re-training, and have to stretch their per capita budgets for specialty training to fund an I+R scheme. Wales Deanery provides GPs on its scheme with an “educational grant” of £2500 a month from the £24 000 it sets aside for each GP’s six month placement.

Health boards in Scotland receive funding towards the scheme direct from NHS Education for Scotland (NES), some of which goes towards the salaries of GPs on the scheme.

Vautrey believes the risk of having no salary or a below average salary is likely to dissuade GPs from taking career breaks and from returning to practice if they do take time out. “If [GPs are] not supported appropriately, then that makes it very difficult for them to return into the workforce,” he says. “Doctors should be treated fairly. If they are employed, in whatever capacity, they should be paid appropriately.”

Fiona Cornish, president of the Medical Women’s Federation and a GP principal in Cambridge, says variation in provision of I+R schemes could disproportionately affect women GPs. This is because many women take time out to start a family at some point in their careers. In fact, the federation encourages women not to take more than two years out of clinical practice if possible. “We get distressed enquiries from people who, for example, have been away in Australia for six years and come back and are told they have to go into the scheme,” she says. “I think people need to be better informed that if they take a two year break they’re going to be in trouble.”

Women will make up more than 50% of the medical workforce by 2017.1 Cornish argues that it is therefore critical that they are retained in clinical practice. “It must be feasible for [female doctors] to have families and work,” she says. “Workforce planning needs to be creative so that schemes are available for women to be retained in the workforce.”

Lewis says, “Once absent GPs hit the two year mark and people demand re-training but there’s no money for it, then they’re lost to the NHS.”

Looking forward

The ongoing healthcare reforms in England, and their effect on how funding for education and training is collected and distributed, could either solve the problems with I+R schemes or lead to the death of such schemes.

Deaneries and primary care trusts will cease to exist on 1 April 2013 and be replaced by local education and training boards (LETBs) and the NHS Commissioning Board, respectively.

The Department of Health has said that under the new system LETBs will be able to decide for themselves whether or not to fund an I+R scheme, in the same way that deaneries do now. A spokesperson said: “It is an important principle that decisions on training and development of the healthcare workforce, including the best use of funding, are taken locally, as LETBs are best placed to assess the health needs of their local community.”

Vautrey believes consistency is needed across the country, however, and that Health Education England could take a role in overseeing this. He suggests that the NHS Commissioning Board could take responsibility for greater standardisation of the scheme, because it is the central organisation that will be in charge of performers’ lists for all GPs in England.

Lewis thinks the NHS Commissioning Board should centrally fund the I+R scheme in England. But he says that the board may well use the independent contractor status of GPs to absolve itself of this responsibility. “My argument is that [the NHS Commissioning Board] has a duty to make sure that there is an adequate workforce for it to commission services from,” he says.

Whiteman believes it would be “absolutely fantastic” if the Department of Health centrally provided funding, as it did before 2006. “If you look at the plans for the development of the health service or healthcare delivery, primary care is expanding, or the demand for primary care is expanding,” she says. “The government needs to make sure that it’s got the workforce in place to meet this need.”

Competing interests

None declared.


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