to recognise and invest in engaging supervisors and assure quality placements. Sense of belonging is the psychological feeling of belonging or connectedness to a community [41], some AHPs felt connected to their profession and colleagues. Evidence suggests support from peers and employers, and who are proactive in developing themselves, are most likely to succeed [39]. Feeling valued by management and colleagues helped occupational therapists returning from maternity leave feel comfortable and confident with compromises that were made [42] and is likely to be applicable to other RtP AHPs.

Recommendations:

We would recommend that AHP leaders and workforce leads, to commit to flexible working and to ensure this is available to all AHPs regardless of grade and especially for those on a RtP programme. This should include a mechanism to keep in touch with AHPs who leave practice and invite them back for clinical updates and to advise about the RtP process. AHP leadership regionally and nationally should consider paid placements are available to those who want them as part of the RtP programme. There also needs to be additional research to generate evidence that RtP AHPs' clinical skills meet HCPC standards as part of the programme and explore the quality assurance aspects of a standard RtP process.

Limitations:

The mixed method approach enhanced the robustness of this study but we acknowledge other limitations. The first is in relation to the small sample size and the limitations on how we were able to recruit RtP AHPs. It would have been helpful to have an open call and not rely on the funder of the research to advertise to prospective participants, which may have led us to miss out on some participants.

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There was also some confusion about what was meant by protected characteristics. We had initial enquiries from many AHPs who did not identify as having one of the 9 characteristics, on discussion and so could not be recruited for the interviews and subsequent focus groups.

Conclusion

This study has identified a group of AHPs who have been unable to find employment even after being registered with the regulator. More needs to be done to explore the reasons why and to track this population. We found that for AHPs with protected characterises, flexibility was key to success of return to the workplace. Our research found that many barriers exist in relation to RtP which are dependent on socio-economic situation and availability of support networks. AHP leaders need to reflect carefully on structures that need to be in place to enable a fair and equitable RtP programme. Importantly it also has highlighted the uncertainty about assessment of competencies and AHP supervisors' confidence to supervise RtP AHPs.

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Declarations:

Ethics approval and consent to participate:

This study was granted ethical approval by the London Southbank University Research Ethics Committee (ETH 2223-0100). All Participants gave informed consent for the interviews and focus groups. All methods used were performed in accordance with the relevant guidelines and regulations.

Consent for publication:

Not required

Availability of data and materials

The datasets generated during the study are available from the corresponding author on reasonable request.

Competing interests

The authors have read the journal's policy and have the following competing interests: AA works as an Associate Professor in Inter-professional Working for London Southbank University. VS is a paid employee of University Hospitals Bristol and Weston NHS Foundation Trust and the NIHR Applied Research Collaboration in northwest London. The authors declare that this article presents independent research facilitated by the National Institute for Health and Care Research (NIHR) under the Applied Health Research (ARC) programme for Northwest London. The views expressed in this publication are those of the author(s) and not necessarily those of the NHS, the NIHR or the Department of Health.

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Authors' contributions

AA - Conceptualisation, Investigation, Methodology, Project administration, Writing – original draft, review and editing.
VS - Methodology, Writing – review & editing.
All authors have read and given approval for this version of the manuscript. AA is the guarantor of the manuscript.

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Authors' information

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AA and VS are Occupational Therapists. AA and VS identify as BME. Both authors have worked in healthcare and academic settings and have experience in research methods and have mentored occupational therapists and other health and care professionals as part of their career.

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Return to Practice for AHPs with protected characteristics: Interview Topic Guide

Brief introduction and format of interview (interviewer)

- Thank you for agreeing to take part in this study to share your opinions, perspectives and experiences.
- I hope you have had the opportunity to look at the Participant Information Sheet and complete the consent form. (Do you have any questions?)
- Please contribute as much as you feel able to each question.
- The interview is scheduled for a maximum of 60 minutes and if you need a break from the discussions at any point feel free to do so.
- If at any point you decide that you do not want to continue, you are free to withdraw at any time without the need to explain your decision.
- The interview will be visual and audio recorded, however as indicated in the PIS the recordings will be destroyed once your responses have been transcribed and the accuracy of the transcriptions confirmed.
- All identifiable personal data will be removed, and any quotations made by you will be non-attributable to you in any publication, report, or presentation of the research project.
- A debrief opportunity will be offered to all participants after their participation in the interviews.

HCPC registrants with protected characteristics who did not return to practice following the completion of a return to practice programme

- Would you mind sharing your protected characteristic, your profession, and some information about your work experience?
- Would you mind telling me why you left practice?
- What made you decide that you wanted to return to practice and subsequently sign up to the return to practice programme. Did you encounter any challenges?
- You completed the return to practice programme what was your experience/perceptions of it?
- Was there an expectation that you would return to the work force and was this the outcome you wanted?
- Can we discuss some of the reasons associated with your decision – are you happy to share some of the factors that contributed to this decision?
- What are your future plans? Do you expect to return to practice? What would make your return to practice more effective?
- Do you have any other comments/thoughts you want to share?

HCPC registrants with protected characteristics who contacted a return to practice help line but did not seek any further assistance

- Would you mind sharing your protected characteristic, your profession, and some information about your work experience.
- Would you mind telling me why you left practice?
- What made you decide that you wanted to return to practice and subsequently contact a practice helpline? Did you encounter any challenges contacting the

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helpline and or information about return to practice?

- You never took your initial inquiry any further -can you tell me why this was?
- Can we discuss some of the reasons associated with your decision not to return to the work force?
- What are your future plans? Do you expect to return to practice? What would make you more likely to complete a return to practice programme?
- Do you have any other comments/thoughts you want to share?

Thank you for your time and contributions today. Please note if you change your mind, you can still withdraw from the research up till a couple of weeks after today.

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Return to Practice for AHPs with protected characteristics: Focus Group Guide

Introductions- name, area of work and why here today, safety, and debrief procedure.
Brief introduction and format guidance for focus groups (facilitator)

- Welcome to the Return to Practice Focus Group
- Thank you for agreeing to take part in this study to share your opinions, perspectives and experiences.
- We will start by introducing ourselves and we will ask you to do likewise.
- I hope you have had the opportunity to look at the Participant Information Sheet and complete the consent form. (Do you have any questions?)
- Please contribute as much as you feel able to each question, and we would very much like to hear from each participant.
- The focus group is to run for a maximum of 90 minutes (1 hour and 30 minutes) and if you need a break from the discussions at any point feel free to do so.
- We have also created a breakout room where you can have the space to pause and rejoin the group if/when you feel ready again.
- If at any point you decide that you do not want to continue with the focus group, you are free to withdraw at any time without the need to explain your decision.
- We ask that you have your cameras on if possible as this enhances group interaction and the flow of opinions and discussions.
- The focus group with be visual and audio recorded, however as indicated in the PIS the recordings will be destroyed once the focus groups have been transcribed and the accuracy of the transcriptions confirmed.
- All identifiable personal data will be removed, and any quotations made by you will be non-attributable to you in any publication, report, or presentation of the research project.
- A debrief opportunity will be offered to all participants after their participation in the focus group research activity.

Open-ended Focus Group Questions:

- Would you mind sharing how return to practice persons with protected characteristics are currently supported?
- What are the reasons for leaving practice- are the numbers higher for persons with protected characteristics?
- Should the focus be on retention rather than return to practice?
- What is the current challenge's when a former HCPC registrant decided they want to return to practice?
- What are the current challenges facing return to practice persons with protected characteristics?
- What if any are the difficulties experienced by persons who want to return to the HCPC register?
- What potential skills and experience do returners bring to the workforce?
- What do you think if any, are factors that stop registrants with protected characteristics returning back to practice? (prompt - access to placements, childcare, adjustments, culture of organisations, financial, HEI, Information on HEE and HCPC website).
- Are return to practice initiatives achieving their desired outcomes for persons with protected characteristics?
- Any other comments or thoughts?

Thank you for your time and contributions today. Please note if you change your mind, you can still withdraw from the research up till a couple of weeks after the focus group itself has taken place.

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Return to Practice for AHPs with protected characteristics: synthesis of data

Synthesis of data from interviews and focus groups
Motivating Factors to Return to Practice
Interview- Friends, Shadowing, Pandemic, financial reasons, HCPC registered but never found job in UK
Focus Group- AHP from Romania was excluded from a placement due to language concerns despite being HCPC registered. Inclusivity of Interviews could be a barrier. Return to Practice advertisements attracted international recruits who have HCPC registration, AHPs who have not worked in the UK and or international recruits who did not fit the return to practice workstream
Personal Sacrifice
Interview- money issues that included nursery fees, benefit sanctions, impact of paid versus nonpaid placement. Paid placement meant did not have to work. Balancing family responsibility Flexible employer valued and RtP process. Dependent on networks Can be overwhelming so set up own networks. Time Frames could be shorter
Focus Group- AHPs had different thought about whether returners should be paid on placement. Barriers to payment included benefit sanctions. Trust not willing to give you a placement if it involved payment. Flexibility was acknowledged to be important factor but was not visible within adverts and often available to senior staff.
Process for return to work
Interview- RtP process is dependent on whom you know to find placement, Need central list of placement. RtP can be over whelming and isolating so set up own networks. Like flexibility of RtP, Concerns applying for jobs,
Focus Group- Support from peers was viewed as important in focus group. Need multifaceted approach which would include access to schools where mums and dads were often present, and more assistance form regional teams (Other strategies including adverts in libraries, pharmacist, and places where there was high public footfall and or GP websites which are accessible by most of the public (FG2 HB, JL).
Retraining vs refreshing knowledge and skills:
Interview- Limited clarity of role or RtP AHP, supervisor not interested in RtP, Supervisors do not know how to supervise RtP AHP, excluded from training, concerns about using technology and confidence
Focus group- Return to Practice Supervisors did not know their role in professional practice. AHP was not sure of her role. RTP AHP was not a student. Limited clarity as to the role of supervisors in relation to assessment of competence. \

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Return to Practice for AHPs with protected characteristics: synthesis of data

Supervisors were used to supervising students but not RTP AHPs Assessment of AHPs could self-assess their own competences, should be a baseline of what 'you Need to know core competences
Inclusive return to practice
Interview- Health issues childcare issues including childcare costs. work force issues such as service closures, maternity leave issues limited flexible working Paid to undertake RtP competence development Unaffordability
Focus group- If the NHS was more inclusive, we would not have left Need more help from regional teams Advertise in other places where footfall is better

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