Lost in the global sum?

Professional and practice development in primary care after the new general practice contract

There is concern that the new UK General Medical Services contract[1] pays no attention to the continuing professional development needs of the multidisciplinary primary care health team. Although some organisational indicators were included, personal professional development and practice team development in primary care were not considered. The 2006 contract revision has also overlooked this area, and focused mainly on new clinical indicator targets in the Quality and Outcomes Framework (QOF).

Practices in the UK have been increasing in complexity for decades, and the new contract has fuelled this trend. New roles are being developed to meet new expectations. Many practices have recruited IT specialists, and existing staff are extending their roles as care is devolved from doctors to others, including nurses and healthcare assistants. These changes carry with them significant implications for staff development, as well as for practice team development.[2] The new contract is silent on these issues and we contend that this is an important oversight.

Professional development prior to the new contract

Before the new contract was introduced, professional development budgets for nurses and other staff employed by practices were held by primary care organisations, primary care trusts (PCT), and their like. These budgets were outside the control of practices, although in some areas, they had been devolved. Resources for professional development were typically available on application, with allocations decided by professional advisers. It was felt that this allowed NHS management to take strategic views about training direction and influence services to fit local need.[3] In the new contract the 'training budget' was included in the 'global sum' and the responsibility for its use rests with the practice partnership or equivalent.

The problematic arrangements for primary care teams and the often lack of coordination had been identified in the Chief Medical Officer's 1998 report on continuing professional development in primary care.[4] The report advocated 'professional development plans' to help deliver the 'modern, accountable and efficient health service' promised by the Labour government.[5] The report's vision for multidisciplinary continuing professional development married to practice needs was never widely adopted.[6]

The new GP contract and the global sum

Under the new organisation-based contract,[1] partnerships (or other contract holding organisations)[7] have been given a global sum to cover a range of fees and services, calculated partly using the size of the overall practice patient list. Budgets for training and development activities have been subsumed into the global sum. There was apparently a lack of clarity about how to calculate the correct figure for 'training and development': for instance, some PCTs based allocations on previous-year spend. Because of this new arrangement, responsibility for training and development now rests with the contract holders. There is uncertainty about how strategic direction should be maintained and how employees or professionals should access independent advice about professional and personal development issues.

To add to the complexity, many general practices are evolving into organisations that have an increasing distinction between employees and profit-sharers. Where partnerships remain as the contract holders (still the typical model), it is common to find individuals taking executive and managerial roles, perhaps reducing their exposure to clinical work or seeking external opportunities to diversify income. To enable this, salaried doctors and other health professionals are being employed, often in part-time roles, increasing the difficulty of providing personal continuity at the patient level. In other words, at a time when professional development needs and team coordination are increasing, the new contract is deficient. Practice nursing provides a good example.

Freed from traditional NHS constraints, practice nurses, when supported to do so, have been able to develop their clinical repertoire rapidly. Note the recent change in diabetes care and similar developments in the monitoring of chronic diseases, such as hypertension, asthma, and epilepsy. On the whole, GPs have facilitated this process, encouraging nurses to undertake training in areas of interest and of benefit to patients. PCTs, and family services health authorities before them, have often provided or funded staff to attend relevant courses.

Failure to protect resources for the team and professional development brings the risk that some contract holders may view expenditure in this area as a threat to profit. Although many practices have achieved their QOF points by delegating work to salaried doctors and nurses, the tight focus on QOF targets may limit innovation. A clinician who wishes to provide an improved family planning service, for example, is unlikely to be supported with training needs under current conditions. Some areas have 'protected learning schemes' in the form of multi-practice events. These may help staff to achieve dedicated time to engage in joint learning, but it remains far from clear whether such schemes are sustainable or effective at supporting individual professionals.

We could be reassured if the new contract demonstrated wide improvements in the quality of care, and could be persuaded that, in the long run, training would be oriented to meeting adjustments in the 'pay-for-performance' framework — enlisting the market forces argument. But there is already some evidence emerging

that meeting targets does not necessarily equate with best practice. A high QOF score in case stroke management did not correlate with adherence to recent stroke guidelines by the Royal College of Physicians.[8] A recent editorial in this journal argues that QOF is inflexible and unable to meet local needs.[9]

The importance of good teamwork has also been highlighted and is currently unsupported: the formative and participative approach of the Royal College of General Practitioners' Quality Team Development programme has been highly valued by participants.[10] Other, similar tools, such as the Maturity Matrix, have had a similar reception.[11] The existence of an informed, motivated 'team' is not easily measurable by the existing contract, yet has a huge impact on the function, morale, and organisational ethos. The lack of attention to training, development, and practice development may well put organisations into difficulty. There is a concern that as high profits are achieved by contract holders, tensions are emerging in different parts of primary care organisations.[12]

There is no doubt that the UK pay-for-performance framework is being observed with interest at an international level. The finding that exception reporting is associated with highest financial attainment has attracted interest,[13] and is only one of a number of articles suggesting that gaming may be occurring in some organisations.[14,15] If, in addition, long-term organisational development is damaged by a potential lack of balance in the investment of rewards, observers should guard against the possible negative impacts of incentivisation schemes.

Practice-based training budgets, if they could be protected and well managed, may be a means of ensuring response to training needs and lead to a requirement for each practice to produce annual development programmes that are not guided solely by targets. Whatever the solution, we feel that the area requires more thought. Many practices will, of course, invest in the development of the organisation — balancing the interest in profit against the need to look after the requirements of staff and patients. However, some may well take the view that professional development budgets are best 'lost in the global sum'. We see this as an approach that will put the stability and sustainability of primary care organisations, as currently conceptualised, at risk.[16]

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