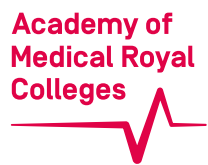
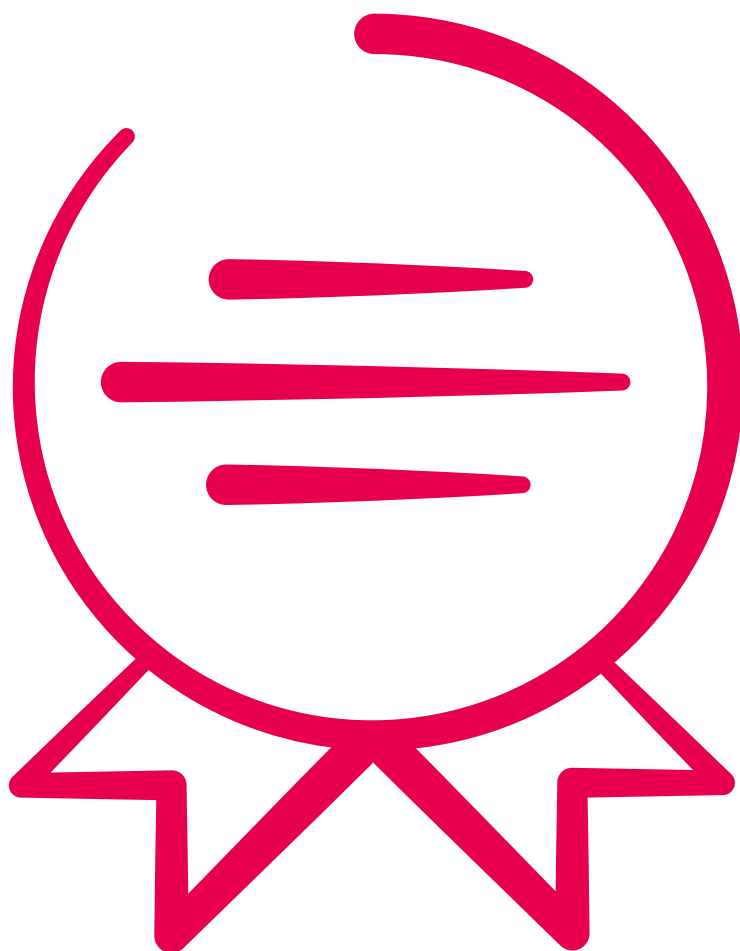


May 2026



Return to practice guidance



Contents

03	Introduction
05	Who should use this guidance?
07	How should this guidance be used?
11	Return to practice plan
13	Return to practice policy
14	Planning an absence from practice checklist
16	Return to practice checklist
18	Appendix 1: Doctors with unresolved issues
19	Appendix 2: Organisations offering return to practice advice
20	Appendix 3: Evidence from the literature
24	References

Introduction

All doctors returning to practice should feel safe, valued and supported. This guidance sets out a process that enables doctors to return to the NHS in a supportive and inclusive way. Doctors returning to practice bring much-needed clinical knowledge and skills, and often valuable learning and insight gained during their time away.

Doctors take planned or unplanned career breaks for a wide range of reasons, including maternity or paternity leave, caring responsibilities, working abroad, sabbaticals, or other personal circumstances. This guidance can be applied in all such situations as part of the return to practice process. In some cases, reasonable adjustments may be required to support a safe and successful return to clinical practice. In others, doctors may have unresolved issues that require additional input to their return process.

This guidance replaces the previous 2017 Return to practice guidance¹ and offers practical advice for all involved in the return to practice process. It is not a guide to obtaining re-employment.

Updates are based on the considerable experience of the stakeholders involved and a review of the previous and latest literature.

Guiding principles

The return to practice process and guidance is underpinned by the principles of **patient safety** and a **positive, supportive and personalised approach** that prioritises doctors' wellbeing and enables a smooth and stress-free return to practice.

These principles align to the NHS [safety culture](#) that provides the foundation for return to practice. This is crucial to a returning doctor, those working with them, and their patients. This culture:

- Supports continuous learning and improvement of safety risks
- Promotes supportive, psychologically safe teamwork
- Enables and empowers speaking up by all, including returning doctors.

Who is the guidance for?

- Doctors who have been absent from practice for three months or more, for any reason, including those returning to their usual practice after working in a different area of clinical practice. This also includes doctors whose licence to practice was surrendered and subsequently restored by the General Medical Council (GMC). All returning doctors have a duty to ensure they are safe to return to practice.
- Employers, contracting bodies and managers, designated bodies and responsible officers (RO), all of whom have a duty of care to support the doctors' safe return to practice.

Who should use this guidance?

All those mentioned here should be aware of, and refer to, this guidance as necessary when a doctor is absent from practice for three months or more. The longer the absence the more helpful this guidance is to ensure a safe and supported return to practice. The general roles and responsibilities of those who this guidance is relevant to are outlined below.

Doctors

Doctors have a professional duty to ensure that they are up to date, competent and safe to return to practice after an absence. They should identify and address any issues arising from their absence and actively engage in arranging processes to support updates to their skills and knowledge. Doctors should expect support from their organisation to plan their absence and a supportive conversation to help plan their return to practice — including phased returns where appropriate. For doctors in training, key individuals in the process will be the Postgraduate Dean and Training Director.

Employers — including GP partners, designated bodies and Responsible Officers

Organisations should have a return to practice policy that supports planning absences and returns. It should help to identify any issues and agree processes to provide appropriate, targeted and proportionate support and training to the returning doctor. Responsibility for facilitating a doctor's return may be with a Senior Clinician or equivalent (such as a Medical Director, RO, Clinical Director, PGD, Lead Clinician, or peer evaluator). For GPs, a meeting with the practice manager and/or a peer could be sufficient to get them ready for practice.

Regulators including the General Medical Council

Regulators should be aware of the processes used to support doctors returning to practice and ensure that ROs and designated bodies are also aware of the processes. Regulators, such as the GMC may only get involved in the return to practice process where concerns about a doctor are raised, or in cases where a Licence to Practice needs reissuing.

Appraisers

Appraisers should help identify any issues affecting a returning doctor and ensure that the appropriate processes are followed. A doctor's previous Personal Development Plan (PDP) aims and objectives may no longer be relevant, particularly after unplanned absences. Therefore, the first appraisal after returning should focus on supporting a doctor's transition back to practice, identifying immediate development needs and checking on their wellbeing. Elements of the return to practice process may be useful for this.

Locums, their employers and contracting agencies

Employers and contracting agencies should clarify locums' employment records and where appropriate liaise with the locum agency RO. Once a locum doctor has secured a role, a supportive conversation should take place with the employer/employing practice. This guidance may apply to periods of less than three months for locum doctors who have not been in regular practice.

Organisations holding performers' lists

NHS England currently holds the performers' list in England. In Scotland and Wales it is the Local Health Boards, and in Northern Ireland it is the Business Services Organisation.

These organisations may need to consider a process to ensure that doctors absent from practice for three months or more can return to practice safely. This should include a supportive conversation with the returning doctor to identify any support and needs they may have.

Doctors who want to rejoin the performers' list are advised to speak to the appraisal service and/or a clinical advisor in the Region/designated body where they want to rejoin.

Those designing and delivering training

Returning doctors may require a tailored and supportive approach that differs from 'traditional' training. Those who design and deliver training should be aware of the return to practice process so that doctors can be safely supported in their return.

Organisations offering continuing professional development and support to doctors, including medical royal colleges and faculties

These organisations may offer advice and updates to clinical skills that can be tailored to the learning and confidence building requirements of returning doctors. Some colleges and faculties may have their own guidance on return to practice.

How should this guidance be used?

Designated bodies, ROs, doctors, employers, contractors and regulators all share responsibility for ensuring the appropriate processes are followed when a doctor returns to practice — to protect patient safety and support the doctors' wellbeing. This guidance provides checklists and advice to support that process.

The guidance applies to all doctors who have been absent from practice for three months or more as time is a key factor influencing a doctor's successful return. However, return to practice needs vary according to individual experiences and circumstances, not just time out of practice. Relevant factors might include, previous experience, skills and responsibilities, activities undertaken during the absence and any prior periods out of practice. Similarly, whether the doctor is in employment, practices as a GP or in private practice, may also impact the return to practice process and needs.

Keeping these exceptions in mind, where possible the return to practice process should include the following elements.

1. Most absences can, and should, be planned for. Where possible, the '**Planning an absence checklist**' should be completed before an absence. This helps both the organisation and doctor to prepare for the absence.
2. When a doctor returns, the '**Return to practice checklist**' should be completed ahead of, or as part of the supportive conversation. Ideally, a doctor will complete both checklists with input from a senior clinician [or equivalent]. However, there may be times when a doctor will do this on their own or with support from a colleague.
3. A '**supportive conversation**' is an opportunity for a returning doctor and a senior clinician [or equivalent] to discuss any concerns and/or needs that they may have. It can provide a chance to discuss the answers to the checklists. The supportive conversation should be handled sensitively according to individual circumstances. Having a supportive conversation does not assume that the returning doctor is not fit to practise.
4. A '**Return to practice plan**' should be devised using the completed checklists and where appropriate, the supportive conversation, to help identify and record any issues, support needed and potential training requirements. Ideally the 'Plan' will be made collaboratively with the doctor and their employer. Depending on the length of absence and any other relevant issues, the Plan may be a short list of actions or a longer more formal plan for review and/or reskilling over a period.

Reasonable adjustments can be made at any stage in the process if needed.

The final decision about the support a doctor needs for a safe return to practice rests with the relevant body. This may be the employer/designated body, the practice or the regulator.

Designated bodies and ROs should use the checklists as part of the return to practice process. They should consider the doctor's revalidation dates and their need to gather supporting information, including any continuing professional development (CPD) completed during the absence and any future CPD needs.

Employing organisations should support the process with their own Return to practice policy. Suggestions for what to include in a policy are discussed later.

Key considerations in the return to practice process

Length of absence

Generally, the longer the absence, the more robust the return to practice process should be, while remaining proportionate and tailored to individual circumstances — as well as any other factors identified the checklists and supportive conversation. All support should be decided on a case-by-case basis.

Shorter absences (less than three months) are unlikely to cause significant difficulties, but a doctor's confidence or skills may be affected. Most doctors can return to practice safely and successfully with minimal support. In some cases, a supportive conversation may still be useful, for example, if there have been special circumstances.

Longer absences (more than three months) are more likely to significantly affect skills and knowledge. It is recommended that a supportive conversation is included in the return to practice process, at which any targeted support that may be needed (e.g. supervision or mentoring) can be identified and recorded.

Extended absences (more than two years) will usually require a doctor to do some formal updating, particularly if they have been entirely out of practice in that time.

Typically, the amount of support a doctor will need will vary depending on the length of absence within these definitions. For example, those who have had a longer absence but closer to the three-month cut off point, may not need a retraining programme. Whereas those whose absence is closer to the two-year mark may find formal updating and training beneficial. In all cases it will depend on individual needs.

Should further evidence on length of absence emerge these suggested 'cut off' periods may need to be reviewed.

Notification and documentation

Doctors are responsible for notifying organisations of an absence, and the organisation is responsible to work collaboratively with the doctor to identify their return to practice needs. Planned absences (e.g. maternity/paternity leave or periods of working abroad) should be prepared for where possible using the appropriate checklist. Early notification of an absence helps better plan for the absence and return, including keep in touch arrangements and identifying appropriate support needs.

Doctors should play an active role in arranging and developing their [Return to practice plan](#). For many, the supportive conversation will be an opportunity to develop their Plan. This should be done with an appropriate senior clinician (or equivalent), depending on the context. Precisely who it will be is for employers/organisations to decide. The person carrying out the supportive conversation may need to judge the level of insight the doctor has into their own needs when creating the 'Plan'.

For resident doctors the Plan should also include return to training arrangements.

Notes and records should be kept. Answers from the [Return to practice checklist](#) should be reviewed against the [Planning an absence checklist](#) (if completed) by the doctor and their employer, partner or contracting agency. Any changes from expectations and/or progress during the period of absence should be recorded.

The familiarity of returning to practice at an organisation the doctor has previously worked at may make the return process smoother. However, this is not always possible, therefore, making the completed checklists available to the new employer will assist with a smooth return to practice.

Doctors who do not have an organisation may be able to obtain help from one of the organisations listed in [Appendix 2](#).

Doctors without an employer, including independent practitioners, remain responsible for managing their return to practice and securing appropriate support. For GPs, a meeting with the practice manager and/or a peer could be sufficient to get them ready for practice.

Should disagreements or issues arise, established dispute resolution processes should be followed. Most doctors will not require escalation. However, if concerns about patient safety arise at any stage, appropriate processes must be followed before the return proceeds ([Appendix 1](#)).

Maternity leave and shared parental leave

For absences relating to maternity and parental leave it should be noted that:

- Employers are legally required to assess and manage workplace risks to new and expectant mothers in line with the Management of Health and Safety at Work Regulations 1999.
- Keep in touch (KIT) days are optional arrangements between doctors and their employers. It is good practice to offer and facilitate them where the doctor is willing able to participate. Maintaining some form of contact during longer absences is helpful and advisable.

Useful resources regarding shared parental leave are available from:

- [Shared parental leave GOV.UK](#)
- [Shared parental leave BMA](#)
- [Shared parental leave NHS Employers](#)
- [Shared parental leave ACAS](#)

Return to practice plan

The 'Plan' should set realistic targets and include agreed review dates. Ideally it should be developed collaboratively between the employer and doctor. However, there may be times when it is the sole responsibility of a doctor to make their own plan. A plan can be helpful to the return process regardless of who has been involved in its development.

The following areas should be considered when creating a doctor's Plan.

Learning needs

Learning needs should be identified using the 'Planning an absence from practice' and 'Return to practice' checklists and should consider:

- How the doctor has learned successfully in the past
- Any new learning required to support safe patient care
- How this learning will fit into the doctor's job plan
- How and when learning will be assessed and reviewed
- How learning will be funded.

Actions that support a safe return to practice

- **Doctors** should record any work or CPD that has been completed during their absence. They should also list any plans for education on their return to practice, such as specialty specific updates.

Doctors are not expected to do any CPD while on maternity/parental/sick leave. Therefore, CPD must be proportionate to the length of time they have been working since either their previous appraisal (excluding their absence), or if they had an approved missed appraisal since their maternity/parental/sick leave, potentially since their return to work.

- **The organisation or employer** should ensure that, where possible, the first patient contact or list(s) is straightforward and that additional support is available as needed. The longer the doctor has been absent, the longer this support may be necessary.

- **The organisation or employer** should ensure that enough time is allowed when the doctor first returns to work for discussions with colleagues and managers, and for them to respond and assist where necessary. It is likely that more time will be needed for those doctors who have been absent longer.

Other methods of support

This may include:

- Arranging for periods of observation of the doctor (either by a peer or organisation/ employer, or both)
- Supernumerary arrangements for a period
- Professional development, e.g. Essential Knowledge Update, or refresher courses where they exist — including guidance on using any new IT systems
- Setting up formal or informal mentoring arrangements
- A phased or staged return to work
- Flexible hours or other flexible arrangements that may be necessary.

Review and oversight

A supportive conversation provides a chance to discuss the return to practice process, the checklists and Plan with a skilled and trained colleague, often a senior clinician (or equivalent). For GPs, a meeting with the practice manager and/or a peer could be sufficient to get them ready for practice.

Those responsible (e.g. Medical Director, Clinical Manager, Appraiser, RO) should receive updates about the doctor's return to practice plan, and of the satisfactory completion of any necessary processes. If this is a formal plan due to a longer period of absence, the employer and the RO should review progress after three to six months, or more frequently if other causes for concern are identified.

Doctors who do not have employers are responsible for managing their own return to practice, including making their Plan and ensuring the necessary support and arrangements are in place for their return. This could also involve informing their RO of their return. [Appendix 2](#) lists organisations that provide advice to doctors who are returning to practice.

Return to practice policy

All organisations employing or contacting doctors should have a clear and supportive return to practice process, underpinned by [patient safety](#) processes and a positive [safety culture](#). An return to practice policy can help with this. Employers should ensure the return to practice process for doctors aligns with similar processes for other healthcare professionals they employ.

A return to practice policy should include recommendations for:

- Preparation **before** an absence from work, where possible, by a doctor and those working with them using the checklist suggested in this guidance.
- 'Keeping in touch' arrangements **during** the absence to support reasonable ongoing communication between the doctor and their employer.
- Holding a supportive conversation to discuss the doctor's needs on their **return** to practice, using the suggested checklists and recommendations in this guidance.
- Making a Return to practice plan with a proportionate, tailored response to the doctor's needs, with the appropriate level of formality.
- Agreed timescales for completing of any necessary support, training or evaluation.

Planning an absence from practice checklist

The following checklist should be used, where possible, before a doctor's absence to help identify potential issues and facilitate support planning. Both the employer and doctor should keep a copy of the completed checklist.

Evidence suggests that self-reporting and discussion with a senior colleague may be valuable for the doctor.² The checklist can be adapted as necessary for self-completion.

The checklist of questions below is available as a [Microsoft Word document](#) for more accessible use.

1. How long is the doctor expected to be absent? (Is there likely to be an extension?)
2. Are there any training programmes (including mandatory training) or installation of new equipment due to take place in the doctor's workplace in the period of absence? If so, how should the doctor become familiar with this on return?
3. How long has the doctor been in their current role? Is this relevant in determining any potential support the doctor needs for a safe return to practice?
4. During their absence, will the doctor be able to participate in CPD or e-learning to keep up to date?
5. During their absence, will the doctor be able to participate in any keep in touch (KIT) days or other means of keeping in touch with the workplace? If so, how will this be organised? If the doctor is returning to a different Trust, how will KIT days be organised?
6. Does the doctor have any additional educational goals during their absence?
7. Are there any funding issues related to question 6 which need to be considered?
8. If known, what CPD, training or support will be needed on the doctor's return to practice?
9. Will the doctor be able to retain their licence to practise and fulfil the requirements for revalidation?
10. Are there any issues relating to the doctor's next appraisal which need to be considered? If so, does the Responsible Officer/representative need to be informed?

11. If the doctor is a resident doctor, how do they plan to return to training?
12. What will the doctor's full scope of practice be on their return?
13. If the doctor will be returning to a new role, what support relating to this will be needed, and how can the doctor prepare?

Signatures

Doctor:

Date:

On behalf of the organisation:

Date:

Return to practice checklist

The following checklist should be used after an absence to help identify any support needed and support the return to practice Plan. Both the employer and doctor should keep a copy of the completed checklist.

The checklist of questions below is available as a [Microsoft Word document](#) for more accessible use.

1. How long has the doctor been away?
2. Was a 'Planning an absence checklist' completed? If so, this should be reviewed.
3. Was the absence longer than originally expected? If so, what impact has this had? (If it was an unplanned absence, the reasons may be particularly important).
4. What relevant contact with work and/or practice during absence has the doctor had, e.g. Keep in Touch days?
5. Prior to their absence, how long had the doctor been working in the role they are returning to?
6. How is the doctor feeling about their return to work, generally?
7. Has there been any impact (negative or positive) on the doctor's confidence or abilities?
8. How aware is the doctor of their support needs and the resources available to them?
9. What support would the doctor find most useful in returning to practice?
10. Would a period of shadowing or mentoring be beneficial?
11. What responsibilities, particularly new ones, does the doctor have in the post to which they are returning?
12. On their return, what will the doctor's full scope of practice be?
13. If the doctor is returning to a new role, what induction support will they need?
 - Will they require any specific support because they have been out of practice?
 - What can the doctor do to prepare themselves?

14. Have there been any changes since the doctor was last in post that they will need training or updating in? For example:
 - Training to use new equipment or medication. Any changes to infection control, health and safety or quality assurance. New procedures, NICE guidance, or any mandatory training missed
 - Changes to common conditions or current patient population information
 - Significant developments or new practices within their specialty
 - Service reconfiguration
 - Changes to procedures due to learning from significant events
 - Changes in management or role expectations. What time will the doctor have for patient care?
15. Are there any teaching, research, management or leadership roles required?
16. Has the absence had any impact on the doctor's licence to practise and revalidation? What help might they need to fulfil the requirements for revalidation?
17. Has the doctor been able to keep up to date with their CPD while they were away from practice? (If they were unwell or on parental leave, this may not have been expected)
18. Are there any issues regarding the doctor's next appraisal which need to be considered? Is the revalidation date affected? (If either applies, the Responsible Officer/Appraiser should be informed)
19. If the doctor is a resident doctor, what are the plans for returning to training?
20. Is the doctor having a staged return to work on the advice of Occupational Health? If so, are there any reasonable adjustments that need to be considered?
21. Is a period of observation of other doctors' practice required and/or does the doctor need to be observed before beginning to practise independently again?
22. Will the doctor need training, special support or mentoring on return to practice? If so, are there any funding issues related to this which need to be considered?
23. Are there other factors affecting the return to practice or does the doctor have any issues to raise?

Signatures

Doctor:

Date:

On behalf of the organisation:

Date:

Appendix 1

Doctors with unresolved issues

Unresolved issues that need to be addressed separately should be dealt with via the normal processes. This Return to practice guidance may also be helpful alongside those processes. Examples of unresolved issues include:

- Health issues. These should be addressed through occupational health processes. Where health is a major reason for absence and is not resolved by the point at which the doctor returns, an occupational health opinion should be considered to receive advice on any necessary adjustments to the doctor's role.
- Conduct issues. These should be addressed through Human Resource Management processes.
- Capability issues. These should be addressed through remediation processes.

Appendix 2

Organisations offering return to practice advice

- [British Medical Association](#)
- [General Medical Council](#)
- [Royal College of Anaesthetists](#)
- [Royal College of Emergency Medicine](#)
- [Royal College of General Practitioners](#)
- [Royal College of Obstetricians and Gynaecologists](#)
- [Faculty of Occupational Medicine](#)
- [Royal College of Ophthalmologists](#)
- [Royal College of Paediatrics and Child Health](#)
- [Royal College of Pathologists](#)
- [Faculty of Pharmaceutical Medicine](#)
- [Royal College of Physicians of Edinburgh](#)
- [Royal College of Physicians London](#)
- [Royal College of Physicians and Surgeons of Glasgow](#)
- [Royal College of Psychiatrists](#)
- [Faculty of Public Health](#)
- [Royal College of Radiologists](#)
- [Royal College of Surgeons of Edinburgh](#)
- [Royal College of Surgeons of England](#)
- [Local Deaneries](#)
- [Medical Women's Federation](#)
- [NHS Resolution](#)
- [NHS Careers](#)
- [NHS Employers](#)
- [Academy of Medical Royal Colleges](#)
- [NHS Confederation](#)
- [Return to Practice \[RtP\] programme. NHS England programme for qualified GPs.](#)

Appendix 3

Evidence from the literature

Original literature review

An extensive literature review conducted for the original 2012 report found that while there is no shortage of opinion in this area there is little clear evidence on skills attrition. The strongest published evidence came from a United States³ study of a re-entry programme for doctors absent from practice for 18 months or more. The study found that 67% of doctors had educational needs that required moderate to considerable re-education or training, and that 'many re-entering physicians may not be ready to jump back into practice'. It also found that the more years the doctor was out of practice, the more likely they were to have poor performance ratings.

A subsequent report by the United States' Federation of State Medical Boards⁴ noted that 'More than two years away from practice is commonly accepted as the timeframe for when physicians should go through a re-entry process.' It emphasised in the absence of data there was a 'need for flexibility when applying the two-years-away-from-practice timeframe to an individual practitioner, as there is great variability in specialty, type of practice, etc.'

Evidence added for the 2017 revision

In 2014, the United States' Center for Personalised Education for Physicians and The Physician Reentry into the Workforce Project published the Roadmap to Reentry.⁵ This stated that physicians who have been out of clinical practice for 'two or more years and are applying for initial licensure, reinstatement, or reactivation of a license must demonstrate competence to practice and meet other state medical board requirements'. It stated that a 'clinician may choose to participate in a formal reentry training program [...] or engage in a self-managed reentry process.'

In 2014, the GMC published Skills fade, which reviewed evidence on the decline of clinical and professional skills during time out of practice and how 'skills fade' may be measured or remediated.⁶ The report echoed the findings of the Academy review in 2012^{7,8} concluding that evidence on the rate and timing of skills decline is 'limited and mixed'. It noted that healthcare professionals take time out of practice for various reasons and 'may be accompanied by voluntary removal from the register for that profession. It may also be as a result of enforced removal from or suspension from the register'. It went on to say that little is 'known about the impact that this time out may have on the registrant's competence, performance and skills. Whilst the requirements for registration

on returning may be set down in legislation, there is little evidence to demonstrate how exactly the specifics of those reregistration requirements were determined. There is evidence that skills decline according to a curve, with the greatest decline being during the first few months, and subsequent decline being at a much slower rate. However, other studies contradict this. Many studies of retention of specific skills measure retention at six, twelve, eighteen and twenty-four months.' It noted that there was some healthcare professional and stakeholder consensus that 'two or three years out of practice should signify a need for reassessment and retraining prior to a full return.'

New literature

Literature published since the last update in 2017 does not substantially change the evidence base but provides greater insight into the wider needs of doctors returning to practice.

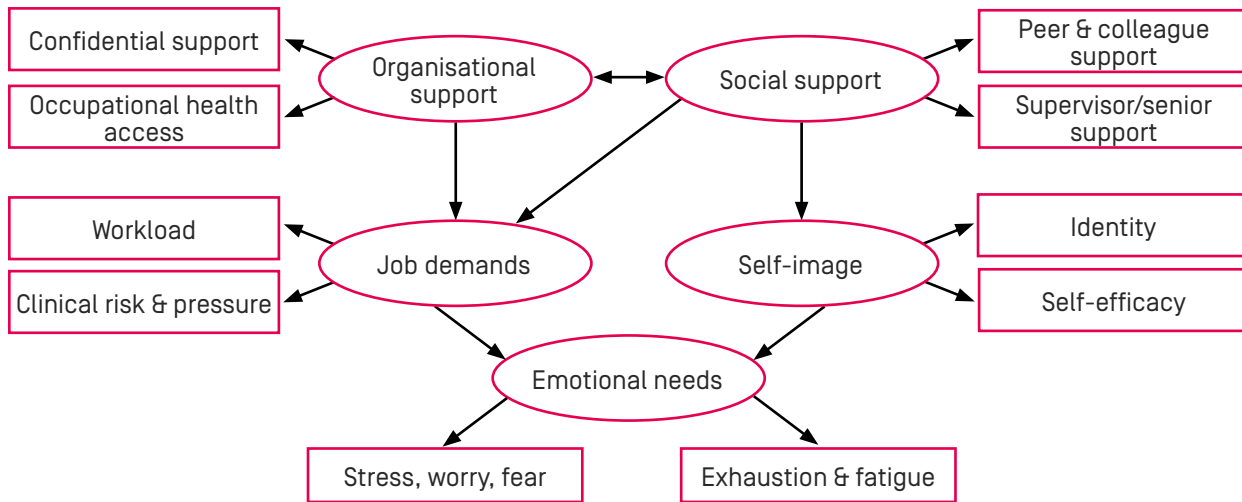
In 2022, a systematic review identified that the key challenges faced by doctors returning to practice⁹ included emotional regulation (e.g. stress about working without supervision) childcare and infant feeding needs, identity changes (including self-stigma) that occurred because of the absence (e.g. being unwell/a patient, or becoming a parent) and social needs, including professional relationships, work culture, and stigma.

The review also identified several factors needed to create a successful return to work, including a clear process of return (which the doctor was involved in creating), flexibility, work/life balance, supportive and positive work relationships and opportunities for career development.

In 2025, a mixed methods study² further explored the needs of doctors returning to practice after an absence. It most frequently identified self-efficacy, colleague support, workplace culture, flexibility and stress the most significant needs or factors in supporting doctors' successful return.

The study conducted further analysis to identify five interlinked domains of need when returning to work — organisational support, social support, job demands, self-image, and emotional needs.

Figure 1. Structural model of domains of need when returning to practice



Source: adapted from Attoe C. (2025)²

The study recommended that interventions should take place at the level of the:

- Individual — 'Every person can be mindful of needs and resources'
- Group — 'Peer groups and clinical teams [...] should consider the role that they have in supporting returning doctors'
- Leadership — 'organisational medical leaders, senior medical workforce managers, senior medics with supervisory responsibility, and recently created RTW champions with funded sessional time to support local returners'
- Organisation — 'support officially offered by an organisation, to complement more informal support and resources'
- And the overarching or social context, e.g. through workplace culture.

The Supported Return to Training Programme (SupportTT) introduced by Health Education England (HEE) in 2017 provides resident (previously trainee) doctors with a supported and safe return to training. In 2021, an evaluation of the impact of the scheme found that most resident doctors using SupportTT agreed or strongly agreed that it had updated/enhanced their ability to carry out safe and high-quality clinical practice [58%], confidence to make sound clinical decisions [55%] and clinical knowledge [49%].¹⁰

From the range of services offered, the most popular activities used by resident doctors were: a pre-absence meeting with supervisor (51%), KIT days (47%) and enhanced supervision (40%). Awareness of SuppoRTT was increasing. It also found that resident doctors' concerns about taking time out have decreased since 2019 suggesting that perceptions are changing around the practice of taking leave.

The Academy considers that the more recent literature does not substantially alter the recommendations in the return to practice guidance. However, small changes have been made to the questions used in the checklists.

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