Developing primary care through education
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An aphorism often invoked by politicians is that 'problems can't be solved simply by throwing money at them'. In the UK, a beleaguered National Health Service (NHS) is faced increasingly by greater demands on its resources, and this statement is likely to be heard in response to pleas for increasing resources, particularly when these are for new services, or for arrangements which support rather than deliver front-line health care. Evidence will be required that new investments can fulfil the main aim of the NHS, which is to deliver the best possible health for the population within available resources. The London Initiative Zone Educational Incentives Scheme (LIZ EI) is providing an important testbed for one such proposal, that investment into educational support for GPs working in London will lead to enhanced quality of care for patients by alleviating the morale and recruitment problems which permeate the capital.

The past 10 years have seen considerable changes in the working arrangements of general practice in the UK and in the composition of its workforce. Important factors include substantial changes in the proportion of female GP principals, the numbers of principals choosing part-time contracts and the mobility of the medical workforce. These and other factors have led to destabilization of the structure of general practice, and declines in morale and recruitment have been discussed widely. Historically, general practice in inner cities, in particular in London, has been underdeveloped, and placed at even greater disadvantages by such problems.

Against this background, the Tomlinson Report on the organization of health services in London, and the response to it by the Government, Making London Better, had significant implications for the future of general practice. The creation of the London Implementation Group (LIG) to oversee developments in the London Initiative Zone (LIZ) included investment in primary care, with infusion of resources into new and refurbished premises, and primary care development plans produced by all London health authorities. It was recognized, however, that additional support would be required for the GPs providing the services. There were already indications of morale and recruitment difficulties in London, and evidence that a national decline in the popularity of vocational training for general practice was more marked in London than elsewhere.

London Initiative Zone Educational Incentives (LIZ EI)

The LIZ EI scheme arose from a conference organized jointly by the Royal College of General Practitioners, the General Medical Services Committee of the British Medical Association, and inner-London health authorities in early 1994. It became apparent that personal factors, in particular amongst GPs, would be at least as important as structural improvements in enhancing the climate for development of inner-London general practice. The aims of the LIZ EI programme are to address problems at all stages of a GP's career—hence the '3 Rs' strategy, aiming to improve recruitment, retention and refreshment. The components of LIZ EI have involved GPs in educational activities for undergraduate medical students, vocational training registrars, developing practitioners, and established practitioners.

Only two of the many schemes, both involving variations on traditional patterns of vocational training for general practice, have operated across London, which is divided into north and south administrative regions by the river Thames. In one scheme 18 months or 2 years of the 3 years of vocational training is spent in general practice instead of the standard 1 year. In the London Academic Trainee Scheme (LATs), an additional fourth year (following completion of vocational training) is spent in an academic department to learn teaching and research skills, and includes working, with a reduced clinical commitment, in a local non-training practice.

Other schemes are co-ordinated either by academic departments of general practice or by local boards at health authority (district) level. A number of primary care/GP resource centres have been set up, and these provide a focus for educational activities, in particular in areas where traditional postgraduate medical centres have not been well established.

The LIZ EI programme has provided real resources to back up what otherwise have been idealistic proposals. In the first full year of operation of the programme, over 900 GPs, or almost 40% of the London total, participated in one or more of the available schemes. Successes include the following.
Community Medical Education North Thames (CeMENT)
CeMENT involves all London undergraduate departments north of the Thames in a major training programme to enable GPs to participate in teaching basic clinical skills of history taking and examination to medical students in general practice, in co-operation with hospital colleagues. Typically students spend half a day per week in general practice and the GP becomes an honorary member of the hospital teaching ‘firm’. This scheme allows a substantial incremental shift of teaching from hospital to general practice to take place.

MRCGP course for mature principals
There are now three such courses in South London. The first course in south-west London attracted 14 mature principals, of whom 12 were non-UK trained, and the majority were not vocationally trained. Protected time is allocated for 1 day per week with locum cover. Evaluations show increasing confidence in study methods for the group after initial difficulties in returning to study. The outcome measure for this initiative is a robust one.

Personal Development Plans (PDPs)
These are proving popular across all areas. One great strength of LIZ EI has been to provide new resources for genuine personal education plans, together with educational guidance and support. For example, PDPs in West London range from attendance at courses for intra-articular injections and a co-ordinated practice programme for utilizing computers for audit and development through to a Masters degree in medical education.

In East London, the accent is on practice-based education and on practice, as well as personal professional development. A successful mentoring scheme set up in Barking is being extended to neighbouring areas. There is also an unusually large number of academic attachments to the medical school in East London, for both principals and salaried fellows, to learn and to apply research skills. These doctors have fewer academic sessions than LATs trainees. The first peer learning group set up is dealing with research skills. Others to follow will focus on clinical and managerial skills.

LATs
The LATs programme is providing a substantial increase in academic skills, particularly in teaching, research and development, for young GPs straight after vocational training. Funded part-time clinical work continues in a non-training practice. The aim is to seed a number of skilled GPs in the London area, each having a strong link with an academic department. Individual learning and supervision within departments is supplemented by group learning sessions drawing on the expertise of all academic departments of general practice in London. Evaluation to date shows that 75% of the first LATs cohort are continuing to practise in London, with academic links.

Mid-career breaks
These schemes are proving popular across London. In South London, for example, established GP principals have opportunities for substantial periods of study, either on a day-release basis or on the ‘prolonged study leave’ model. Although GPs’ contractual regulations theoretically allow the latter under existing terms and conditions of service, the process of approval can be tortuous. Two major advantages provided by LIZ EI, in addition to rapid access to such study leave, are academic support and guaranteed clinical cover within the practice.

Academic assistant programme
Very few of the LIZ EI schemes would be feasible without consistent and reliable clinical cover for the practitioners who are released to participate in them. Health authorities are unable to employ doctors as GP locums, and existing locum services were unable to meet demand. In a number of areas ‘academic assistant’ schemes have provided a highly acceptable solution. Doctors, usually recently vocationally trained and, typically, working seven clinical and three ‘academic’ sessions per week, are employed by medical schools. They provide regular clinical cover for two or three LIZ practitioners, and have three development sessions for themselves per week, in which they may contribute to teaching, carry out projects, or pursue postgraduate diplomas. For example in south-west London, 13 full-time-equivalent academic assistants based at St George’s Medical School, have provided clinical cover for over 60 principals.

Problems with the LIZ EI programme have involved a certain amount of bureaucracy in starting the projects, and changes in administrative arrangements which created further delay. Because academic support was needed to run and co-ordinate a number of the projects within the programme, time was lost before projects were working at full pace. The major problem of providing sufficient clinical cover to enable doctors, particularly those working in small practices, to come out of clinical work and take advantage of the educational schemes has been addressed by ‘academic assistant’ scheme described above. However, such schemes portray one of the first examples of the employment of GPs on a salaried basis in the UK by institutions which do not provide general medical services. Advantageous terms of service have created some political concerns. Nevertheless, the recent Government White Paper on the future of primary care offers the opportunity for this model to be developed further. Any such problems are greatly outweighed by the opportunities which are being realized for many hundreds of inner-London GPs, and also by the increased
co-operation occurring between health authorities, service general practitioners, and academic departments, undergraduate and postgraduate.

One of the main concerns has been uncertainty about the future of these welcome developments. Already, in the second year of three, there is anxiety as to how the most effective components of the LIZ EI programme may be retained in London and, hopefully, introduced in other inner-city areas. The overall LIZ programme finishes in 1999, and an interim decision to allow LIZ EI to continue for a further year, to be coterminous with this, might offer a rational way to deal with this question. Other possible sources of funding to pick up the ‘resource tail’ include contributions from undergraduate, postgraduate and R&D financial levies, but it is unlikely in the foreseeable future that health authority funds, which are under severe pressure, will be able to sustain all of these initiatives, even where they are able to demonstrate improvements in patient services and care.

There is a pressing need for thorough evaluation, which defines the benefits accruing to practitioners and to the quality of care for patients. An external evaluation of the programme is being carried out by Nottingham University, and each of the projects includes an internal evaluation. GP satisfaction and academic achievement will carry less influence than demonstrated improvements in recruitment, retention and standards of care, and if the latter can be demonstrated there will be considerable pressure on government to continue and expand the approach. In essence, LIZ EI is providing a new system of funding postgraduate education which empowers GPs to plan their own continuing professional development. The key differences are that it is being properly funded, with new money and with appropriate support. Although the sums involved are large, they comprise only a small proportion, less than 10%, of the sum spent annually on general medical services in the LIZ area. Such resources could provide a telling long-term investment to create an effective inner-London workforce with higher morale and greater job satisfaction.

References