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Lifelong learning, its facilitators and barriers in primary care settings: a qualitative study

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Although the need for lifelong learning, with implications for the development of all primary healthcare team members has been emphasized by policy documents and the new General Medical Services (nGMS) contracts, inter-professional facilitators and barriers for lifelong learning have not been fully investigated. This article presents common facilitators and barriers to lifelong learning as perceived by both implementers and recipients of a regional primary care workforce development strategy. It is based on a wider formative explorative evaluation study involving semi-structured interviews and focus groups in 22 primary care trusts (PCTs) and associated general practitioner (GP) practices in South East England. Twenty-nine strategy implementers, comprising Associate Deans, Lifelong Learning Advisors, Primary Care Workforce Tutors, GP Tutors, PCT Educators, were interviewed and 12 took part in two focus groups. Thirty-one strategy recipients, GPs, Practice Managers, Practice Nurses were also interviewed. Interviews and focus groups were recorded, transcribed verbatim and analysed using thematic framework analysis. This study provides evidence that traditional cultures, marked by a lack of inter-professional learning still exist in primary care settings and may obscure lifelong learning. Common facilitators to both implementers and recipients were influential professional networks, managerial and peer support, recent policy changes and protected learning time. Common barriers to both groups were insufficient organizational support, time constraints, lack of funding and boundaries between PCTs and general practices. Strategies to overcome barriers and reinforce facilitators need further exploration. PCTs and general practices should become learning organizations that provide continuous learning opportunities, support collaboration and foster links between organizations and individuals. Lifelong learning development can only flourish when a support system is created, composed of clearly allocated time, budgets and a sustainable support framework.

Key words: barriers; facilitators; lifelong learning; primary care; qualitative study; workforce strategy

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Introduction

Background

Lifelong learning is key to delivering the Government's vision of patient centred care and effective organizational development (Department of Health, 2001). It refers to learning for creativity and continuous improvement, it is about growth and opportunity, about ensuring that staff, teams and organizations can acquire new knowledge and skills, both to realize their potential and to help shape and change things for the better. It is highly dependent on building, investing in and sustaining knowledge, learning environments and infrastructure. All contracted National Health Service (NHS) staff need to

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take responsibility for their professional development. Whenever practical, learning should be shared by different staff groups and professions. In addition, the need for continuous professional development (CPD) as a structured approach through which individuals undertake lifelong learning (Department of Health, 1998), has been seen as fundamental to quality assurance, clinical governance and effective risk management (Charlton, 2001; Institute of Clinical Research, 2005).

The new General Medical Services (nGMS) contracts emphasize the need for learning, education and training, with implications for the development of all primary healthcare team members linked to new career opportunities for staff including nurses and managers (Royal College of General Practitioners, 2004a). Consequently, the practice managers' needs relating to job competencies, support and training have been reviewed (Royal College of General Practitioners, 2004b). Lifelong learning through CPD is also supported by the Nursing and Midwifery Council (NMC) via post registration education and practice (PREP) standards (Nursing and Midwifery Council, 2002).

Following these developments, ensuring that the future workforce is fit for purpose in terms of professional knowledge, lifelong learning skills, recruitment and deployment has been challenging. The need for change has been addressed by implementing lifelong learning and CPD strategies at national, regional and local levels. Although successful implementation is dependent on overcoming barriers to change, such barriers and facilitators in primary care settings have not been fully investigated.

The present study

This article reports findings of a wider formative explorative evaluation (Shriven, 1991; Clarke, 1999) conducted over a 10-month period (May 2004 to February 2005). It was designed to evaluate the impact of a regional primary care workforce development strategy from the perspectives of those involved in development and implementation (implementation group) together with the intended recipients (recipient group) (KSS, 2003). The strategy, implemented early in 2003 in South East England, following the success of a local pilot, encompasses the NHS lifelong learning framework applicable to all health professionals. It focuses on the development and implementation of appraisal linked to personal development planning and CPD.

The aims of this article were (1) to explore the lifelong learning culture in primary care settings and (2) to explore common inter-professional lifelong learning facilitators and barriers as perceived by both those involved in implementation (implementers) and the intended recipients (recipients) of the strategy. Due to space limitations, those barriers and facilitators not shared by both groups are not presented.

Methods

Study design

A formative evaluation framework was utilized for the wider project, including quantitative and qualitative methods, since the intent was to provide feedback to commissioners and the other strategic groups responsible for rolling out the strategy (Shriven, 1991; Clarke, 1999). An exploratory, qualitative evaluation of the experiences of those who implemented and received the strategy is presented here.

Setting and recruitment

The strategy implementation involved 24 primary care trusts (PCTs) encompassing 900 general practitioner (GP) practices within three regions in South-East England. Twenty-two PCTs agreed to participate following Multi-site Research Ethics Committee (MREC) and local research governance approval.

A purposive sample was drawn from implementers working within PCTs and the regional Postgraduate Deanery according to their professional and strategy implementation role. This encompassed 40 implementers, including Associate Deans, Lifelong Learning Advisors, Primary Care Workforce Tutors, GP Tutors and PCT Educators. Half of those sampled were in the medical profession.

Randomly stratified proportional sampling was used to sample 10% of all GPs, practice managers and practice nurses from practices in the three regions; including a total of 79 recipients of the strategy: 49 GPs, 15 practice managers and 15 practice nurses. GP details were found in a public domain website listing, NHS online. Care was

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taken to sample single-handed practices as well as bigger practices.

Participation and methods

Implementers and recipients were invited to participate by letter accompanied by study information, consent forms and availability sheets. Where names were not available for recipients, the study pack was addressed to the GP, practice manager and practice nurse.

Potential participants were offered the choice of either a face-to-face or telephone semi-structured interview; implementers were also invited to participate in focus groups. The choice of telephone and face-to-face interview was employed to generate new data and also facilitate wider participation. Focus groups were employed to provide the opportunity for a group discussion and explore issues identified in interviews in greater depth. Topic guides were developed based on key areas for investigation, including lifelong learning barriers and facilitators.

Interviews were conducted with 29 implementers and 31 recipients and lasted between 30 and 60 min. Two focus groups ($n = 12$) with implementers, of 60–180 min duration, were also conducted.

Data analysis

Interviews and focus groups were tape recorded and transcribed verbatim. All recordings were checked against transcripts to verify clarity and accuracy. Transcripts were returned to half of the participants for validation, comments on accuracy, confidentiality and exclusion of particular views expressed at the interviews, if they so wished at this stage.

The data were analysed using thematic framework analysis, involving a systematic process of 'shifting, charting and sorting material according to key issues and themes' (Ritchie and Spencer, 1994). Transcripts were read repeatedly to identify key themes, codes and categories, which were then developed into a coding framework. The framework was used, amended or modified accordingly by MB, SM and LW. Multiple coding of data tested the acceptability and reliability of the designated categories. The final framework, which formed the basis for data interpretation, was discussed and agreed by the three researchers.

Results

Participants' characteristics

A breakdown of participants by strategic and professional roles, participation method and region are summarized in Table 1.

Pre-existing lifelong learning cultures (Figure 1)

Given the relatively short timescale since the strategy implementation, exploration of pre-existing cultures was considered important, as they may have had facilitated or prohibited lifelong learning processes.

Traditional cultures

The view that independent, small business culture, traditional operational ways and reluctance to change still existed in general practice was expressed in several occasions. This culture may have affected lifelong learning negatively:

> I see it as very much a shift in cultures, yes. It's very hard because primary care, general practices are independent, small businesses, that can feel as though they exist inside, and yet outside the NHS. Because of the tradition of the independent contractor status, it's got its advantages and disadvantages, and one of the disadvantages is that it is possible to work with the feeling that nothing's ever changed, it's been working that way for 100 years …
>
> (Implementer – Interview 21, p. 7)

Traditional attitudes of some GPs in particular, associated with time and workload limitations may have impeded lifelong learning of other practice staff:

> I find it's very hard to make myself available for a day away from the practice, and you know I think sometimes GPs probably feel, you know, that my time is better spent here than out probably you know developing myself …
>
> (Recipient, PM – Interview 46, p. 4)

There was also a perception that lifelong learning was not inclusive, open and available for all PCT

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Table 1 Participants' characteristics

Implementers by region and participation method[a]

Regions	Focus groups		Interviews		
	Group 1	Group 2	Telephone	Face-to-face	Total interviews
Region 1	1	1	6	5	11
Region 2	1	3	3	5	8
Region 3	1	5	5	5	10
Total	3	9	14	15	29

Recipients by region and professional role – participation in interviews

Regions	Telephone interviews			Total interviews
	GPs	Practice managers	Practice nurses	
Region 1	4	7	5	16
Region 2	0	4	5	9
Region 3	1	5	0	6
Total (n = 31)	5	16	10	31

[a] Professional role of implementers has not been included to protect anonymity and confidentiality.

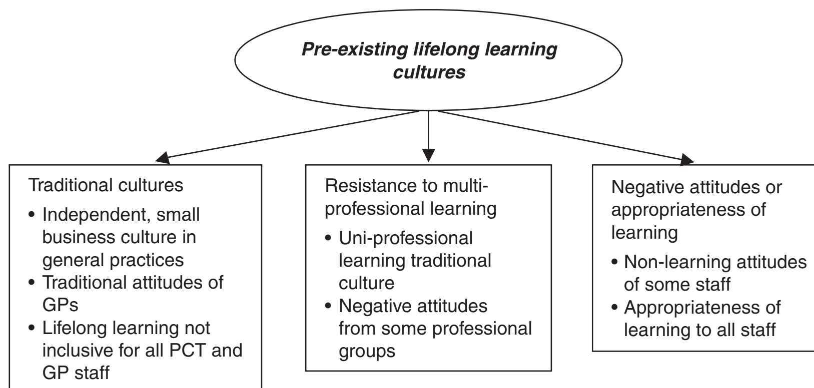

Figure 1 Pre-existing lifelong cultures

and general practice staff. It was only for those who expressed a relevant interest:

> I think there was an expectation that lifelong learning was for those who wanted it and those who wanted it expected it to be delivered on a plate, paid for, supported, etc. and those who didn't want it saw no reason to be involved in any shape or form. It was new [to] staff and they didn't want to be there …
> (Implementer – Interview 15, p. 1)

Resistance to multi-professional learning

Multi-professional learning and sharing were not traditionally part of the culture in both PCTs and general practices. The view was expressed that joint learning was difficult to operate; and even if it was accepted and not clearly opposed, was resisted by some staff:

> … you can see sometimes conflicts between what's said and what's done. But the general sort of ethos and opinion of the primary care

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> trust and the people out there is yes they want this to happen, everybody says they want this to happen, whether that's because one person says it so everyone thinks I'd better say it as well otherwise I'll be going against the flow sort of thing, but secretly they're resisting but it is something that is wanted, something that is accepted is going to happen.
> (Implementer – Interview 25, pp. 4–5)

In some occasions, negative attitudes, stereotypes and expectations from particular professional groups obstructed multi-professional learning settings:

> I think not all the players … are that convinced that it's important. I've had discussions with GP tutors, for example, who have said, if we put on joint learning things none of the GPs want to come so I'm not going to. We've done that on half days and it doesn't work, I'd rather let the nurse tutors deal with the nurses, I'm supposed to be here for GPs.
> (Implementer – Interview 12, p. 3)

Negative attitudes or appropriateness of learning

The traditional cultures and resistance to multi-professional learning were combined with non-learning, negative or non-participatory attitudes towards learning of selected practice support staff:

> … found it difficult engaging some of the staff in the process. That was reception staff generally … I think they found difficulty engaging them in the process and getting people to see that there was a value in learning and people perhaps wanted to come to work and do their job and go home again, pick up their pay packet …
> (Implementer – Interview 34, p. 3)

The question of the appropriateness of learning to all staff, regardless of professional role, age and other attributes, was also raised by participants. This was considered to be particularly the case for support staff, such as receptionists and cleaners who had perhaps already achieved their learning goals:

> I mean an example … is that we have a cleaner. And I can't even persuade her at the moment to go on an introduction to health and safety course because she's been here some time, I have no problems with her work, she has read and conforms to all the procedure manuals, but she doesn't feel that at 63 it is something for her, and that's the bit I find difficult. I'd like her to, but I equally have to say, yes, you know, I'm not convinced that you should spend half a day a year doing it, I don't know …
> (Recipient, PM – Interview 37, pp. 3–4)

Common facilitators to both implementers and recipients (Figure 2)

Professional networking

Professional networking facilitated the whole lifelong learning process. Building relationships across PCTs, general practices and practice staff, offered opportunities for building trust and understanding for both implementers and recipients:

> I think the key is networking and building teams … I've focused on building the relationship with the practice, the centre manager and the staff. Being with the GPs at lunch time meetings, building trust and understanding.
> (Implementer – Interview 5, p. 4)

> There are regular meetings between practices and the primary care trust whereby obviously issues are discussed and needs identified, and we within this area, practice managers, we have an informal get together every three weeks or so to discuss current issues and that, so there's a good support network within the area …
> (Recipient, PM – Interview 35, pp. 2–3)

Some implementers formed close working partnerships and shared learning collaborations with each other and also with working teams, thus creating great opportunities for shared learning and support:

> In some cases the [named role] and the [other named role] have kind of struck it off like a house on fire right from the start, and have worked well together, shared their perceptions and views, and developed lots of useful ways of working with PCT and the doctors in that area.
> (Implementer – Interview 21, p. 5)

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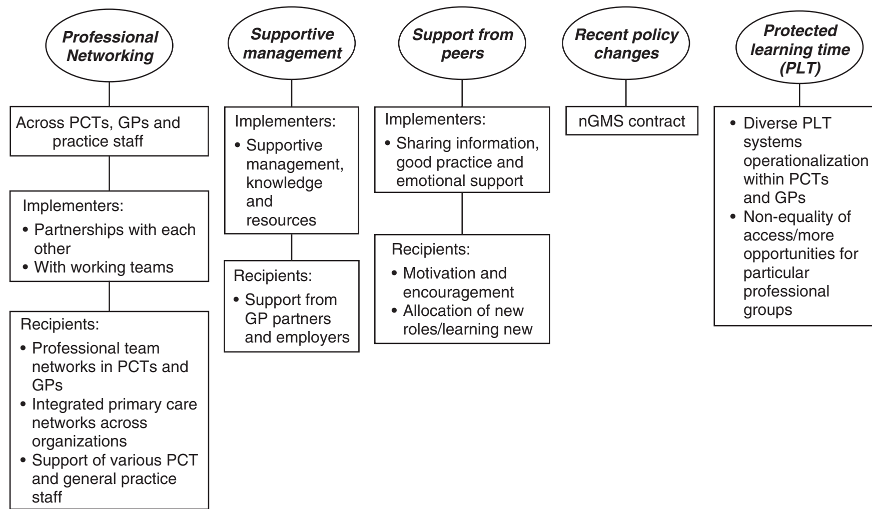

Figure 2 Common facilitators to both implementers and recipients

Professional team networks in PCTs and GP practices as well as integrated primary care networks across organizations offered support to different professional groups of recipients. Recipients also experienced support of various PCT and general practice staff:

> … we've become Nurse Practitioners, we have developed our own Nurse Practitioner Forum amongst ourselves because we felt we needed to support each other, which has been great …
>
> (Recipient, PN – Interview 38, p. 4)

> The support network, there are people in the PCT, there are the practice managers, and people that you can bounce ideas off and things like that.
>
> (Recipient, PM – Interview 45, p. 4)

Supportive management

Support from management, existing knowledge and resources facilitated lifelong learning processes for implementers, especially those newly employed:

> They [Line Managers] helped me understand the culture of primary care, they enabled me to make some contacts at the beginning and in fact a lot of their work that they were doing was quite a tight fit with what was in the aims of the project anyway, so there's an integrated approach I think, they helped me in that way, supported me.
>
> (Implementer – Interview 34, p. 1)

Support from general practice partners and employers was essential for some recipients. This support appeared in various forms, that is acceptance or receptiveness towards learning programmes:

> My partners are quite receptive to anything that I wish to do, it comes at my initiative but they're quite happy to go along with it as long as they feel it would be beneficial and that's about it really … I don't think they identify training needs, I think what they might do is identify with me areas where perhaps they'd like to see me develop and then it's up to me …
>
> (Recipient, PM – Interview 40, p. 2)

Support from peers

Sharing information, good practice and receiving emotional support from peers with similar professional roles, as associated with the strategy, was important for implementers:

> I have on my desk the contact details for the other {peer} and I know that I only need to

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> send an email or make a phone call … We try and sort of buddy each other, you know, we each have an informal agreement that we would link with one other area and if we had a bad day or a particularly good day that we could just sound ideas off one another. If we've got a particularly good piece of literature or we've found a really nice website or something then we'll share that.
> (Implementer – Interview 15, p. 9)

Provision of motivation and encouragement or simply allocation of additional roles requiring learning new skills from peers with other or similar professional roles was supportive for recipients:

> I think support of colleagues, contemporaries, particularly on courses, are very encouraging and give me a lot of motivation and encouragement. Myself, I've found it so rewarding, it's made such a difference, it's made me want to carry on and not lose momentum, I think.
> (Recipient, PN – Interview 29, p. 5)

Recent policy changes

External drivers such as recent policy changes, the nGMS contract in particular, whilst creating anxiety, initiated organizational changes and facilitated lifelong learning in various ways and to a lesser or greater extent:

> I think it's also helped me with the new GMS contract coming in, because the practices have been well frightened in a way, anxious, you can use all those words and any help that they can actually find, you know to support them within this …
> (Implementer – Interview 14, p. 3)

> … in general practice there's been massive changes over the last year since the new GP contract. But everything that has happened has just evolved because of needs, whether external due to the new GP contracts, or our own internal goals and objectives such as our having become a paperless practice …
> (Recipient, PM – Interview 35, p. 4)

Protected learning time

Protected time for learning and development was another main facilitator for lifelong learning. Importantly, protected learning time (PLT) systems were operationalized in diverse ways within PCTs and general practices depending on PCT and individual general practice arrangements:

> Well within our PCT we, every member of staff should have mandatory training in protected time and up to three days of continuous professional development in protected time during the year, that's all PCT staff …
> (Implementer – FG1, p. 37)

> One of the most positive developments that we've had in the last couple of years is to actually see PLT and that occurs in two forms really. The PCT allows for closure of practices for half a day approximately once a month and they are used in central forum events, where one area meets together with a keynote speaker and workshops. Or alternatively, practices are allowed to develop their own in-house learning for an afternoon.
> (Implementer – Interview 4, p. 6)

These different practice arrangements may have affected equality of access to lifelong learning and created more opportunities for particular professional groups, such is GPs than others:

> I think the protected time we have for the GP afternoons is great in that it's protected time, so all the surgeries close, and I think if that could be used better that would be the best way because everyone in the area goes and it's protected time, and as a salaried doctor I will always go even if I think it's something I don't need to know about, but it's protected so I go …
> (Recipient, GP – Interview 7, p. 5)

Common barriers to both implementers and recipients

Insufficient organizational support and arrangements (Figure 3)

Strategy implementers encountered several challenges working across organizational boundaries due to their overarching complexity and competing agendas. Some felt that there was insufficient organizational support, while others

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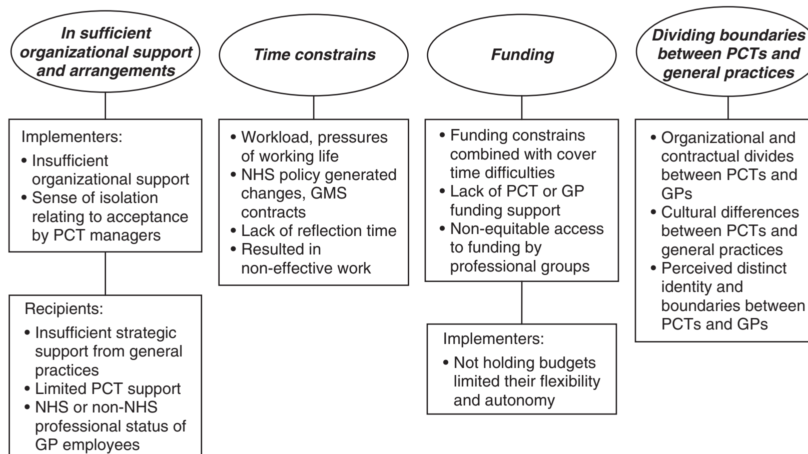

Figure 3 Common barriers for both implementers and recipients

expressed a sense of isolation relating to acceptance by PCT managers:

> I think there was insufficient support from the (name of organisation) … I think that was the main thing, a) because it meant that we didn't have appropriate directions and b) because … without high level buy in from senior people in primary care trusts, it would be very hard.
>
> (Implementer – Interview 9, p. 9)

> … I do feel as though I'm an interloper within the PCT and not accepted, by senior people, rather than by the staff.
>
> (Implementer – FG 1, p. 22)

General practice strategy recipients on the other hand, encountered not only insufficient strategic support from their general practice, linked with time and resources, but also limited PCT support:

> I think commitment of the surgery in that usually they're unwilling to employ a locum whilst you go off and do things, so the length of the course certainly, whatever it is, is a barrier, because the longer it is, the less likely you are to get approval because you're away from the surgery more times, so the length of courses, as well as the financial aspect as well …
>
> (Recipient, PN – Interview 56, p. 4)

> All I would say is that is limited to an immense amount of training opportunities that is fed from the primary care trust into the GP practices. There has not been anything specific directed towards me, but as I say, we do get the opportunity to attend copious amounts of training workshops and seminars, etc. …
>
> (Recipient, PM – Interview 27, p. 3)

In addition, the different – NHS or non-NHS – professional status of GP employees has had an effect on lifelong learning arrangements and opportunities. The non-NHS professional status seemed to limit opportunities for those employees:

> … Now the doctors will get certain things down either through the LMCs, or directly as part of their appraisal processes, and that has developed a lot for them this year. And they're training, they get training opportunities, but I think outside of the medical line, there is an issue about we are not NHS employees, but the people at the top, i.e. the ministers, etc., consider we are. But there's somewhere we aren't included.
>
> (Recipient, PM – Interview 37, p. 5)

Time constraints

Time constraints linked with change processes and workload pressures impacted negatively on lifelong learning. NHS policy generated changes, increased working life pressures and perceived as

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increasing time barriers. Time demands may be linked to the nGMS contract, as the view that it has placed demand on both clinical and administrative staff was expressed:

> Incredible demand on time as the NHS, both primary wise and secondary wise, changes its focus in terms of meeting what I would say is a more modern business model than perhaps the NHS has ever been used to. The prime example of that is the introduction of the new contract and the focus on 10 chronic disease groups … So, that in itself has caused a tremendous demand on the time of both clinical and administrative staff within primary care, so really, the only drawback is time.
> (Recipient, PM – Interview 27, p. 5)

Participants from both groups indicated that there was no reflection time either individually or as a team. Time constraints may have further resulted in non-effective work and decreased satisfaction:

> The problem always is that the process of change is so rapid that there is a perception that we're keeping up, we're fire fighting, we're dealing with problems, we're not reflecting ourselves individually, collectively, so we're carrying out procedure rather than sitting back. …
> (Implementer – Interview 11, p. 3)

> I wish I had more time to have a bit more reflection with my team. I'd like to sit with my nurse practitioner at the end of every day and say what was good today, what was bad today, how could we have done things differently? And time for reflection to support my team would be nice.
> (Recipient, GP – Interview 28, p. 9)

> Time is a problem … Yeah, so it's needing to be aware that people need specific time to do this properly. It's not a rush thing, you do need that time to be able to do it effectively I think …
> (Recipient, PN – Interview 57, pp. 3–4)

Funding

Funding constraints or funding clarity for PLT affected lifelong learning for all primary care professionals in various ways. Funding limitations combined with difficulties in covering time by locums or other staff and lack of PCT or general practice support for professional development severely limited lifelong learning access. In addition, access to funding was greater with particular professional groups than others:

> And you know for the GPs we'll get a locum in to cover them to do their work, although they still complain and say that a lot of their work's still sitting there when they go back, but for the District Nurses, the Health Visitors and School Nurses and people like this, there is no locums to cover them, and there is no backfill money to cover them either.
> (Implementer – FG2, p. 37)

> … funding is always a problem, and in that the GPs are not particularly happy to fund things so unless you've got something that's funded purely by the PCT, or you can get a rep to fund you which means a lot of ringing around and a lot of time consuming interviews with reps, to get the funding, then that's always a problem … And that's the battle, you know yes they'll do it if you find the funding, to foot the bill and that's what I find difficult about it, in a GP practice.
> (Recipient, PN – Interview 56, pp. 1–2)

Lack of or insufficient funding was perceived as important barrier, especially for those who had to implement the strategy. Not holding budgets limited their flexibility and autonomy:

> I think the other challenge I find within my role is that I'm not responsible, I don't hold a budget and I'm not responsible for implementing any sort of decisions that I make, I have to basically, you know if it's around training if I want to put on any training, I have to go through the training department …
> (Implementer – Interview 32, p. 4)

Dividing boundaries between PCTs and general practices

The organizational and contractual identities and differences between PCTs and general practices have created divides in the provision and access to

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lifelong learning:

> It's very difficult, PCT is like a general body, and GPs are independent contractors, and when it suits them PCT say oh, I'm sorry, you're independent contractors, it's your problem. But when it doesn't suit them they say we control you, you've got to do it. So it's a very difficult relationship with these practices and PCT. And CPD could be a wonderful, you know, way to build that bond, a bridge, you know, a facilitative bridge, you know, but nobody from PCT has asked me how they could help me with my career development.
>
> (Recipient, GP – Interview 28, p. 10)

Cultural differences between PCTs and general practices together with the attitudes each embodied also obstructed learning opportunities:

> It {the culture} varied, varied enormously, I think I'd say in general practices, some were very clued into the learning process and the need to learn, as far as the PCT is concerned, again I think that was more established but I would say that there was a lot of talking around it …
>
> (Implementer – Interview 14, p. 5)

The perceived distinct identity and boundaries between PCTs and general practices made working together and lifelong learning difficult:

> … you know PCT is somebody out there, Big Brother … One GP, when I went along with the Practice Nurse lead, the GP said oh Big Brother have come to see us as he stepped out of his big BMW you know …
>
> (Implementer – FG1, p. 5)

> It has to be said that working with the PCTs is not as easy as it sounds, and getting information out of PCTs and getting them to see appraisal as a priority is a continual battle, but it's a battle worth fighting but it does continue to be a battle.
>
> (Implementer – Interview 19, p. 10)

Discussion

Summary of main findings

This study identified that similar barriers and facilitators exist for various primary care professionals both in PCTs and general practices. It has found that traditional non-sharing, non-multi-professional lifelong learning cultures still exist in primary care settings and may obscure lifelong learning. Influential professional networks, managerial and peer support, policy changes and PLT may facilitate lifelong learning for all primary care professionals. Insufficient organizational support, time constraints, lack of funding and boundaries between PCTs and general practices may prohibit lifelong learning for all primary care professionals.

Strengths and limitations of this study

Inter-professional lifelong learning barriers and facilitators in primary care, with particular regard to both implementers and recipients of regional workforce strategy have not been investigated elsewhere. The only exception is perhaps the Wessex study (Cross and White, 2004a, b), which, however, only looked at GP Tutors', GPs' and Practice Managers' experiences.

Due to the space limitations of the article, this article reports only common inter-professional barriers and facilitators to both implementers and recipients of a strategy. Furthermore, the study's specific context should be considered when interpreting the findings. A regional workforce development strategy, set against recent national policy changes, was implemented 18 months prior to the data collection period, a relatively early process stage.

Comparison with existing literature

It has been recognized that changing the CPD culture within general practice would be challenging (Department of Health, 1998). Our findings reflect other literature that supports that learning can be enhanced by organizational structure and climate changes; organizational arrangements can foster or inhibit the learning process (Wensing *et al.*, 1998; Davies and Nutley, 2000); culture shapes individual engagement with the learning process (Elwyn and Hocking, 2000). Differences in perceptions and attitudes of 'working together' and inter-professional learning may exist (Elston and Holloway, 2001). Negative lifelong learning attitudes combined with lack of awareness of national reforms and regional policies (Chambers and Schriver, 2001) by some groups of staff (Block and Justman, 2004) within practices have also been identified. Studies have also

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found that adequate PLT was necessary to support engagement (Cross and White, 2004a), effective delivery and implementation of lifelong learning (Curtis *et al.*, 2004). Cultural changes are needed to acknowledge PLT and that CPD opportunities apply to both clinical and non-clinical staff (Brooks and Barr, 2004).

However, different access and arrangements for lifelong learning for particular professional groups in combination with the above factors, revealed important equity and equality issues in both PCTs and general practices in the present study. Access to funding, organizational support, time availability in general and PLT arrangements in particular, differ greatly for professional groups in primary care settings.

In addition, most of the literature identified focuses on a specific professional group, GPs. Time pressures (Mamary and Charles, 2003), financial constraints, workload, practice organizational issues and lack of peer support have been found to have a negative impact on GPs (Bligh and Slade, 1996; Smith *et al.*, 2000; Huby *et al.*, 2002; Lewis *et al.*, 2003). Considering the effect of policies, earlier studies showed that the nGMS contract and pay reform system have changed workload and increased stress for doctors (Lees and Bosanquet, 1995). Financial incentives for GPs may affect cultural change and facilitate the lifelong learning process for all staff members, assuming that they are used to promote appropriate goals (Rodwin, 2004).

Comparatively little is known about other professional groups, that is management and nursing staff responses to lifelong learning opportunities. It has been suggested that practice managers are the coaches of changes, whilst GPs are still the corporate leaders of their organizations (Laing *et al.*, 1997). Leadership styles of managers may influence nurses' perceptions of the CPD values, as well as their ability to reflect, which affects the application of learning (Hughes, 2005). Networking and peer support, in the form of substantial informal teaching, learning and learning facilitation through work-based contacts with other healthcare professionals, complemented by support from other non-healthcare related significant individuals have been shown to facilitate lifelong learning in nursing (Gopee, 2002). In another study, nurses were found to consider that management should provide study days and workshop teaching relating to new policies (Block and Justman, 2004). In contrast, the present study reveals a rather proactive attitude of nurses towards learning opportunities and effective collaboration between managers and nurses.

Barriers and facilitators relevant to implementers of strategies or programmes and PCT staff have been explored even less. Barriers identified elsewhere included differing professional cultures (Degeling *et al.*, 2003), a sense of history and tradition in GPs, isolation from other authorities and organizations, and minimal teamwork or effective collaboration between health authorities and doctors (Marshall, 1999). These may tally with this study's findings about pre-existing cultures, boundaries between organizations and professional networking, as barriers and facilitators to lifelong learning strategies.

Conclusions and implications for future research

Few studies have found that organizational structures and culture may enhance learning in primary care. Time, funding, organizational support or lack of them may either enhance or obscure learning in primary care. However, inter-professional common barriers and facilitators to lifelong learning in primary care for both implementers and recipients of a regional workforce development strategy have not been investigated elsewhere. Similarly, equity and equality issues on provision and access to lifelong learning in PCTs and general practices and in relation to particular professional groups, that have been highlighted here, have not been explored elsewhere.

Although primary healthcare professionals have faced a rapidly changing work environment, only some of the policy implications, that are linked to the nGMS contract were identified here. Implications of ongoing policy developments, such as the NHS Knowledge and Skills Framework, which aims to support effective learning and development of individuals and teams (Department of Health, 2004) remain to be seen. Likewise, the new Personal Medical Services (PMS) contract, which enhances team working and provides more opportunities for primary care professionals to use their skills in different ways and extend their roles (Primary Care Contracting, 2004). Other factors, such as the commissioning changes in PCTs (Department of Health, 2005), may also affect the organizational culture and subsequent facilitation of lifelong learning. Lifelong

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learning barriers, facilitators, and how these may be overcome or reinforced in a primary care setting for all professional groups need further exploration.

Primary care settings should become learning organizations that provide continuous learning opportunities, support collaboration and foster links between organizations and individuals. Lifelong learning development may only flourish when a support system is created, comprising clearly allocated budgets, experienced facilitators and a sustainable contractual framework for general practice.

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Details of ethical approval

Ethical approval was granted from the Trent MREC.

Competing interests

None. All authors/contributors are independent from the NHS KSS Postgraduate GP Deanery.

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