

**Contractual Change and UK General Practitioners: Still a  
Case of Street-Level Bureaucrats?**

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## **List of Abbreviations**

<b>APMS</b>	Alternative Provide Medical Services
<b>BMA</b>	British Medical Association
<b>BP</b>	Blood Pressure
<b>CDM</b>	Chronic Disease Management
<b>CHD</b>	Coronary Heart Disease
<b>CHI</b>	Commission for Health Improvement
<b>CKD</b>	Chronic Kidney Disease
<b>CQC</b>	Care Quality Commission
<b>DES</b>	Direct Enhanced Service
<b>EBM</b>	Evidence Based Medicine
<b>EBP</b>	Evidence Based Practice
<b>FPC</b>	Family Practitioner Committee
<b>FHSA</b>	Family Health Service Authorities
<b>GMS</b>	General Medical Services
<b>GMSC</b>	General Medical Services Committee
<b>GP</b>	General Practitioner
<b>GPFH</b>	General Practice Fundholding
<b>HA</b>	Health Authority
<b>HCA</b>	Health Care Assistant
<b>ICT</b>	Information Communication and Technology
<b>LES</b>	Local Enhanced Service
<b>LMC</b>	Local Medical Committee
<b>MPIG</b>	Minimum Practice Income Guarantee
<b>NES</b>	National Enhanced Service
<b>nGMS</b>	New General Medical Services
<b>NHI</b>	National Health Insurance
<b>NHS</b>	National Health Service
<b>NICE</b>	National Institute for Health and Clinical Excellence
<b>NIHR CRN</b>	National Institute for Health Research Clinical Research Network
<b>NP</b>	Nurse Practitioner

<b>NPM</b>	New Public Management
<b>NSF</b>	National Service Framework
<b>NVQ</b>	National Vocational Qualification
<b>OECD</b>	Organisation for Economic Cooperation and Development
<b>P4P</b>	Pay-for-Performance
<b>PBC</b>	Practice-Based commissioning
<b>PCAPs</b>	Primary Care Act Pilots
<b>PCG</b>	Primary Care Group
<b>PCRN</b>	Primary Care Research Network
<b>PCT</b>	Primary Care Trust
<b>PCTMS</b>	Primary Care Trust Medical Services
<b>PHCT</b>	Primary Health Care Team
<b>PI</b>	Principal Investigator
<b>PMS</b>	Personal Medical Services
<b>PMS+</b>	Personal Medical Services Plus
<b>PN</b>	Practice Nurse
<b>QMAS</b>	Quality Management and Analysis System
<b>QOF</b>	Quality and Outcomes Framework
<b>R2</b>	Round 2
<b>RCGP</b>	Royal College of General Practitioners
<b>RCT</b>	Randomised Controlled Trial
<b>REC</b>	Research Ethics Committee
<b>SBM</b>	Scientific Bureaucratic Medicine
<b>SLB</b>	Street-level Bureaucrat
<b>TJC</b>	The Joint Commission
<b>TPP</b>	Total Purchasing Pilot
<b>UK</b>	United Kingdom
<b>US</b>	United States

## Abstract

General practice emerged as a distinct medical discipline in the nineteenth century. As independent contractors, General Practitioners (GPs) have however largely been 'untouched' by centrally derived policy. As a result, the profession has possessed wide discretion in relation to the way they dealt with their patients. However, due to increasing concerns over the cost and quality of care within the NHS, general practice increasingly became a focal point for the attentions of central policy makers who sought to control aspects of frontline practitioner behaviour. In order to do attempt to align the frontline behaviour of GPs with such policy aims, policy makers turned to their main tool, the contract. In this thesis I am concerned with the most recent contractual changes (and its later variants) introduced in 2004. In particular, the study is concerned with the impact of the large element of Pay-for-performance (P4P) known as the Quality and Outcomes Framework (QOF) contained within the new contract. QOF rewards practices on the basis of meeting a number of targets in relation to clinical, organizational, and patient experience indicators. As a result of the scale and prescriptive nature of the targets, QOF had the potential to change the nature of GP work at the micro-level should GPs choose to follow this voluntary policy. Previous evidence in relation to GP responses to other prescriptive policies such as National Service Frameworks (NSFs) and clinical guidelines suggests that GPs responded as workers, specifically as street-level bureaucrats (SLBs) by selectively by choosing aspects of policies based upon the on the criteria of whether or not they made the practicalities of processing their daily workload easier. However, the evidence suggests that there were also instances of GP principal (those that (part-) own their practices) behaviour that did *not* conform to expected SLB behaviour but instead resembled behaviour that would be expected of those managers who are 'results oriented.' Based upon this evidence and the analytical possibilities the SLB framework provided, the theoretical view of GPs as frontline public sector workers or street-level bureaucrats (SLBs) was employed to understand the continuing perceived impact and responses of GPs to the new contract and in particular QOF. Unlike previous analyses of GPs as SLBs however, this study distinguished between GP principals and salaried GPs employed by the GP principal counterparts. Ultimately, the aim of the thesis was to address the question of whether or not the conceptualization and responses of GPs as SLBs was still relevant and useful post-contractual change. Data was collected (between Feb 2008 and Sept 2009) via semi-structured interviews. In total 62 first round interviews and 24 second round interviews were conducted and analysed thematically. The findings indicate that the financial incentives within the QOF appear to strongly influence the responses of GP principals and reflect their priorities as owners of, rather than workers in their organisations. In addition, it appears that the Evidence Based Practice (EBP) movement means that salaried GPs priorities are also aligned to those of their organisations as they believe most of the QOF to be evidence-based. As a result, the application of Lipsky's SLB framework to explaining GP behaviour in relation to QOF is less useful than previous applications.

### **Declaration**

No portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.

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No qualitative research project can ever occur without willing participants. I wish to take this opportunity to thank each and every one of the GPs who took part in my research as well all of the participants of the wider research project this PhD derived from.

Now, I come to those closest to me. I couldn't have asked for a more wonderfully loving and supportive family. My mum and dad have been unfailing supportive not only of my education but also simply of who I am and any of the endeavours I have undertaken throughout my life. I hope that I have made you proud and that you can feel that this achievement is something of a formal recognition of the efforts and sacrifices you have made over the years. To my brothers, I hope that you strive to achieve and be successful and enjoy whatever it is you choose to do in life but most importantly remain the genuinely good blokes you are. I also wish to thank my partner Matthew and his family who I have grown extremely close to over the 13 years I have known them. Since my family emigrated, Pauline and Jim have always made me feel as though I have another home where I am always welcome. I have no idea where all the in-law jokes come from! Finally, I need to thank my partner Matthew. You are simply everything to me. You have witnessed the best and worst of me during this work and regardless of this your support was unwavering. Having completed a PhD yourself, you knew more than I did what an undertaking this was. Without you this work would have been much more difficult and more importantly life would be much less wonderful.



**To my grandma**

## **The author**

I have had a varied career to date. I studied Zoology as an undergraduate and then took a graduate job within a pharmaceutical market research company. During this post I gained further skills and specific techniques which allowed me to apply for a research associate post at the National Primary Care Research and Development Centre (NPCRDC). I am grateful to the interviewing panel for taking a chance on someone with no postgraduate qualifications. Having successfully completed this job I was sponsored by the Medical Research Council and the NPCRDC to undertake the MRes in Primary Care. Following my success in this I was offered another research associate post with added bonus of completing a PhD concurrently.

# **Chapter 1**

## **Thesis structure and content**

### **1.1. The scope of the thesis**

This thesis focuses on general practice in England at a time of unprecedented change caused by the introduction of a new contract in 2004. I examine the impact of this contractual change and in particular the introduction of the pay-for-performance scheme contained within it, known as the Quality and Outcomes Framework (QOF), on the work and working lives of General Practitioners (GPs). The purpose of this brief chapter is to outline to the reader the overall structure of the thesis.

### **1.2 The structure of the thesis**

Chapter 2 plays an important role as it familiarises the reader with the broad area of research i.e. general practice. It provides the historical background against which the contractual changes briefly highlighted above, can be interpreted. I am necessarily selective but also fairly comprehensive, as I start the chapter at the very beginning of the GP story i.e. the emergence of ‘the GP’ before moving forward through time highlighting key events which have shaped the profession to date. I end the chapter with a detailed discussion of the substantive topic of interest; namely the new contract, and in particular QOF.

In chapter 3 I briefly discuss some of the traditional theoretical approaches that have often been employed when studying the impact of policies upon medical professionals before outlining the rationale for my chosen approach. I provide a detailed discussion of the chosen theoretical framework, namely Michael Lipsky’s Street-Level Bureaucracy and highlight the reasons for my choice by discussing its prior applications as well as its relevance and limitations when applied to my topic of interest. I conclude by outlining the main research question, namely, whether the conceptualisation of GPs as Street-Level Bureaucrats (SLBS) is still appropriate and useful as an aid to understanding GP behaviour and responses to centrally defined policy since the introduction of the new contractual arrangements, and in particular QOF.

Chapter 4 outlines the overall methodology I used. I provide details and examine the merits and adequacy of the specific research methods. I also discuss the sampling strategy and approach to

data analysis as well as providing the details of the 62 research participants. I conclude the chapter by briefly discussing my role in the data generation.

In chapters 5 and 6 I present the results of my study. In chapter 3 I outline the *a priori* reasons behind the decision to separate out these chapters by GP status, hence chapter 5's focus on the findings from GP principals and chapter 6's focus on salaried GPs.

The concluding chapter draws together my findings presented in chapters 5 and 6 and interprets them in relation to both the existing empirical literature and my chosen theoretical framework before providing my conclusions. I also discuss the strengths and limitations of my study followed by some overall concluding comments.

## **Chapter 2**

### **A historical account of the development of general practice**

#### **2.1 Introduction**

In this thesis I examine general practice in England at a time of unprecedented change caused by the introduction of a new contract in 2004. My focus is to ascertain the impact of this contractual change and in particular the introduction of the pay-for-performance scheme contained within it, known as the Quality and Outcomes Framework (QOF) on the work and working lives of General Practitioners (GPs). In order to ascertain the impact of any change, one needs to be familiar with the context that those changes have taken place in and this is the purpose of this chapter. For ease of presentation, the chapter is divided into 7 major sections. In each major section I discuss chronological periods marked by key internal and external events and I finish with a discussion of the details of the new contract.

#### **2.2 The origins of the Profession**

##### **2.2.1 The appearance of the GP**

In the early 19th century there were technically three recognized medical professions in England; physicians, surgeons and apothecaries. The Royal College of Physicians, established in 1518, was the traditional domain of the educated elite. The Royal College of Surgeons, founded in 1800, represented the growing prestige of surgeons well before the technological revolution in surgery made such a distinction functionally inevitable. Apothecaries formed a third strain.<sup>1</sup> The ‘general practitioner’ appears to have emerged early on in this period, having evolved from the apothecaries or surgeon-apothecaries of medieval times.<sup>2</sup> GPs occupied the lowest rung of the medical hierarchy as hospital medicine was in the ascendancy and physicians and surgeons alone had access to hospital beds.<sup>3</sup> The dominance of hospital medicine, with its focus on the concept of the disease, reflected the fact that this period was characterized by a rapid growth in medical scientific discovery. This has been described as a shift away from the cosmology of ‘bedside medicine’ that views illness within a framework of ‘conscious human totality’, to the new

scientific cosmology of ‘hospital medicine’ or ‘biomedical model’<sup>a</sup> of care.<sup>4</sup> It has been suggested that the dominance of the biomedical model was both a consequence and a determinant of the domination of hospital medicine over its community general practice counterpart.<sup>5</sup> The continued and rapid growth in medical science throughout the late 19<sup>th</sup> and early 20<sup>th</sup> century also gave rise to a period of proliferation in medical specialisation. This trend did nothing to help the position of GPs who had no claim to an area of specialisation.

One area however that did prove fruitful for GPs around this time was the middle classes. These patients were suspicious of the new scientific approach to care and preferred the more ‘warm, friendly, comfortably old-fashioned and unscientific’<sup>6(p359)</sup> approach that the GP provided. In addition, such bedside care was provided within the patient’s own home and therefore appeared to give a degree of comfort and control to patients over the nature of the care received. Such a ‘personal’ approach to care or ‘whole person medicine’<sup>6</sup> was to become the hallmark of the profession, which I return to later.

GPs clustered around areas associated with their middle-class patrons and were less present in poor areas.<sup>7</sup> Poorer patients had access to a cheap ‘sixpenny’ medical service that included a quick consultation with the GP and bottle of medication,<sup>7</sup> allowing GPs to process large volumes of patients, in contrast to the personal/bedside care afforded to middle class patients. This entrepreneurial approach to general practice is one which has been the target of government policy in order to affect desired changes and is an important feature to highlight with respect to the introduction of the recent contract.

### **2.2.2 The National Insurance Act of 1911**

The first years of the twentieth century saw an increase in political interest in the state of the nation’s health. This was stimulated in part by a shift in political attitudes towards the Liberal ideals of the incumbent government,<sup>8</sup> as well as the recognition of the ill state of health amongst the poor.<sup>9</sup> The response from the government was to pass the National

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<sup>a</sup> The biomedical model has its roots in Cartesian dualism i.e. the division between mind and body. Disease is seen primarily as a failure within the body and results from physical trauma occurring due to injury, infection, inheritance and the like.

Insurance Act of 1911. This provided minimal financial relief during sickness; as well as free medical care in the form of ‘panel’ doctors to the *working* population. It was in essence the progenitor for the creation of a national health service. Although the act only provided limited coverage, it did enable a relatively large portion of the working population<sup>b</sup> below a specified income level access to free GP services.<sup>6</sup> Furthermore, the act presented GPs with the first real sign of state recognition and maintained their division from the other medical specialties.<sup>11</sup>

The advent of the panel system was also significant for GPs in other ways: it established the concept of GP registration and provided GPs with a degree of financial security. The capitation system offered insurance payments on the basis of the number of patients on the GPs’ list. The system was so popular that by 1920, three-quarters of GPs were on the ‘panel’ and all had a list of registered patients.<sup>12 (p111-12)</sup> In addition to panel patients, GPs benefited financially from using this baseline to increase their private practice.<sup>13</sup> As a result, it has been suggested that panel patients received comparatively worse care than their middle-class counterparts due to the incentive to minimize costs (e.g. time spent with panel patients) at the expense of quality of care they received.<sup>14</sup> Concerns surrounding quality of care is a key feature of recent and current public service policy in general and will be returned to later.

Finally, the 1911 Act was also significant as it established the way that negotiations between the state and the medical profession were to be conducted for most of the ensuing century.<sup>15</sup> The government had attempted to keep the medical profession (as represented by the British Medical Association (BMA)) as outsiders to the policy making process. However, the government was unsuccessful and as a result, the final Act bore little resemblance to the initial (pre-BMA involvement) draft.<sup>15</sup> Significantly, the medical profession’s intervention ensured that general practitioners were independent contractors who were rewarded by capitation payment.

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<sup>b</sup> The working population was covered (albeit at different rates for men and women) by the national insurance scheme but workers families e.g. wives and children were not. The uninsured were left to the mercy of non-governmental charitable organizations.<sup>10</sup>

### 2.2.3 The Genesis of the National Health Service (NHS)

The inter-war period established many of the values and concepts on which the NHS would be based.<sup>16</sup> It was characterized by various significant events and reports and is summarised as including: the creation of the Ministry of Health in 1919; the Dawson report in 1920;<sup>c,19</sup> The Royal Commission's 1926 recommendation for the extension of the National Health Insurance (NHI) Scheme to cover the majority of the population and finally the BMAs proposals for a 'general medical service for the nation' which suggested that the National Insurance should be extended to hospital services as well as the families of insured workers.<sup>20</sup>

In summary, there appeared to be recognition of the need for a state wide health care system. Affirmative action on this did not occur however until the Second World War during which the *Beveridge Report* was published in 1942. The report recommended a social security system supported by a National Health Service (NHS). As public expectations rose, the government accepted the report's proposals.<sup>11</sup> A White Paper, *The National Health Service*, published in 1944 detailed the plans for such a scheme and proposed a comprehensive and free health service (for all). Essentially these free services were to be accessed in any of the areas of the new system i.e. hospital, community or general practice, this became known as the 'tripartite' system.

The 1944 White Paper proposed that GPs would be *salaried* and work in health centres under the control of a Central Medical Board.<sup>20</sup> GPs however wanted to retain their independence eschewing the salaried proposals in favour of continued capitation.<sup>21</sup> In this way GPs would be able to retain a degree of control over their 'pay' (which for GP principals equates to the profits or share of those profits left over after the practice expenses) rather than receive a fixed salary. GPs (via the BMA) successfully negotiated on this key issue<sup>15</sup> and with the formation of the NHS in 1948 they maintained their status as independent

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<sup>c</sup> This recommended 'primary health centres' (staffed by GPs) as well as 'secondary health centres' that would deal with more difficult cases requiring specialist care. The terms 'primary care' and 'general practice' are often used interchangeably within the literature. There is however a school of thought that see primary care as being broader than general practice (see<sup>17,18</sup>) however we are concerned here with primary *medical* care which is delivered in general practice.



contractors,<sup>d</sup> a status which the majority of GPs (80%) have to this day.<sup>22</sup> With this status as independent contractors, GPs engage in a contract '*for service and not of service*; they are not employees.'<sup>23</sup> (p133)

The formation of the NHS was therefore significant for GPs in two major ways. First, GPs now had registered lists of patients that covered the 'whole' of the population thereby strengthening the role of GPs as family doctors<sup>6</sup> by providing care to the 'whole' family (it was likely that the families of workers would register with the same GP as the already registered male worker). Secondly, it institutionalized the role of the GP as gatekeepers to secondary/specialist care as some hospitals patient entry criteria was the referral of the patient by their NHI doctor.<sup>24</sup>

#### **2.2.4 The 1950s – low morale and the poor state of General Practice**

Although the formation of the NHS had been positive for GPs in many ways, the 1950s was also a period of low morale amongst the profession, with a dip in status relative to other specialties. The correspondence section of the British Medical Journal in the early 1950s provides a snapshot view of this via the published letters from disillusioned GPs.<sup>e.g.25</sup> GP complaints reflected their lack of specialist status and facilities to practice the scientific type of medicine that formed the basis of hospital medicine which commanded the dominant proportion of NHS spending. A major factor in the low morale of GPs however was the difference in remuneration that specialists and GPs received. In 1946 and 1948, the *Spens Committees* recommended that a specialist ought to receive twice the monies that of a GP, reinforcing existing differentials.<sup>26</sup> The level of pay that GPs received not only adversely affected the morale of practising GPs, but also potentially affected recruitment into general practice by deterring medical students from choosing it over hospital medicine.<sup>e</sup>

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<sup>d</sup> Independent contractor status refers to 'Principals' i.e. those GPs who held the contract with the state and owned or part-owned their own practices. For many decades this was the sole way of working, however future changes (discussed later) led to the introduction of the 'Associate' or 'Salaried' GP.

<sup>e</sup> Recruitment and retention concerns have also featured more recently and played a part in prompting later contractual changes as will be outlined.

In addition to GPs' own concerns over pay, a series of reports published throughout the 1950s (The Collings report;<sup>27</sup> The Hadfield report<sup>28</sup> and The Taylor report<sup>29</sup> respectively) highlighted GPs' resources and working conditions as inadequate. The first of these in 1950 noted the poor condition of GP surgery premises, equipment, practice organisation and staffing and sympathised with their working situation.<sup>30</sup> The second described GPs working alone in their own homes, each with a patient base of between 1500-2500, and with the only form of assistance being their wives.<sup>28</sup> GPs appeared to be permanently on duty (day and evening surgeries plus home visits) and could see approximately 25 patients in one and a half hours.<sup>28</sup> The heavy workload subsequently also impacted on patients who were reported as receiving care not in line with the way that GPs were trained at medical school i.e. GPs were "forced by necessity to short-cut the detailed method" (ibid p 685).

Finally, the Taylor report in 1954 highlighted the negative impact of fatigue and decline in efficiency of GP performance due to the heavy workload.<sup>29</sup> The report recommended that improvements in quality of care as well as the reduction in pressure on individual GPs, could be achieved by GPs practicing in groups supported by ancillary staff.<sup>29</sup> In summary, the formation of the NHS had done nothing to improve the service and the NHI scheme has simply increased the workload and placed a strain on GPs.

### **2.3 The re-birth of general practice**

The 1950s reports are credited by some as being a key catalyst in the subsequent rejuvenation of general practice.<sup>31</sup> Leading GPs of the time, Drs FM Rose and John Hunt argued for the formation of a professional college. A steering committee was brought together and the formation of the college occurred in November 1952.<sup>32</sup>

In addition to the formation of a recognizable professional body, GPs also received a boost in their finances from the Danckwerts pay award.<sup>26</sup> Such a boost enabled the realization of some of the recommendations of the various reports outlined in section 1.2.4; however progress was slow, and the issue of pay continued on and again came to prominence in the late 1950s. The Royal Commission of Doctors' and Dentists' Remunerations (1960) recommended a new pay award for GPs, with regular reviews but it

was not until the threat of mass resignation in 1965 that the issue was really resolved with the agreement of the Family Doctor's Charter in 1965, the recommendations of which were accepted in 1966.<sup>23</sup> The four principles of the Charter were: 1) the right to practise good medicine in up to date, well staffed premises; 2) the right to practise medicine with the minimal intrusion by the state; 3) the right to appropriate payment for services rendered; and 4) the right to financial security.<sup>33</sup> The Charter resulted therefore in an increase in GPs' overall remuneration and a reduction in list sizes. There was also additional remuneration for 70% of the wage costs other employee nurses and ancillary staff (i.e. the advent of the primary health care team (PHCT)), money for improving premises as well as financial incentives to encourage group practice. The advantages of group practice for GPs included immediate financial rewards from sharing premises and more general long-term opportunities for increasing income.<sup>34</sup> From this point onwards the proportion of GPs working alone fell steadily and was accompanied by an increase in the average number of staff employed per practice.<sup>35</sup>

Although the Charter raised the status of general practice and moved it towards a more familiar organizational form, the it has been suggested that it was also significant as the *General Medical Services* (GMS) contract tied GPs more closely than ever to the NHS due to their resulting financial dependency.<sup>11</sup> Despite this, GPs were still relatively free to practice as they wished as the initial contract was not very prescriptive; in fact, it simply required the GP to 'render to his [sic] patients all necessary personal medical services of the type usually provided by general practitioners.'<sup>36</sup> In other words the profession was simply trusted to provide services adequately according to need. This vague statement led to this type of contract being commonly known as the 'John Wayne' contract i.e. 'a GP's got to do what a GP's got to do.'<sup>37</sup>

Before moving on to examine the later policy and some of the broader changes affecting the development of general practice to present day, the account pauses here to discuss a key aspect of the re-birth of general practice, namely how the profession made claims to the unique and distinguishing features that forms the basis of its disciplinary identity i.e. 'biographical medicine'. This is important for the current work as the new contractual

arrangements have been criticized by some commentators as risking the profession's identity and preferred and/or prior models of working.

### **2.3.1 Defining the central tenets of the profession**

The biomedical model of care was instituted as the dominant mode of care with the formation of the NHS. In the 1950s however, general practice began to establish its own separate identity, one that was not based on the biomedical model of care. Key to this was the creation of the College (later the Royal College) of General Practitioners (RCGP) in 1952.<sup>38</sup> Although established initially as an academic institute charged with identifying and developing a unique GP approach to care it eventually became the voice of general practice as it developed into a discipline in its own right.<sup>39</sup> The unique and alternative approach to hospital medicine that was identified and adopted by the College and its members has been referred to as a 'biographical approach', and originates from the seminal work of Balint<sup>40</sup> who highlighted the value of doctor-patient interactions. The biographical approach focuses on:

...the individuality of the patient, the unity of the psyche and the soma and the need to get beyond the presenting symptoms to explore the history and circumstances of the patient's life.<sup>41(p230)</sup>

This approach therefore emphasizes the whole person, taking into account not only the biomedical, but also the psychological and social aspects of the patient's presenting problem. It has been argued that the shift from biomedical medicine allowed GPs from the 1960s onwards to develop a distinct sense of identity and their own ideology that had previously been lacking.<sup>42</sup> This allowed them a basis from which to counter the dominance of the biomedical hospital-based approach to medicine.<sup>43</sup>

By the early 1970s the RCGP had adopted the biographical approach as their own model of care and the language of the biographical model became the hegemonic discourse of their institutions e.g. the college publication "*The Future General Practitioner*"<sup>44</sup> defined general practice as being 'patient-centred' and concerned with the patient's total experience of illness. The features of this approach and their institution in to the

professional rhetoric was aided by the fact that from this point biographical medicine went on to form the basis of much of the undergraduate teaching and postgraduate training.<sup>45</sup>

The move towards a biographical model of care as a basis for professionalism was aided by the fact that this was taking place in a wider context of change within medicine as a whole i.e. one where there was explicit criticism of the biomedical model because of its 'somatic reductionism.'<sup>46</sup> Psychoanalysts in particular found the biomedical model to be lacking as there were difficulties in relating the observable afflictions of the mind to a specific physical origin. The psychiatrist George Engel in 1977 proposed an alternative approach which he termed the 'biopsychosocial model.' In his new model Engel proposed that the appearance of illness results from a diverse interaction of causal factors, from the molecular level through to the social circumstances in which the illness arose.<sup>47</sup> The RCGP also adopted this term and this type of language continues to dominate official professional publications and rhetoric. For example, the current the RCGP curriculum core statement states that 'holism and patient-centredness are core values of general practice.'<sup>48</sup> The RCGP uses the term holism here as defined by Kemper in that it involves:

caring for the whole person in the context of the person's values, their family beliefs, their family system, and their culture in the larger community, and considering a range of therapies based on the evidence of their benefits and cost.<sup>49</sup>  
(p214)

In the literature the terms 'holism,' 'biographical medicine,' 'biopsychosocial medicine' and 'patient-centred' medicine are often used inter-changeably. In this thesis the term holism is preferred as it is the current terminology espoused at an institutional level and may therefore be the terminology that practitioners are most familiar with. Recent work also indicates this i.e. holism is still central to the self-representation of rank and file GPs<sup>50</sup> and is also still used by GPs to distinguish themselves from other types of practitioners.<sup>51,52</sup>

### **2.3.2 Holistic care: Rhetoric or Reality?**

The subtitle above is borrowed from an article<sup>53</sup> and alludes to the fact that thus far the historical account has suggested that the profession successfully adopted and defined itself via a discourse of holism. However, whether or not this was the type of medicine that rank

and file GPs actually deliver remains an empirical question. GPs were historically subject to high workloads with inadequate resources leading to negative consequences for the type care provided. Although various policies were intended to alleviate some of these burdens, these issues continued to plague the profession. For example, an article in 1984 by a Professor of General Practice, questions the ability of GPs to practice in line with their espoused professional ideals:

One remembers the description of the French Military Brothel as sacrificing quality to speed of throughput. This, more than Balint, is our sort of world<sup>54(p86)</sup>

In other words the day to day pressures of processing patients meant that the practicalities of dealing with patients in their ‘six-minute consultations’ (ibid p85) was the overriding factor on the approach to care. Ten years later, another study investigated the issue of rhetoric or reality of care provision in general practice.<sup>53</sup> The authors of this study surveyed all RCGP members to explore the extent to which the rhetoric of holism corresponded to the reality of GP views about their professional responsibilities. The results revealed that whilst GPs considered that patients with physical conditions (acute or chronic) to fall within the remit of their work they were more ambivalent about psychological problems, and social problems were not considered to be appropriate presenting problems at all. Further qualitative research by the same authors confirmed these findings: the model of care that GPs actually appeared to work to at this time was more reflective of a biomedical approach to care.<sup>55</sup>

Providing personal care to the individual patient has been a constant aspect of the role of a GP since their appearance in the nineteenth century and in particular since the advent of patient registration. It is also an aspect of care that policy and organizational changes have affected over time. The recent contractual changes which form the focus of this thesis have been no exception and therefore a more detailed discussion of this aspect of GP work is now presented.

## 2.4 Personal and continuous care in general practice

### 2.4.1 Personal care

Personal care has been defined as care that focuses on the *individual* as opposed to groups or populations of patients.<sup>56</sup> It is also care that is tailored to the individuals needs and is aided by a continuing relationship between a GP and a patient. It is linked to a GP's increasing personal knowledge about the patient over time,<sup>57</sup> and is seen as a facilitator of personal care.<sup>58</sup> Personal care, has long been a feature of the definitions of the role of a GP. In the 1970s the best two known definitions of a GP placed 'personal' at the head of the list of words that define a GP's role.<sup>58</sup> However over time some commentators have suggested that this aspect of a GP's role is lessening.<sup>56,59</sup> This is reflected by a 21<sup>st</sup> century definition of general practice published in the British Medical Journal did *not* feature 'personal care' as such but simply discusses the individual patient and how the GP should organize the available resources within the system to the best advantage of patients.<sup>60</sup> The RCGP's own website however still appears to place the word personal at the start of its description of the GP role:

GPs are personal doctors, primarily responsible for the provision of comprehensive and continuing medical care to patients irrespective of age, sex and illness. In negotiating management plans with patients they take account of physical, psychological, social, and cultural factors, using the knowledge and trust engendered by a familiarity with past care. They also recognise a professional responsibility to their community.<sup>61</sup>

However, the question remains as to whether or not the description above is again rhetoric or reality remains as many would argue that policy changes since the 1990s in particular have placed more emphasis on general practice and the role it can play in the wider NHS. As a result policies have placed more of an emphasis on providing care to local populations over personal individual care. This in turn had implications for another traditional aspect of the GPs' role i.e. acting as advocates for their patients.<sup>62</sup> The policy context will be returned to after the completion of discussing a facilitator of personal care, namely continuity of care.

### 2.4.2 Continuity of care

Continuity of care is considered to be a key factor in providing personal care to patients.<sup>e.g.</sup>  
<sup>58</sup> Continuity of care has also been a key feature of general practice and was instituted as part of the GP role when patient registration became standard practice. It is traditionally related to patients visiting the same doctors over time i.e. ‘personal or ‘longitudinal’ continuity. However, in addition to this definition, continuity can also refer to the way that care is organized i.e. care that is coordinated across providers or ‘management continuity.’<sup>63,64</sup> A third definition of continuity has also been forwarded which relates to ‘informational continuity’ i.e. ‘the use of information on past events and personal circumstances to make current care appropriate.’<sup>65 (p354)</sup>

Personal continuity of care, has consistently been an aspect of care that patients desire and value.<sup>66-68</sup> However, there appears to be limited evidence as to the relationship between personal continuity and actual clinical outcomes<sup>69</sup> and in some cases it has been shown to be disadvantageous to patients.<sup>70</sup> Personal continuity has also been shown to be important to the providers i.e. GPs themselves in terms of both job satisfaction and the practicalities of the job, such as saving time in consultations.<sup>71</sup>

The distinctions between the various types of continuity are important for the current study as various policies as well as trends in general practice have combined to bring different aspects or types of continuity to the fore and dampen others in the work of general practice. For example, one of the reasons that personal continuity has been decreasing is due to the fact that GPs are working fewer hours and in groups employing ancillary staff, most significantly practice nurses. It is to this key development in general practice that the discussion now turns to and combines the introduction and proliferation of the practice nurse, with the a discussion of the major policy drivers that encouraged their widespread employment and development before proceeding on in the historical account of key developments in both policy and within medicine itself.



## **2.5 General practice nursing**

### **2.5.1 Practice nurses**

The development of the practice nurse (PN) and the PHCT was largely stimulated by the Family Doctor's Charter in 1965, which resulted in an increase in GPs overall remuneration as well providing additional remuneration for 70% of the wage costs other employee nurses and ancillary staff.<sup>11</sup> Numbers of PNs were slow to increase, but by 1977, 84% of practices had at least one PN.<sup>72</sup> This, in combination with the fact that virtually all practices now employed a secretary or receptionist, meant that GPs became outnumbered in general practice for the first time. This trend was continued by the introduction of practice managers in response to the steady increase in the organizational complexity and associated administrative workload.<sup>72</sup>

The second major factor that affected the development of practice nursing in the 1980s was an increased focus on health promotion. The interest in health promotion at this time was aroused by concerns regarding quality. Concerns arose due to variability in various measures of clinical activity, such as prescribing costs, childhood immunisation rates and hospital referral rates.<sup>42</sup> The 1986 Green Paper on primary care also reflected concerns about cost and quality.<sup>73</sup> The main recommendation was the introduction of a 'good practice allowance,' which would provide financial incentives for good quality of care. This quality initiative was however rejected by the profession, who argued that any payment for quality of care should be achievable by all general practitioners and such an allowance would only serve to widen the inequalities in care between good and bad practitioners.<sup>33</sup> Although the government conceded to the profession over this, it shortly after succeeded for the first time in imposing a new contract on the profession in 1990. This contract was the third key factor in the development of practice nursing and is considered by some to be the single most important factor in the proliferation of PNs,<sup>74</sup> with the actual number of PNs quadrupling between 1985 and 1995.<sup>75</sup>

The stated aims of the 1990 contract,<sup>f</sup> were to provide increased consumer choice and satisfaction, increase the range of services within practices and to link for the first time an element of performance with pay.<sup>76</sup> The 1990 contract also provided a focus on health promotion activities by incentivizing certain health promotion activities (for details of these activities see<sup>77;78;79</sup>). An investigation of the impact of the 1990 contract on general practice found that GPs did not view many of the newly incentivized tasks as relevant.<sup>78</sup> GPs considered the health promotion activities to be of ‘dubious’ value as well as aiming to change the focus of General Practice inappropriately i.e. the perceived move away from the individual patient, towards a more public health or population view of care. However, many practices pursued the available health promotion payments and rather than doing the health promotion work themselves, GPs delegated it to their PNs.<sup>78</sup> PNs positively embraced the new work<sup>78</sup> but also resulted in an estimated increase in workload by 75%, despite the delegation of some PN tasks down to Health Care Assistants (HCAs).<sup>80</sup>

The 1990 contract also saw changes to the remuneration system for ancillary staff in general practice and replaced 70% remuneration of support staff salaries with a total staff budget, making it easier to take on a diverse range of staff.<sup>72</sup> The diversification of staff included HCAs, as well as Nurse Practitioners.

### **2.5.2 Nurse Practitioners**

Nurse practitioners (NPs) arose in the mid-1960s in the United States (US). They started off working alongside doctors but subsequently extended their role by undertaking clinical assessments of patients, managing a range of common disorders and in some areas of low physician provision, acting as surrogate or substitute doctors.<sup>81</sup> They are generally distinguished from their PN colleagues by their additional knowledge and skills which enable the autonomous front line and first contact management of patients.<sup>11</sup> However, it should be noted that ambiguity exists over the use of the term ‘nurse practitioner,’ with much debate about the remit of their role and the qualifications that they need to hold.<sup>82</sup>

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<sup>f</sup> The 1990 contract will be returned to later on in the historical journey, however the reader is introduced to some of the core aspects now in order to explain the influence it had in shaping the PHCT we are familiar with today.

The introduction of NPs into United Kingdom (UK) general practice was recommended in 1986 by Baroness Cumberlege in her report, *Neighbourhood Nursing*.<sup>83</sup> The author envisaged the role as focussing on diagnosing and treating minor illness, work which would have previously been the sole remit of GPs.<sup>84</sup> In the US, NPs have been seen as cheap doctor substitutes. Forthcoming recruitment and retention issues amongst the GP workforce and increasing demand on general practice meant that NPs in a resource limited system like the NHS are an attractive option. The issue of substitution in this manner and extension of nurse roles has been a key aspect of the recent emphasis in the NHS on ‘skill-mix.’<sup>g</sup> Skill mix in UK general practice is largely focused on the transfer of ‘tasks’ from highly qualified, expensive professionals to less highly qualified, less expensive professionals.<sup>86</sup>

In general practice therefore as we have seen, NPs and PNs have been delegated tasks by their GP employers. PNs however, are also witnessing this movement of tasks down the hierarchy as Health Care Assistants are increasingly employed in general practice.<sup>h</sup>

### **2.5.3 Health Care Assistants**

The final commonly employed member of the general practice clinical staff is the HCA. In the UK, HCA is the title formally applied to those staff working at National Vocational Qualification (NVQ) level 2 or 3 in healthcare.<sup>89</sup> They are found in hospitals, but also increasingly in general practice, with a survey in 2006 suggesting that there were approximately 6700 HCAs employed in general practice.<sup>90</sup> As with NPs however, the HCA label is applied without strict criteria and therefore estimates of their numbers are to be taken with caution. As highlighted above, HCAs are delegated tasks that were previously within the remit of PN work and the types of clinical tasks they perform include the taking of various morphological measurements, phlebotomy, blood pressure checks etc.<sup>86</sup> Evidence as to the impact of the role and issues such as competence and

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g Skill-mix can be defined in individual, organisation and/or sectorial terms and involves: 1) mix of disciplinary groups involved in the delivery of a service; 2) mix of skills within a given disciplinary group; and 3) and/or the mix of skills possessed by an individual.<sup>85</sup>

h For further information on this topic the reader is referred to two reviews:<sup>87 & 88</sup>

patient satisfaction is scant due to the relative recent introduction of their role in to general practice.<sup>89</sup>

## **2.6 The Modern General Practice**

### **2.6.1 Managing general practice**

During the first three decades of the NHS, the medical profession enjoyed considerable autonomy, which has been termed the ‘golden age of doctoring.’<sup>91</sup> GPs could refer to any hospital within the UK (with financial consequences falling on the hospital) as well as to prescribe freely from the NHS pharmacopoeia.<sup>92</sup> However, due to the ever-rising costs of providing ‘free’ public health care, the system was seen as unsustainable and interest grew in curtailing the spiralling costs. In 1971 the Conservative Secretary of State, Sir Keith Joseph suggested that reorganization and improved management of the NHS was necessary.<sup>93</sup>

The Conservative government from 1979 onwards made a clear move towards more closely managing the NHS as well as other public services<sup>11</sup> and key driver for this was the 1983 Griffiths report.<sup>94</sup> This report is widely seen as instigating a paradigm shift in the future running of the NHS and introduced the hitherto foreign principles of management associated with the private sector into the public health sector. The report contained proposals for ‘general managers’ to be installed at every level of the NHS from the central government department of health to the individual hospital.<sup>i</sup> The ensuing managerial developments (despite the identification of general practice as a budget drain) did not however extend to general practice. However, throughout the 1980s general practice came under increasing scrutiny as: expenditure rose faster in general practice as compared to hospitals; attempts to limit hospital spending drew attention to the source of secondary care workload i.e. GP referrals and their role as gatekeepers; there were anxieties about the state of inner city general practice; a growing interest in prevention and the role that GPs could play and finally the government was committed to encouraging consumer choice, whether in health or education.<sup>15</sup> One response to the situation of rising expenditure seen in general practice was the introduction of the ‘limited

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<sup>i</sup> It should be noted that the BMA did attempt to resist the perceived incursion and restrictions that general managers (as proposed by Griffiths) represented, but they were as the reader becomes aware unsuccessful.<sup>95</sup>

list' to GP prescribing in 1985.<sup>11</sup> This move effectively 'black-listed' a number of drugs from being prescribed from the NHS coffers. This relatively simple and externally imposed mechanism designed to manage an aspect of GP behaviour was the first action of many to come from central government, as GPs increasingly, and in particular from 1990, came under the NHS managerial gaze.<sup>96</sup>

### **2.6.2 Griffiths Reforms**

The recommendations contained within the Griffiths report stemmed from the author's experience within the private sector and this application of private sector managerial principles to the public sector has come to be widely known as New Public Management (NPM). The advent of NPM in the UK is not unique and has been traced to the introduction of broadly similar administrative doctrines in public administration within OECD countries to around the end of the 1970s.<sup>97</sup>

The appropriateness of the application of private sector managerial techniques to the public sector has been the subject of debate, as various analysts have argued that the public sector is unique and distinct from the private sector.<sup>e.g. 98</sup> Despite these reservations the principles of NPM have been adopted and widely applied to the NHS and general practice. NPM has been described as emphasizing features such as:

..cost control, financial transparency, the atomisation of organisational sub-units, the decentralisation of management autonomy, the creation of market and quasi-market mechanisms...contracts and enhancement of accountability to customers for the quality of service via the creation of performance indicators'<sup>99</sup>  
(p43)

Due to the occurrence of the reforms of the early part of the 1990s there is ample evidence of the occurrence of NPM themes of disaggregation, competition and use of contracts in the wider NHS and general practice and it is to the first major development, the 1990 contract that we now turn to.

### **2.6.3 The 1990 contract**

The 1990 contract arose out of a series of government Green and White Papers in the 1980s, including the aforementioned 1986 Green Paper which specifically drew attention

to issues such as the cost, lack of service responsiveness to patients and quality of care in general practice.<sup>73</sup> The stated aims of the 1990 contract, were to provide increased consumer choice and satisfaction, increase the range of services within practices and to link for the first time an element of performance with pay.<sup>76</sup> This more prescriptive contract, made visible for the first time some specific requirements of the GP's job. As a result, the 1990 contract has been seen to represent the first attempt by government to exert managerial accountability over services provided by GPs.<sup>96</sup> Since the medical profession had previously been successful in bending negotiations towards their own aims, the 1990 contract was a clear turning point.

The BMA's General Medical Services Committee (GMSC) and the majority of BMA members voted to reject the new contract.<sup>15</sup> Although the government made some minor concessions they eventually succeeded in imposing their contract and on the profession. This development has been characterized as the end of the 'gentleman's agreement' between GPs and the government.<sup>100</sup> Whereas GPs' status as independent contractors had previously placed them outside the focus and remit of wider NHS changes, the government used their most effective method of instigating change i.e. contracts, in order to move general practice towards the centrally defined and desired aims. This was in part achieved by the advent of pay-for-performance (P4P) in general practice. In other words in 1990, the government treated general practitioners as rational economic individuals who would respond to financial incentives provided in order to address some of the areas of concern. For example the issue of disease prevention, was to be addressed by the government offering incentives focussing on the practice operating health promotion clinics, conducting certain numbers of vaccinations and reaching certain cervical screening targets.<sup>15</sup> Managerial control of GPs also increased with the advent of Family Health Service Authorities (FHSAs). These new bodies took over from FPCs and were led by non-clinicians. They were empowered to control health care provision and to hold GPs to account for their spending.

In addition to the introduction of the NPM features of contracting, pay for performance and the decentralisation of management authority (via the FHSAs) the 1990 contract also created more intra-professional competition, as the increased element of capitation

payments within GPs' remuneration package increased interest in attracting new patients. Those practices that responded quickly to the incentives and provided the additional services could be seen as attempting to lure patients from other practices.<sup>96</sup> The creation of this type of intra-professional competition was however limited when compared to the effects of the other major reforms in 1991 which created the so-called 'internal market'.

#### **2.6.4 1991 reforms: The purchaser-provider split, NHS Trusts and GP fundholding**

The 1989 White Paper, *Working for Patients*<sup>101</sup> contained the outline for the application of various NPM principles to the NHS and general practice. The proposals included within it were: an internal market through the separation of purchasers and providers; General practice fundholding (GPFH); self-governing trust status for providers; medical audit and capital charging.<sup>11</sup> This marked a watershed moment for general practice as for the first time GPs were brought into the central structure of the NHS. It was also the first move towards the government's vision of a 'primary-care led' NHS.<sup>102</sup>

Prior to this, the NHS was organised via public agencies called (district) Health Authorities (HAs). HAs functioned as both commissioners/purchasers of local health services as well as providers of those services. However, the 1991 re-organisation resulted in a so-called 'purchaser/provider split.' HAs were split into purchaser and provider units and resulted in HAs losing the control of their local NHS hospitals and community services, which were subsequently transformed into quasi-independent NHS Trusts.<sup>95</sup> This led to further competition as Trusts could compete with other providers such as non-local trusts and privately run hospitals for the contracts to treat the purchaser's patients.<sup>103</sup> In addition, this re-organisation introduced another type of purchaser, the GP Fundholder.<sup>104</sup>

GPFH was a voluntary scheme which allowed GPs with practices who held a patient list size of over 9000 patients, to hold budgets to purchase a range of elective secondary care services for their patients.<sup>105</sup> They could purchase care from existing NHS providers, from private providers or they could provide certain services themselves.

The scheme was voluntary and GPs' varied in their enthusiasm and entrepreneurial focus. GPFH was therefore unevenly spread.<sup>96</sup> It was popular with GPs overall however as any savings made could be kept by the practice. In 1996 the scheme was extended<sup>j</sup> and enthusiastic GPs were able to set up total primary care purchasing (TPP) schemes. TPP has been defined as:

where either one general practitioner, or a consortium of practices are delegated money by the relevant health authority to purchase potentially all of the community, secondary and tertiary health care not included in standard fundholding for patients on their list.<sup>106 (p5)</sup>

However, as the GPFH scheme grew so too did the concerns about its effects, as there was no clear independent or systematic evidence as to how savings were made or the impact of patient care. The overall evidence suggests that the benefits of fundholding were 'patchy',<sup>107</sup> with a recent review of the GPFH scheme suggesting that GPFH had limited benefits.<sup>108</sup> However as no data on outcomes or on the way in which savings were used were available it was not possible for the authors to comment on the extent to which savings were achieved at the expense of patient care. The literature also suggests that Fundholders were able to achieve shorter waiting times than non-fundholding GPs pointing to the development of a 'two-tier' system. In addition, GPs' budgets were funded on historical patterns, and were generally greater per patient than non-fundholders.<sup>11,15</sup> However, a post-hoc analysis showed that GPFH patients were overall, *less* satisfied than those in non-fundholding practices.<sup>109</sup>

GPFH was a key factor in the development of general practice management. Historically managerial responsibilities included and were limited to the employment, supervision, and human resources associated with their staff. Whilst, they had also in effect been managers of NHS resources via their gatekeeping function, GPs were not directly accountable for their decisions regarding NHS resources. GPFH gave GPs a new managerial function by extending their managerial tasks to include purchasing. Fundholders were provided with a 'management allowance' and many used this to employ managers from outside the

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<sup>j</sup> There were TPP pilots from 1994 but the scheme was officially available from 1996.



NHS.<sup>72</sup> This brought new skills into general practice. In addition, each fundholding practice had a 'lead GP,' who took on part-time managerial responsibilities.<sup>110</sup>

## **2.7 1997 – The Act and the White Paper**

The 1990 GP contract (with its narrow range of performance indicators and quality assurance mechanisms) had proved limited in its ability to address quality issues, especially those arising due to poor organisational integration.<sup>96</sup> In addition, the single national contracting arrangement was insufficient to address the new needs and trends that had occurred within the profession. For instance, rank and file GPs complained of the rigidity of the working modes that existed in general practice when compared to the wider labour market, as well as the fact that many new recruits expressing a wish to avoid the commitment of a partnership.<sup>33</sup> In addition, the remit of general practice increased to accommodate areas of work such as health promotion and screening, as a result of the 1990 contract, which meant increased demand on general practice. Furthermore, the 1990/1 reforms also led to an increase in the administrative workload.<sup>111</sup> By 1990, the average GP did a 65 hour working week (not counting medico-political activity and continuing professional education) with just under 24 of these hours was being on call.<sup>112</sup> As a result of the reforms and high workload, GP job satisfaction between 1987 and 1990 declined.<sup>113</sup> Work-related stress around this time was also high in 1990 compared to 1987, due to the day to day demands of the job.<sup>114</sup> An increase in stress and a decrease in job satisfaction was also identified when GP responses were compared in 1987 and 1993.<sup>115</sup> A postal survey found that one of the key work-related factors for young GP principals, of both sexes, leaving the profession was that they wanted choice in the level of responsibility they wanted at work.<sup>116</sup> In addition, one of the most significant personal-factors was due to their childcare commitments, a factor reflective of the fact that females were increasing a major component of the GP workforce. Such issues had started to affect GP recruitment<sup>117</sup> and therefore had to be addressed by the government. Three Conservative government White Papers were published and culminated ultimately in the NHS (Primary Care) Act 1997. This was followed by the 1997 Labour government White Paper *The New NHS – Modern, Dependable*<sup>118</sup> which continued many of the Conservative government themes. Some of the key changes as a result of these policies are now discussed.

### **2.7.1 Personal Medical Services (PMS) Pilots**

The 1997 Act contained various measures intended to free up some of the perceived barrier to providing quality care as well as addressing some of the recruitment issues within the GP workforce. In particular, it introduced a new voluntary scheme Primary Care Act Pilots (PCAPs). The scheme meant that that GPs could now be *employed* on a more flexible salaried basis by local providers i.e. HAs, Trusts or GP practices. A first wave of PCAPs began in April 1998 and were soon renamed Personal Medical Services (PMS) pilots.<sup>119</sup> Unlike GMS contracts, they are negotiated between the local commissioning organisation and the individual GP practice (not the individual GP), and are not subject to direct national negotiations between the Department of Health and the General Practitioners Committee of the BMA. The terms of these PMS contracts are designed specifically to meet those local needs and contributing to poor quality care e.g. deprived areas with low GP provision.<sup>120</sup> In addition to PMS, there was also a PMS plus (PMS +) option, which provided in addition a range of community services.<sup>121</sup> These arrangements meant that GPs were accountable for both the financial consequences of their actions and for the quality of care they provide. PMS contracts proved popular as by 2008, 47% of GPs were in practices with a PMS contract.<sup>122</sup> At the time of writing, the latest available figures show that salaried GPs are an increasingly large proportion of the workforce, from 3% in 2001 to 20% in 2008. In 2003, there were 1712 salaried GPs in England, this rose to 6022 by 2007 and by a further 10% in the past year.<sup>122</sup> GP principals however still comprise the majority of the GP workforce and were numbered at 28, 607 as of the 30<sup>th</sup> of September 2009.<sup>122</sup> This figure represented 80% of the GP workforce. Significantly, the new PMS arrangements meant that the professions long fought rights and privileged position associated with their status as independent contractors was being undermined, but the impetus for the introduction of these salaried posts had arisen primarily from within the profession due to the desires for flexible working and a reduced workload.

### **2.7.2 1997 - The New NHS – Modern, Dependable**

The proposals contained within the 1997 White Paper<sup>118</sup> represented some major changes for general practice, most of which remain in place today. The first key proposal was the

abolition of GPFH (in all forms), which occurred in 1999. In its place the government established Primary Care Groups (PCGs) which contained all the practices (approx. 50) within one geographic area (equivalent to approx. 100,000 people) meaning that all practices had to work collaboratively. Although they were initially presented as voluntary and operated as subcommittees of health authorities, the government stated in 2001, that they would make all PCGs freestanding Primary Care Trusts (PCTs) by 2004, with a responsibility to provide and in particular commission (including hospital) health care for their areas from a single cash limited budget.<sup>123</sup> This development represented a partial return to the integrated system, but one which all GPs were now subject to.<sup>11</sup> However, PCGs were relatively popular with GPs as the management structure, gave substantial control to an executive committee on which GPs comprised the majority.<sup>95</sup> As a result of these changes GPs, were moved away from a position of being able to protect their relationships with patients by blaming the faceless HA for the consequences of rationing as they themselves were now in that rationing position.<sup>96</sup> This also had the implication of moving those GPs holding managerial posts into considering their decisions away from the (traditional) individual patient and towards a population view.

A second central feature of the White Paper was an emphasis on managerial accountability and performance management. PCTs were to be subject to ongoing assessments of performance via performance indicators (PIs). PCTs were to be accountable to health authorities, and to work towards agreed targets and annual accountability agreements for improving health.

A third key feature was the development of local systems of clinical governance, officially described as:

a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.<sup>124 (p33)</sup>

Clinical governance was intended to comprehensively address poor performance, wherever it was found within the clinical team, although the mechanisms by which this would be accomplished remained obscure.

The final key feature of the proposals was the establishment of a new set of NHS Institutions, namely, the National Institute for Clinical Excellence, now the National Institute for Health and Clinical Excellence (NICE) and the Commission for Health Improvement (CHI), subsequently the Healthcare Commission and now the Care Quality Commission (CQC). The formation of NICE was intended as a way of promoting clinical and cost-effectiveness as well as producing and disseminating clinical guidelines illustrating best practice. NICE is supposed to achieve its aims by undertaking 'evidence-based' appraisals on new or existing clinical interventions, the result of which determines whether or not that intervention becomes a feature of NHS provision. Compliance with NICE recommendations was to be monitored by CHI. CHI has been described as the 'enforcer' to go alongside the 'standard setter' role occupied by NICE.<sup>125</sup> The White Paper's proposals therefore in theory posed a considerable threat to GPs' prescribing or referring autonomy, as they would be restricted by the recommendations made by NICE.

### **2.7.3 Evidence Based Medicine (EBM)**

The story thus far has suggested that General Practice has progressively become more actively managed by external parties i.e. the government. One key development however which aided in this process is the rise of evidence based medicine (EBM). EBM has been defined by one of its leading proponents, as:

the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients.<sup>126(ibid p71)</sup>

The sentiments of this statement have been extended across other professions, such as nursing but also across others such as teachers and social workers. As a result the catch all phrase of Evidence Based Practice (EBP) is now commonly used. Given that work in general practice can be conducted by a number of health professionals, and due to the common use of the term EBP in the current literature, EBP is preferred here.

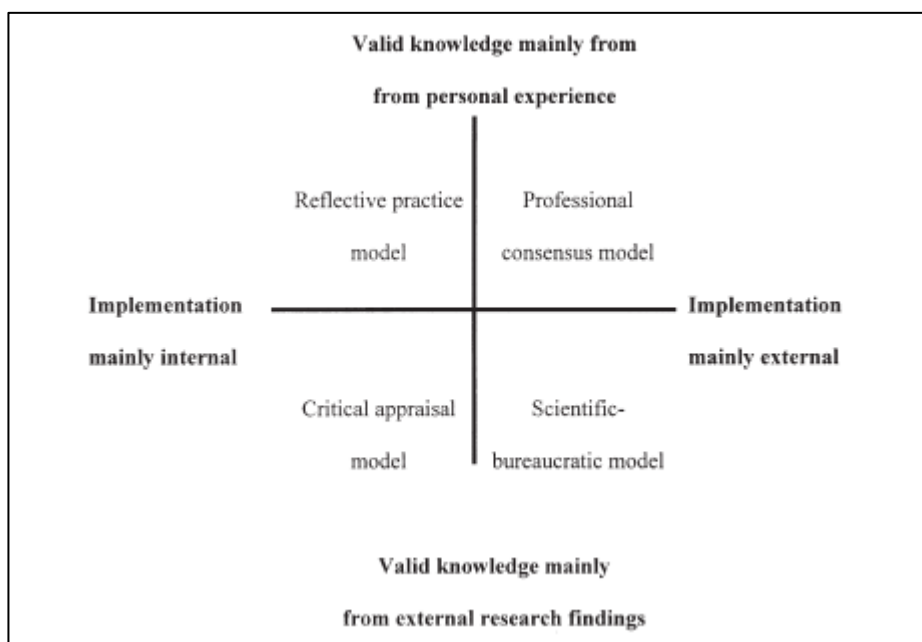
Through EBP it is assumed therefore that one can obtain valid and reliable knowledge via the accumulation of sound research which can then be used to formulate 'clinical guidelines'. These have been defined as 'systematically developed statements which assist clinicians and patients in making decisions about appropriate treatment for specific

conditions'.<sup>127</sup> The validity and reliability of such scientifically produced knowledge however is not equal, there is a 'hierarchy of evidence' with meta-analyses and Randomised Controlled Trials or RCTs sitting at the top (see table 1).

**Table 1** The 'hierarchy of evidence' (source <sup>128</sup>)

<b>Level of evidence</b>	<b>Description</b>	<b>Grade of recommendation</b>
<b>1</b>	Meta-analyses or individual randomised trials in which the lower limit of the confidence interval for the treatment effect exceeds the minimal clinically important benefit	<b>A</b>
<b>2</b>	Meta-analyses or individual randomised trials in which the lower limit of the confidence interval for the treatment effect overlaps the minimal clinically important benefit	<b>B</b>
<b>3</b>	Non-randomised concurrent cohort studies	<b>C</b>
<b>4</b>	Nonrandomised historic cohort studies	<b>C</b>
<b>5</b>	Case-series	<b>C</b>

It has been argued that EBP has become official policy in the NHS<sup>129</sup> and that there are in fact four models of the way that medical knowledge can be implemented<sup>130</sup> (see Figure 1).



**Figure 1: The Four models of EBP (source: <sup>133</sup>)**

Figure 1 illustrates two spectrums, one around knowledge and the other around its implementation. The personal knowledge pole implies that the individual, in this case clinicians, internalise and then apply the knowledge, so that the application of the EBP is a result of the internal motivation of the individual. The other pole implies that external forces via managerial and/or organisational effort are required in order to implement EBP. This knowledge may take the form of standards as contained within protocols or clinical guidelines as described earlier. This is not to say however that there are not areas of discretion left for the individual, as the so called ‘gold-standard’ of EBPs i.e. (RCTs) are conducted for a specific patient population under experimental procedures and not at the individual patient level.

In the *reflective practice model*, professionals are assumed to be self-critical and reactive to the observations of the effects of the clinical care of individual patients (using for example systematic methods of audit). The *professional consensus model* takes this concept further by the bringing together of professional elites at consensus conferences to discuss both formal, published knowledge with informal personal knowledge. The results of which are intended to guide the rank and file practitioners.

The third model, the so-called *Critical appraisal* model, reflects its preferred approach to the interrogation of published research. This is the model favoured by David Sackett, a key proponent of the EBP approach. Valid knowledge is derived from RCTs and individual practitioners are supposed to devote time to integrating this source of knowledge with that derived from their personal interactions with a particular patient. However, not all practitioners are equipped with the necessary skills or time in order to be an effective appraiser of the available evidence and therefore additional training may be required, however there can be an issue when attempting to teach these skills.

The final model is called *Scientific Bureaucratic Medicine* (SBM). This model prioritises knowledge derived from the hierarchy of evidence, particularly RCTs and meta-analyses. It downgrades the relevance of personal experience and assumes that as busy practitioners, individuals will not have the necessary time or skills to follow the critical appraisal approach. Subsequently, the findings from the literature are distilled into manageable ‘bytes’ of knowledge in the form of protocols or guidelines that are assumed (and enforced in some cases) to influence practice:

The logic, though not always the overt form, of guidelines is essentially algorithmic—that is, it guides the user to courses of (diagnostic or therapeutic) action, dependent upon stated prior conditions: ‘if ... then’ logic. The logic is also normative—that is, it tells the clinician what ought to be done. In general, guidelines do not claim either to be applicable to all patients or to determine clinical action completely, so degrees of discretion are left. Albeit in the highly professionalized context of healthcare organisations, such guidelines are a species of bureaucratic rule, hence our chosen label.<sup>130 (ibid p6)</sup>

Some argue that the SBM model had become institutionalised within the structure of the NHS from the 1990s in three key areas.<sup>95</sup> The first area is that clinical guidelines have become ubiquitous and arose during a period of increasing managerial, professional and organisational pressures for their implementation. The advent of NICE, as discussed above, also contributed to the proliferation of such guidelines.

Second, there was the introduction of National Service Frameworks (NSFs) first mentioned in the 1997 White Paper. These detailed documents provide defined care pathways through all levels of care (primary through to tertiary), in which a particular type

of patient (e.g. coronary heart disease, mental health etc) are expected to pass through.<sup>131</sup> Although they are to some extent evidence based they are also heavily concerned with the organisation of those services in question. All those working in the NHS are expected to implement NSFs as part of the clinical governance arrangements and the CQC are required check on these arrangements. An investigation into the implementation of NSFs (across 5 general practice case-study sites) however revealed that in practice implementation was uneven. This has been attributed to the fact that although GPs reported positive attitudes to the concept of NSFs, they were in practice not using them due to the perception that the NSF documents were too large and complex to aid in the practical requirements of processing their day to day patient workload.<sup>132</sup>

The third and final institution of SBM, and the focus of this work is the 'new' (2004) GP contract and the associated QOF. QOF is essentially a pay-for-performance scheme based on the achievement of various, largely clinical, indicators which are in some way evidence-based.<sup>133</sup> One can say therefore that style of medicine that QOF encourages (with its clinical content being underpinned by large scale population RCTs) is usually recognisable as being from a public health perspective. However, as described earlier, GPs have traditionally defined themselves and their role in terms of a holistic approach to care, with the *individual* patient being the focus of their work. There is therefore potential for role tensions to occur, although of course as has been discussed, this may be more of a fiction than fact.

## **2.8 The New General Practice**

In March 2003, the majority of GPs (79.4%) voted in favour of the adoption of new GMS contracting arrangements which contained a prescriptive but optional (146 incentivised targets) pay-for-performance scheme in the form of QOF.<sup>134</sup> Given that the 1990 contract, which contained by comparison a small element of P4P targets, was rejected by the profession, it seems pertinent to outline briefly the reasons underlying this sea-change in opinion in only a decade or so later and which led to significant change occurring in general practice.



Familiar issues within the workforce had re-surfaced and needed to be addressed. A survey conducted by the BMA revealed that over half of the GPs at the time in UK would consider resigning (or early retirement) if new contractual arrangements could not be reached and that addressed the issues such as recruitment and retention and pushed the profession to the ‘edge of collapse.’<sup>135 (p1381)</sup> The negative attitudes of GPs however reflected the situation at the time in general practice. This had largely arisen due to the poor definition of expectations of GP services under the 1990 contract, as well as GPs’ obligation to provide 24 hour ‘out-of-hours’ care to their patients. As a result, practices were unable to control their workload.<sup>133</sup> In addition, the then current GMS contract did not reward practices providing additional services.<sup>133</sup> This in turn inhibited the development of new services and GPs who wished to pursue their areas of special interest, thereby restricting career progression. General practice was becoming a less attractive career option for medical students and added to workforce issues as retention was also an issue.<sup>134</sup> In order to alleviate the situation underlying the revealed negativity, GPs collectively asked for the limits of their responsibilities to be clearly defined.<sup>133</sup> They wanted choice in whether or not they provided certain services and they wanted to be properly resourced in order to provide high quality care to their local populations. The principles surrounding the new contracts were designed and intended therefore to address such issues. However, before moving on to discuss the government’s new contracting arrangements and the solutions they offered, it is important to briefly highlight an important preceding step, the publication of *The NHS Plan*.<sup>136</sup>

In ‘The Plan’ the government stated that its aim was to continue to support the founding principles of the NHS, but to also design services that were more patient focused. It also identified areas that required significant improvement such as for example variations in standards of care or the so-called ‘postcode lottery’ and practitioner pay. In order to achieve the stated aims the government stated that they recognised that significant modernisation and investment was required in order to address poor infrastructure and staffing issues. The backdrop to *The Plan*, was the commitment to a substantial increase in resources for the NHS, promised for the next 5 years. Investment in general practice therefore came about as a result of the government’s overall NHS strategy and led to an increase of funding in general practice from, £4.9 billion in 2002-2003 to 6.9 billion in

2005-6.<sup>137</sup> Without such an investment, the new contracting arrangements, and funding they required would not have been possible.

### **2.8.1 New contracts and key changes**

As a result of the investment, the government and the BMA were able to design new contracts which were to address some of the issues as highlighted earlier. Firstly, the government expanded its contracting options by creating a 'new' version of the General Medical Services contract (nGMS), it retained the PMS contract but added two new options: the PCT Medical Services (PCTMS) contract; and an Alternative Provider Medical Services (APMS) contract.<sup>138</sup> The PCTMS contract enabled PCTs to employ GPs on a salaried basis according to need. The introduction of the APMS contract, was introduced by the government to encourage NHS commissioners to explore alternative organizational models of primary care, particularly from the private sector.<sup>139</sup> The introduction of APMS however was particularly controversial as it effectively ended the traditional GP principal monopoly over primary care provision to NHS patients.<sup>140</sup>

Secondly, there were changes to the legal basis of the nGMS contract as it is held at the practice level rather than with the individual GP, as was the case with previous contracts. GPs therefore no longer have a direct contractual relationship with the state because the contract is between the practice and the state (or in the case of PCTMS or APMS with the Trust or for example the private company respectively). GPs therefore no longer have individual patient lists as the responsibility of caring for an individual patient lies with the practice.

Thirdly, GPs funding arrangements changed and meant that they would be paid according to the work they actually do. This was aided by the separation of general medical services into essential, advance and enhanced as well any potential income gained from the QOF, should the practice opt in to the *voluntary* P4P scheme. All practices have to provide essential services that cover most of the day to day work of general practice but can now opt out of additional (e.g. cervical screening, immunisations etc) or enhanced services. Enhanced services come in three forms: National, Direct and Local (NESs, DESs, LESs respectively). Most practices do provide additional services but enhanced provision is

more patchy and dependent upon local needs and resources.<sup>134</sup> Practices receive their main funding for the provision of essential services via a ‘global sum.’

The global sum payments in addition to funding essential services, also cover staff costs and locum reimbursements (for appraisal, career development and protected time) – which are paid from the PCT’s unified resource allocation. It is calculated via the Carr-Hill formula, a weighted-capitation formula which is applied to the practice’s registered list size in order to generate a number of notional patients that the practice is liable to provide services.<sup>141</sup> For an average UK practice, with an average practice weighted population, this results in an award of around £300,000 in 2004/05.<sup>134</sup> The new funding formula was seen as more sensitive to the needs of patients and practice workload and was in particular a boost for practices in deprived areas as the funding was focused on patients rather than the number of GPs in post.<sup>142</sup> However, there were some practices that would potentially lose out financially as a result of the move from the old funding arrangements. Provision was made for such cases, as practices were eligible for a ‘Minimum Practice Income Guarantee’ (MPIG). This figure was calculated by comparing the 1 April 2004 initial global sum with uplifted historic income from relevant fees and allowances between 1 July 2002 and 30 June 2003.<sup>134</sup>

Fourthly, in addition, to the choice of service levels that practices could provide, GPs were also able to opt out of their 24hour patient care responsibilities, for a relatively small fee of £6000 per GP. The new range of service level options therefore meant that GPs from this point should be better able to control their workload, and should they choose to, trade income for leisure.<sup>142</sup>

Fifthly, the new contract offered incentives to practices in order to update the available Information Communication & Technology (ICT) in practices. This was crucial to the implementation of perhaps the most significant aspect, the QOF, as practices had to collect and record the necessary patient data as required by the targets. The discussion now focuses on the details of the QOF which is of central importance to the current study.

## **2.8.2 The Quality and Outcomes Framework (QOF)**

### *2.8.2.1 Why did GPs vote in favour?*

The QOF as outlined earlier is a P4P scheme that rewards practices according to their achievement against detailed targets or indicators. It is perhaps the most controversial element of the new contracting arrangements and has been described by one commentator as representing ‘the boldest such proposal on this scale attempted anywhere in the world’,<sup>143 (p457)</sup> and critically by another as moving GPs to ‘an unprecedented system of central control and external surveillance.’<sup>144 (p888)</sup> Others critics have seen its centrally-derived clinical targets as a threat to clinical judgement and autonomy.<sup>145</sup> The reader may therefore wonder why the profession overwhelmingly voted in favour of such a controversial system. One commentator identified four key factors that affected GPs’ votes in 2003.<sup>77</sup> First, since the mid-1980s and the profession’s rejection of the Good Practice Allowance, the EBP movement had begun in earnest and rapidly gained credence. During the 1990s therefore there was a growing recognition and acceptance that good quality care could indeed be defined and measured, at least for some conditions. Subsequently the profession accepted that there were widespread demonstrable deficiencies in care and that something had to be done to address the situation. Secondly, as a result of the variations in quality of care there was increasing public disquiet and pressure regarding the variation in quality of services. Thirdly, as a result of the EBP movement and public opinion, the government was increasingly under pressure to react and they did this by planning an injection of funds into general practice, which would in part be due to the QOF. The QOF with its detailed and largely evidence based framework of indicators seemed to provide a solution to addressing the variation in quality (by paying for standardised care) but also potentially could address the issue of pay which had been detrimental to recruitment to, and retention within the profession. Fourthly, negotiations were extensive (over an 18 month period) and the content of the QOF received considerable professional input by academic advisors and therefore was largely in line with professional opinion. Finally, as noted elsewhere, the contract was sold to GPs as providing increased flexibility and freedom.<sup>146</sup> In summary therefore, a number of factors acted in combination and were responsible for the profession’s decision to work under the new system, and most practices have. The detail regarding the types of activities GPs are incentivised to conduct as part of this new system is now outlined.

### 2.8.3 QOF: the detail

The discussion starts with an outline of the initial version of QOF in 2004, however the QOF was from 2006/7 subject to annual review and subsequent key changes to its content during the study period will also be discussed later.

The initial 2004 version of the QOF comprised 146 indicators covering a range of clinical and non-clinical domains pertaining to practice organization, provision of additional services and patient experience criteria. Additional points are also available in the form of holistic care<sup>k</sup> and quality practice payments as well as an Access bonus. Each indicator is worth a specified number of 'points', with 1050 available in total and each point in 2004/5 worth approximately £75. Of the 146 quality indicators, 76 were clinical, spanning ten clinical areas (see table 2), chosen because of their prevalence or their importance in terms of the burden of disease.<sup>77</sup>

**Table 2 Clinical Indicators and Assigned Points in the 2004 Quality and Outcomes Framework (source:<sup>77</sup>)**

Condition	Number of Indicators	Maximal no. of points
Coronary heart disease	15	121
Stroke, transient ischemic attack	10	31
Hypertension	5	105
Hypothyroidism	2	8
Diabetes	18	99
Mental Disorder	5	41
Chronic Obstructive Pulmonary Disorder	8	45
Asthma	7	72
Epilepsy	4	16
Cancer	2	12
Total	76	550

<sup>k</sup> In contrast to the definition of holism as defined and described earlier as relating to the individual patient, holistic here refers to the breadth of achievement across all disease areas.

Each clinical indicator measures the quality of a specific aspect of clinical care for example in the case of hypertension, the regularity of the blood pressure (BP) monitoring. In other cases, points may be awarded simply for collecting data i.e. setting up a disease register for epilepsy. GPs can earn points therefore for ‘process measures’ e.g. patients have had their BP or cholesterol recorded as well as for ‘intermediate outcomes’ i.e. such risk factors have been managed within defined and reasonable limits. More points are available for the intermediate outcome measure and reflect the increased level of effort or workload required for their achievement.<sup>77</sup>

The organisational indicators (worth 184 points) were spread across five categories: 1) records and information about patients, 2) communication with patients, 3) education and training, 4) management of medicines, and management of physicians’ practices. In the additional services domain (worth 36 points), practices are rewarded for the achievement of 10 indicators for variety of tasks. An example being that the practice has a policy for auditing its cervical screening service, and for performing relevant audits of inadequate cervical smears. In the patient experience section of the QOF (worth 100 points), practices are rewarded on the basis of achieving 4 indicators spread across two areas relating 1) to the conducting of and reactions to patient satisfaction surveys and 2) consultations e.g. there is an incentive for practices who routinely book 10 minute appointments. The responsibility for the delivery of these non-clinical QOF areas is largely the responsibility of practice managers and hence are not focused upon or discussed in great detail in the current study.<sup>147</sup>

Incentive schemes can vary in structure, with some paying for progress towards a target and others adopting an ‘all-or-nothing’ approach, under which payment is only made when the target has been met.<sup>148</sup> QOF involves payment for practices making progress towards the target. For example, in the case of one of the hypertension indicators, practices are paid according to the percentage of patients that have had their blood pressure recorded in the previous 15 months. The lower threshold of achievement is 25% of these eligible patients (worth 1 point) and the upper threshold of 90% of eligible patients which at the time translated into 7 points. The threshold at which maximum points can be gained varies across the clinical areas. One of the reasons that the QOF

negotiators adopted this approach ‘progress towards targets approach’ was to avoid the possible inappropriate treatment of patients. Two mechanisms were used in the QOF which were supposed to act to prevent such occurrences.<sup>149</sup> First, by setting maximum thresholds below 100%, practices can earn the maximum available points and financial rewards, without achieving the targets for all eligible patients. The second allows practices to ‘exception report’ patients i.e. exclude them from the performance calculations by removing them from the numerator and denominator of any individual (inapplicable) indicator. Consequently practices are not ‘unfairly’ financially penalised for work they are unable to perform for valid reasons. A summary of legitimate reasons to exception report patients is provided in table 3.

**Table 3 Legitimate reasons for exception reporting patients. (Source:<sup>149</sup>)**

<p>The patient has received at least three invitations for review in the preceding 12 months but has not attended.</p> <p>The indicator is judged to be inappropriate for the patient because of particular circumstances, such as terminal illness, extreme frailty or the presence of a supervening condition that makes the specified treatment clinically inappropriate.</p> <p>The patient has recently received a diagnosis or has recently registered with the practice.</p> <p>The patient is taking the maximum tolerated dose of a medication, but the levels of the biological parameters of relevance remain suboptimal</p> <p>The patient has had an allergic or other adverse reaction to a specified medication or has another contraindication to the medication</p> <p>The patient does not agree to the investigation or treatment.</p> <p>A specified investigative service is unavailable to the GP</p>
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Practitioners are allowed to use their clinical judgement in order to apply the exception criteria and there are no limits on the number of patients that a practice may exclude.

The ability to exception report is intended to avoid 1) patients receiving inappropriate treatment and 2) GPs feeling pressured to pursue areas of work that are inappropriate. However, it also raises the possibility of an unintended consequence i.e. ‘gaming.’ This occurs when practitioners knowingly manipulate measured results e.g. GPs could exploit

exception reporting to maximise their points by excluding patients for whom the targets has simply been missed rather than because of a genuine clinical reason. Gaming is a known phenomenon within the incentives literature and has probably always been in existence as people in economic terms at least are always assumed to maximise their utility. Provisions against gaming regarding exception reporting have been made. Firstly, QOF data is extracted automatically from practices and collated by the Quality Management and Analysis System (QMAS) database. The PCT have access to this data and are able to scrutinise it. It is for this reason that some commentators suggest gaming is somewhat difficult for individual practices to do successfully as PCTs have access to QOF data for *all* practices in their locale.<sup>150</sup> Identifying a practice who has gamed therefore would be relatively easy as the prevalence of each disease is fairly consistent across geographic and a practice showing an unusually low prevalence of patients for a particular disease would stand out. In addition, practices are subject to an annual QOF inspection by PCT representatives and the penalties for errant practices are severe, although the comprehensiveness of the visit may vary.<sup>77</sup> To date, it appears that widespread gaming has not occurred as rates of exception reporting across English GP practices between 2005-6 were low, averaging just under 6%.<sup>149</sup> There is however some recent evidence that shows a small proportion of practices under-recording disease prevalence, thereby falsely increasing their reported achievement rates.<sup>151</sup> In contrast to this type of self-serving behaviour from some practices, it has also been shown that there is altruistic behaviour, with calculations revealing that practices could reduce the number of patients treated by 11.8% *without* losing any QOF revenue i.e. practices are exceeding their maximum thresholds, and the motivation to do so is apparently not financial.<sup>151</sup> This type of ‘moral’ behaviour appears to indicate that something more than personal financial gain is driving professional behaviour<sup>152</sup> i.e. some form of internal motivation is at work. The introduction of QOF (and its external motivators i.e. money) led to concerns for the internal motivation of practitioners. Research early in the lifetime of the QOF (May 2005 to November 2006) suggests that QOF has not damaged the internal motivation of GPs as the clinical content was largely in line with professional opinion.<sup>153</sup>

Practices have scored highly on QOF with an average of 959 points being achieved in the first year.<sup>154</sup> This exceeded the government’s expectations that practices would average



750 points and therefore earn £430m in bonuses. Due to the higher actual achievement levels the bonuses paid out were closer to £630m and in 2004/5 QOF scores determined approximately 20% of practice income.<sup>154</sup> In fact average achievement has consistently been over 90%, with a mean score of 95.4 % in 2008-9.<sup>155</sup> The following sections highlight the main factors that have influenced this high achievement and starts with the widespread introduction of ICT systems across practices and the impact this has had on GP work and patient care.

### **2.8.3.1 Information Communication & Technology (ICT)**

Crucial to the success of the new contracts and QOF was the widespread introduction and implementation of ICT systems capable of capturing, analysing and reporting data as required by QOF. The nGMS contract however, made provisions for this by providing funding for the ‘purchase, maintenance, future upgrades, running costs of integrated systems as well as telecommunications links to branch surgeries and other NHS infrastructure and services.’<sup>134 (p16)</sup> PCTs were obliged to meet practices’ entitlements and expenditure from their unified budgets. In England, this was supplemented by the National Programme for IT in the NHS, which provided an overall investment of over £2 billion in NHS systems and infrastructure. As a result of such investment virtually 100% of UK general practices now use computers to aid in the clinical care of their patients and to meet the QOF.<sup>139</sup>

In order to maximise QOF achievement, practices have opted for and employed the use of specifically designed software such as Population Manager and have developed a series of standardised data entry templates. One study focussing on the impact of these templates provides a description of the main ICT systems in general practice as a result of the data collection needs of QOF.<sup>150</sup> First, the software allows practices to scrutinise their own performance by generating a running total of achievement by indicators and clearly identifying and indicating those areas that are yet are no up to the desired target levels. The programme also generates a series of pop-up boxes that appear on the practitioners’ screen when looking at a patient’s record. These highlight where QOF data is missing for that patient and do not disappear from the practitioners’ view until they dismiss it by actively selecting the box to do so.<sup>150</sup> The other key tool in practices attempting to ensure

that data entry is accurate and focused on the QOF is the development of standardised (electronic) data entry templates for each clinical area. These templates consist of a series of short questions and answers and again act to focus the practitioner on the narrow and biomedical needs of the QOF.<sup>150</sup> As a result this has led to some observational research identifying a trend towards increasing biomedicalisation, despite GPs discursive claims to continue to practice ‘holistically.’<sup>43</sup> The authors state that GPs were not aware of or did not acknowledge this change/biomedicalisation with GPs ‘locating any change at the margins of practice’ and maintaining “a discursive claim to holistic practice’ (ibid p800). These findings are in contrast to those of pre-QOF research, where it was reported that GPs were positioning themselves as biomedical specialists as they dealt with complex care in contrast to the simple work delegated to nurses.<sup>156</sup> However, a further study conducted later on in the lifetime of the nGMS however reported that GPs did express concerns about a focus on QOF activities and therefore a loss of holistic care.<sup>157</sup> In addition the authors of this study reported that a ‘substantial minority’ of GPs appeared to be more dissatisfied with the changes that had occurred as a result of the QOF as they ‘felt their new role to be at odds with their professional training as generalist doctors’ with their new role increasingly focused on management/supervision and standardised care being reduced to a ‘box-ticking’ exercise.<sup>157 (p136)</sup> The sentiments of these GPs and the approach to medicine that electronic templates appear to encourage has been analogised as a ‘Fordist’ approach to medical care;<sup>153</sup> however, practitioners *do* have the ability to dismiss the boxes without completing them in the required manner but the pop-ups will appear each time the record is viewed until all requirements are satisfied.<sup>150</sup> The ability of practitioners to control whether or not they attend to the QOF templates has according to some GPs, allowed them to respond flexibly to the demands of the consultation at hand and therefore GPs have reported that their professional discretion or clinical autonomy had not been adversely affected as a result of such technologies.<sup>146,153</sup> In addition, according to the RCGP,<sup>134</sup> the information required by QOF is no different to that which practices were already recording as part of electronic patient records, such as disease registers. It has been reported however<sup>153</sup> that the new formalised approach to data collection was perceived by some GPs as influencing their consultation agendas with the result being a gap or even conflict between the individual patient’s needs and the GPs’ need to attend to the QOF.<sup>158</sup>

Finally, the ICT systems also enable sophisticated call/re-call functions i.e. the system automatically generates recall letters and reminders for patients to attend the practice in line with the intervals of measurements as required in the QOF.<sup>150</sup> As a result the authors of this study state that patients are identified and managed as a *group*. Furthermore, this somewhat diminishes the traditional system of allowing patients a choice of *when* attend.<sup>150</sup> The reader is reminded that in the case of persistent non-attendance by patients, the practice is not penalised financially due to the exception reporting facility.

In summary, the research concerning the impact of the ICT systems is mixed, with some indicating that such systems act to promote and embed a biomedical approach to care i.e. one that is in conflict with the espoused model of care that underlies the GPs role and identity and others stating that the professional discretion of GPs at least is largely unaffected.

### **2.8.3.2 Practice Nurses**

Although the widespread adoption of ICT has aided practices in collecting the necessary QOF data, the issue of the necessary time and manpower required to perform the QOF related tasks remained. Again, we see from evidence in the literature that, as in the case of the 1990 contract, GPs have primarily turned to their PNs in order to perform contract related tasks. This is illustrated by the fact that total number of consultations carried out in GP practices has increased, whereas the number of consultations that each GP carries out has reduced. This apparent paradox is easily resolved by the fact that there has been an increase in PN workload and consultations,<sup>159</sup> with them now performing tasks which were previously within the remit of GP work. This shift has in turn instigated recent empirical research on the issue of professional hierarchies and boundaries. The results of this research have revealed that although QOF has resulted in a shift of certain areas of general practice work ‘down the hierarchy’ (i.e. from GPs to PNs, and in turn from PNs to HCAs) existing hierarchies have remained ‘largely intact.’<sup>52</sup> As noted above, the delegation of work in this manner has been aided by the use of the prescriptive electronic data collection templates which outline clearly the QOF related tasks. and in turn allows the practice to function more efficiently by less qualified staff who are less likely to

deviate from the templates doing such QOF work and frees up GP time for more complex work such as those patients with multiple chronic diseases.<sup>150</sup> It is worth noting however, that prior to the introduction of QOF in 2004, this trend of delegation in so called medical tasks to PNs had already been identified.<sup>160</sup>

PNs have however had little control over the development and extension of their role in to new areas of work and studies have shown mixed reactions to their changing remit with some expressing concern about changes to their clinical practice.<sup>153</sup> Where PNs have reported positive developments, such an increased (and in some cases novel) aspect of work in terms of interpersonal care with chronic disease patients, this has resulted in a perception in the inequity of financial rewards.<sup>161,162</sup> In other words PNs have taken on a large part of the incentive rewarded work within QOF but are not seeing the financial benefits of doing so.

### **2.8.3.3 Internal re-organisation and surveillance**

Practices are not *obliged* to use computer systems, but clearly the effort involved in maintaining accurate paper records would be extensive and ultimately potentially prove punitive in the successful capturing of clinical quality data. The standardised data entry templates as discussed above were designed to accurately and uniformly collect the data as required by QOF. However, the presence of templates and the attention grabbing ‘pop-up boxes’, on the practitioners computer screen does not ensure compliance with their data entry requirements. In fact there is a literature that illustrates the ways that users can subvert the system such as by manipulating the information that is entered.<sup>163</sup> Early empirical research has however illuminated another major factor as to why GPs have on the whole conformed to the template requirements.<sup>153</sup> The authors discovered that there had been two key changes to the practice organisation. First, the implementation and use of ICT systems and software such as Population Manager, allows for the rapid calculation of overall practice QOF performance and allows for the identification of patients (and by implication the GP(s)) whose progress is to date insufficient. Therefore GP work, although in practice is still conducted in private consultations, is now open to measurement and scrutiny.<sup>153</sup> Secondly, in order to attempt to ensure that QOF achievement is high, practices also appear to have become internally re-organised around

the needs of the QOF, with the development of designated QOF leads or ‘chasers’ who, via the availability of such performance information, are able to directly engage in the monitoring of other practitioners’ (the ‘chased’) performance.<sup>153,164</sup> Research to date has indicated that practices appear to adopt one of two approaches to monitoring: 1) Practices may have multiple QOF leads, with each individual practitioner (which may include salaried GPs and/or PNs) having an area of responsibility or 2) they have an overall ‘QOF lead’ who oversees all the practitioners’ performance. The type of organisational approach taken i.e. one QOF lead vs. multiple leads, as well as the manner or level of scrutiny that QOF leads adopt in directing other practitioners’ performance, has also been shown to have an impact on the level of perceived surveillance and by implication discretion of those under surveillance.<sup>153</sup> Regardless of the approach taken however, the end result appears to be the same i.e. that decision making is becoming concentrated in fewer hands. QOF leads control (to varying extents) the day-to-day work of other practitioners, regardless of the espoused narratives or approaches to care that the practice holds.<sup>165</sup>

In addition to practitioners being monitored by others, some practitioners also engage in QOF self-surveillance and appear to do so for two reasons: 1) having access to their own performance data provides them with a source of motivation and 2) they self-monitor as they do not wish to stand out as a poor-performer within their practice as the achievement of QOF is as described a team approach.<sup>146</sup> This does not mean however that there has been no resistance to the QOF approach to work from individual practitioners but that such deviance is generally minimal. Where cases of resistance (by individual GPs) have been identified, resistance has been due to ‘QOF resisters’ being critical of the QOF approach and/or those who disliked the requirement of the use computer of templates for QOF work.<sup>146,166</sup> Finally, there is another factor and this relates to the surveillance of the overall QOF score that a practice achieves by other external organisations such as other local practices or the PCT as well as patients. There appears to be little evidence regarding the importance of these factors within the literature, however as described earlier practitioners have been shown to be competitive for example as with the competition for patients with the 1990 contract and with GPFH.

### 2.8.3.4 Already doing QOF in all but name?

The final key factor in practices achieving well and above government expectations was the fact that the government had failed to factor in to their negotiations that there was no baseline (i.e. pre-QOF) measure of how well practices were already performing in the targeted areas. Research in to this phenomenon has shown that prior to QOF, quality of care had already been improving in areas such as asthma, coronary heart disease (CHD) and type 2 diabetes, as a result of other quality initiatives, including schemes such as the NSFs and clinical audit. According to trackers studies, the introduction of QOF in 2004 only led to a ‘modest acceleration’ in improvement for only 2 of these conditions, asthma and diabetes as measured in 2005.<sup>167</sup> Such results have led to questions around whether the incentive payments were therefore being made to produce better quality care or were simply awarded to practices on the basis of their increased recording of their activities.<sup>137</sup> In other words, is QOF a quality improvement tool or simply a way to reward the achievement of good quality as defined by QOF? Although it is unclear which of these options has occurred, practices have invested in additional administrative and clinical staff in order to deal with the increased paperwork and running of systems such as the call/re-call arrangements and patient reminder letters that it generates.<sup>147,150</sup>

In summary, these four major factors 1) the widespread implementation of ICT systems; 2) delegation of QOF work to nurses; 3) practices internally re-organised around QOF and engage in internal QOF related surveillance, and 4) care was already improving prior to QOF, all contributed to and facilitated GPs achieving well against QOF targets. These factors, in combination with the majority of practices (99.6%) opting into QOF;<sup>168</sup> and most achieving well over the governments predictions, led to a large (and unaccounted for) extra expense to the tune of £200m.<sup>154</sup> As a result, GPs (primarily GP principals) have enjoyed substantial increases in their incomes,<sup>1</sup> worked fewer hours and has led to higher job satisfaction amongst GPs.<sup>170</sup> This led to somewhat of a media frenzy and backlash, with some headlines claiming that GPs were being overpaid.<sup>171</sup> However, it should be noted that the award of a pay rise to GPs, was part of the government’s

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<sup>1</sup> In the first three years, pre-tax take home pay for GPs in England (including income from NHS and private sources) increased by 58% (from 72,011 in 2002-03 to 113,614 in 2005-06). The average pay for a GMS partner increased to 110,054 and a PMS partner to 121,375. This excludes the amount of money surrendered in opting out of providing out-of-hours care.<sup>169</sup> Increased income and reduced working hours identified as key factors in post-QOF increases in GP job satisfaction.<sup>170</sup>

intentions (and discussed in the *NHS Plan*) when introducing the new contracting arrangements. The government however, clearly did not intend for the extent of the rise and ultimately paying GPs *more* for working *fewer* hours.<sup>169</sup>

#### **2.8.4 QOF post 2004/5: the honeymoon period ends?**

As a result of the 2004 negotiations, the government had been dealt a budgetary blow by GPs 'over-achieving' on QOF and at the first possible point, in 2006/7, showed their reaction and strategy to dealing with their 2004 losses. Essentially the government intended to recoup some monies and control over its providers in general practice by various mechanisms (see table 4 for a summary of these and other key changes during the study period). The major changes to QOF mean that for most of the study period, practices were required to expend greater efforts, for no additional compensation. Furthermore some of the changes (e.g. 2006/7 indicators on depression and chronic kidney disease (CKD)) were not perceived by GPs as evidence based (rather politically driven introductions) and were not positively received.<sup>157</sup>

**Table 4 Summary of key contract and QOF developments in England**

Contract	Key developments
2006/7	<ul style="list-style-type: none"> <li>➤ ‘Major’ reorganisation of QOF               <ul style="list-style-type: none"> <li>○ Decrease in total number of QOF points (1050 to 1000)</li> <li>○ Addition of 8 new clinical areas</li> <li>○ Threshold adjustments (lower thresholds raised from 25% to 40%)</li> </ul> </li> <li>➤ Introduction of ‘choose and book’ DES – incentive to offer choices to patients for consultation referrals and to use ICT to book appointments.</li> <li>➤ No financial uplift in any aspect of the contract (for further details of 2006/7 changes see<sup>172</sup>)</li> </ul>
2007/8	<ul style="list-style-type: none"> <li>➤ No change</li> </ul>
2008/9	<ul style="list-style-type: none"> <li>➤ Recycling of 58 QOF points to incentivise access (48 hour and advanced booking) based on patient satisfaction survey results.               <ul style="list-style-type: none"> <li>○ led to the first dip in the increasing trend for high QOF achievement since its introduction.<sup>173</sup></li> </ul> </li> <li>➤ Extended Access DES               <ul style="list-style-type: none"> <li>○ Participation means that the average 6000 patient practice the DES means opening for an additional three hours a week.<sup>174</sup></li> </ul> </li> <li>➤ 1.5% financial uplift<sup>175</sup></li> </ul>
2009/10	<ul style="list-style-type: none"> <li>➤ ‘Minor’ reorganisation of QOF               <ul style="list-style-type: none"> <li>○ Tightening of some targets e.g. practices now asked to achieve a HbA1c level of 7% (down from previous level of 7%)<sup>176</sup> and focus on clinical domain increased.</li> </ul> </li> <li>➤ Average pay rise of 1.5%<sup>177</sup></li> <li>➤ Funding formula underlying QOF payments adjusted to reflect true disease prevalence and QOF related workload<sup>178</sup></li> <li>➤ NICE now involved in the development and assessment of clinically and cost-effective indicators.</li> </ul>



## **2.9 Summary**

In this chapter I have outlined the key developments in the historical journey of the profession of general practice. I started by describing the emergence of the ‘the GP’ and how these early GPs struggled to establish themselves in comparison to their hospital counterparts. GPs however carved out a niche for themselves by providing personal ‘bedside care.’ The seeds of this type of care eventually led to the formation of a distinct GP professional identity around a discourse of holistic medicine. Poor working conditions and high patient demand however meant that throughout the 20<sup>th</sup> century it was identified that actual care provision not representative of their espoused professional ideals. Several factors including the: recognition of the poor quality of care provision; the role GPs could play in the nation’s health; as well as the inadequacy of their resources led to repeated investment into general practice. However, later cost concerns prompted a move towards increased management of the NHS and over time GPs were increasingly brought under the government’s managerial gaze. As GPs are primarily independent contractors, the government has had to utilise the contract as its main tool of management. As a result contracts became less vague and more prescriptive over time. I ended the chapter with a detailed discussion of the substantive topic of interest in this thesis i.e. the latest contract and in particular the prescriptive pay-for-performance scheme, QOF. The nGMS contract breaks the traditional GP responsibility for 24 hour care provision and is no longer held with individual GPs, but their practices. Furthermore, early research indicates that QOF has resulted in changes in the organisation and running of general practice. Significantly, these have implications for patient care as well as the work of GPs. It is for this reason that I chose to study the continued impact of the nGMS and QOF on GPs. In the next chapter I outline the chosen theoretical framework through which the impacts are viewed through.

## **Chapter 3**

### **Theoretical Framework**

#### **3.1 Introduction**

In the previous chapter I illustrated the various significant changes that have occurred in general practice since its emergence as a distinct medical discipline in the nineteenth century. The account showed that for large periods of time GPs were ‘untouched’ by central policy and that this was largely as a result of GPs’ status as independent contractors. GPs historically therefore have worked in an atomistic manner, within their own practices and have had wide discretion in how they dealt with their patients due to the vague nature of the ‘John Wayne’ contracts. However, due to increasing concerns over the cost and quality of care within the NHS, general practice has increasingly become a focal point for the attentions of central policy makers who increasingly sought to control aspects of frontline practitioner behaviour. In order to attempt to align the frontline behaviour of GPs with such policy aims, policy makers turned to their main tool, the contract. In this thesis I am concerned with the most recent contractual changes (and its later variants) introduced in 2004. In particular, the study is concerned with the impact of the large element of P4P (or QOF) contained within the new contract on the day to day work and workings lives of GPs. Within the literature however, there are various approaches that have been adopted when attempting to analyse the impact of government policy on medical work. In this chapter I discuss the approach adopted in the current study.

#### **3.2 The theoretical framework**

The traditional conceptual approach to analysing medical work has involved the exploration of the status of physicians as archetypal professionals belonging to a professional group. There is a considerable literature surrounding the concept of ‘the profession’ and this is briefly summarised here. Scholars in the first half of the 20<sup>th</sup> century attempted to define a profession (as opposed to an occupation) by simply adopting a ‘trait’ approach (e.g. professional work requires specialised expert knowledge gained by members undergoing extensive education and training).<sup>179-181</sup> Studies of this type were often marked by an approach which assumed a beneficent role of professionals and

ignored the issue of how occupations ascended to the title of profession and neglected to address the need to appeal to 'being a professional.' By the 1970s however analysts adopted a more critical approach and sought to highlight how professions had come to achieve and maintain their professional status. Two notable analyses by Eliot Freidson<sup>182</sup> and Terence Johnson,<sup>183</sup> separately employed the notion of 'social closure'<sup>184</sup> to understand how professions such as medicine has come to occupy their position of power or dominance in relation to other professions (or semi-professions<sup>185</sup>) such as nursing. Professions are therefore marked by hierarchies of status and power within and between professional groups. The following quote from Freidson summarises the key elements of the dominance perspective:

...it is useful to think of a profession as an occupation which has assumed a dominant position in a division of labour, so that it gains control over the substance of its own work... The occupation sustains this special status by its persuasive profession of the extraordinary trustworthiness of its members. The trustworthiness it professes naturally includes ethicality and also knowledgeable skill... The profession claims to be the most reliable authority on the nature of the reality it deals with..... a profession is distinct from other occupations in that it has been given the right to control its own work.<sup>186(p xvii)</sup>

In addition to dominance and autonomy, the concept of collegiality also forms a central aspect of Freidson's and Johnson's theories of professionalism. Collegiality serves to: maintain the appearance of equal status; socialise entrants/members into an attitude of loyalty to colleagues and maintains a public image of equal competence and trustworthiness.<sup>95</sup>

Analyses utilising the professional dominance perspective have concentrated on whether developments as a result of changes to health systems have adversely impacted on the profession's ability to maintain their monopoly and autonomy<sup>187-189</sup> or indeed whether it ever existed in the first place.<sup>190,191</sup> Much of this literature arose in the US and within a hospital context and subsequently crossed over to the UK being applied in various medical contexts including general practice.<sup>192,193</sup> Recent developments in the field question the use of 'ideal type' of professional autonomy employed by the 'professional dominance' perspectives. Specifically, the term 'discretion' has been forwarded as more appropriate

and representative of the important aspects of professional work and decision making.

Specifically:

...professional discretion enables workers to assess and evaluate cases and conditions, and to assert their professional judgement regarding advice, performance and treatment. To exercise discretion, however, requires the professional to make decisions and recommendations that take all factors and requirements into account. These factors and requirements will include organizational, economic, social, political and bureaucratic conditions and constraints. Thus, professional decisions will not be based solely on the needs of individual clients, but on clients' needs in the wider corporate, organizational and economic context.<sup>194(p345)</sup>

However, a focus on professional discretion and in relation to various competing factors as advocated above is not new. Over thirty years ago Michael Lipsky<sup>195</sup> focused on the concept of discretion in relation to professionals working at the 'street-level' of public services. His analysis and classification of public servants as street level bureaucrats (SLBs) has been widely cited and used as a theoretical framework to analyse policy changes at the micro-level of professional work in other areas of the public sector such as social work and education; as well as to understand responses of physicians and specifically GPs (the focus of this study) to the introduction and implementation of other primary care policies.<sup>132,196</sup> Specifically, it has been suggested that Lipsky's work may provide a useful way of understanding the impact of the new contracting arrangements and in particular its P4P scheme or QOF on the work of GPs.<sup>132</sup> On reading, I found that key elements of Lipsky's framework resonated not only with my substantive topic of interest i.e. the introduction and effects of a performance-measurement scheme on professional work but also with many aspects of the data I was collecting. These events constituted the theoretical starting point for the current study. The next section briefly outlines the context and essence of Lipsky's theory before moving on and presenting in more detail the main aspects of the SLB framework.

### **3.3 Street-Level Bureaucrats**

Lipsky first presented his theory of street-level bureaucracy in an article in 1971<sup>197</sup> and in further studies with his former research students,<sup>198;199</sup> before he expanded on these initial thoughts in his seminal book published in 1980.<sup>195</sup> In all of these works, Lipsky was

concerned with the ‘critical role’ of frontline public servants working in an urban policy context during the 1970s in the United States and the dilemmas that such individuals faced as a result of the adverse working conditions they found themselves in. Specifically he was concerned with those ‘public service workers who interact directly with citizens in the course of their jobs, and who have substantial discretion in the execution of their work’ (ibid p3). Such individuals he termed ‘street-level bureaucrats (SLBs)’ and are located in public service agencies or ‘street-level bureaucracies’ which at the time were functioning in an environment characterized by poverty, social diversity and political conflict.<sup>200</sup> Much of his analysis focuses on what he considered as ‘typical’ SLBs such as ‘teachers, police officers and other law enforcement personnel, social workers, judges, public lawyers and other court officers, health workers...’ (ibid p3). Such people he discusses are often drawn to life in public service as they wish to be socially useful i.e. help others. In addition to their altruistic nature, the professional training they receive in their respective areas instils a manner of working that is consistent with an ideal model of service delivery. As a result SLBs strive towards responding in the best interests of each *individual* client as they present to the service in questions. The realization of these service ideals are however thwarted by the nature of their jobs which have analytically similar working conditions and are commonly characterized by high caseloads, inadequate resources, unclear and even contradictory goals due to vague policies and the unpredictable source of the raw materials with which they work i.e. people. Despite this, Lipsky posits that SLBs believe that they are performing their roles to the best of their abilities given the circumstances and conditions they find themselves in.

As a result of the conditions of work, the resulting uncertainties that such conditions create and the wide discretion that SLBs have, Lipsky posits that the mechanisms they turn to in order to cope i.e. ‘the routines they establish, and the devices they invent to cope with uncertainties and work pressures effectively become the public policies they carry out’ (ibid pxii). In summary, the essence of the ‘dilemmas of the individual in public services’ (the subtitle of the book), arises from the fact that they are partly bureaucratic and partly professional. The next sections outline the main aspects of Lipsky’s analysis and starts with the central issue of discretion.

### 3.3.1 Discretion and policy making

At the heart of Lipsky's analysis is the issue of discretion. Fundamentally SLBs have considerable discretion in their roles and in their treatment of clients. In part, this relates to the nature of the SLB role itself which involves tasks too complicated to reduce to 'programmatically formats' (ibid p15) as well as the fact that judgements are required to be responsive to the needs of the individual client in unique circumstances. In other words, the overall unpredictability of the nature of SLBs 'human' caseload means that they need to be able to respond in different ways, depending on the particular situation. Lipsky argues that such responsiveness to the individual situation is not only deemed necessary to the nature of the role but is also desired by society. Despite the requirements for flexibility and need for discretion, SLBs do not have complete free reign in their actions as their working environment and role is characterised by various rules/policies with which they must in some way work with and towards. However, Lipsky notes that the environment is one of uncertainty as the rules and/or policies may be voluminous, vague and even contradictory and therefore an impediment to external supervision or scrutiny. This, Lipsky notes, is particularly the case for professionals who are:

...expected to exercise discretionary judgement in their field. They are regularly deferred to in their specialised area of work and are relatively free from supervision by superiors or scrutiny by clients. (ibid p14)

Lipsky argues that SLBs wish to maintain and even expand their discretionary capacities in order to continue to work in a manner that is in line with their 'own preferences and only those agency policies so salient as to be backed up by significant sanctions' (ibid p19). Where SLBs' priorities are aligned with those of the organisation, there will be little issue for the managers of the street-level bureaucracies in attempting to direct SLB activity; however Lipsky states that this is not usually the case unless SLBs have been recruited with an affinity for the agency's goals. In most cases therefore, SLBs' priorities are different from those of the managers<sup>m</sup> in their agencies who are 'properly results oriented' and are 'concerned with performance and the cost of securing performance and only those aspects of process that expose them to scrutiny (ibid p19).' This is perceived as

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<sup>m</sup> It should be noted however that many managers, for example head teachers, have previously occupied the position of being an SLB and therefore have some understanding of street-level problems but they no longer partake in the day to day client processing work.

being intrinsically in conflict with the interests of SLBs, who in a context of constrained resources, need to process their workloads expeditiously and as a consequence develop shortcuts and simplifications to do so. These coping mechanisms are often unsanctioned by their managers and may not reflect the goals of the agencies. Managers however attempt to restrict workers' discretion in order to achieve the desired agency objectives, but according to Lipsky 'SLBs often regard such efforts as illegitimate and to some degree resist them successfully' (ibid p19) which can result in non-compliance with agency objectives or behaviours to avoid accountability. As a result of the two major factors: SLBs having wide discretion and relative freedom from managerial authority, SLBs are key players in enacted policy i.e. that behaviours and actions observed may not actually reflect the official policy that the agency is attempting to implement from the top. Lipsky states that this is in fact due to 'the routines they establish, and the devices they invent to cope with uncertainties and work pressures effectively become the public policies they carry out' (ibid pxii). Lipsky's work was therefore important in illuminating reasons why 'top-down' implementation did not result in perfect translation down the organization to the actual form of policy enacted on the ground (or street-level) and hence has led to some calling him the 'founding father of the 'bottom-up' perspective.'<sup>201 (p51)</sup> The discretion and resulting policy making aspects of the SLB role are according to Lipsky located in the nature of SLB work and are as a result of the working conditions they find themselves. The following section now presents and discusses the working context in question.

### **3.4 Conditions of SLB work**

Through his analysis across various public service agencies or street-level bureaucracies, Lipsky identified the fact that there were common conditions of work experienced by SLBs which are as follows: 1) inadequacy of resources; 2) demand for services increases to meet supply; 3) goal expectations for the agencies in which SLBs work tend to be ambiguous, vague or conflicting; 4) performance measurement towards agency goals is difficult to measure and 5) clients are typically non-voluntary. It is the presence (or absence) of these conditions that Lipsky posits as being essential to his analysis of SLB behaviour and each are now briefly outlined.

### **3.4.1 Scarce Resources: perpetuated by demand and supply**

The work of the SLBs is characterized by high client caseloads and a need to process this workload quickly and efficiently. The problem for SLBs however is that the agencies they work in typically provide fewer resources than necessary for SLBs to do their jobs in two ways: 1) they have high client numbers relative to the available pool of SLBs and 2) also restrict the available time for SLBs to deal with each client. Clearly the two are related as high case loads affect the available time that can be afforded to the personal needs of each client. As a result, the time available for collecting information and decision-making on the basis of that information for each client, are limited. In addition, Lipsky cites two further factors that affect the work of SLBs. The first, relates to the need to attend to organizational ‘housekeeping’ requirements such as ‘form filling’ which act to limit time for client interaction. This reflects the fact that although SLBs may be professionals, their role is also partly bureaucratic. The second factor relates to the *personal* resources of the SLB i.e. that the individual SLB may be inexperienced or under trained in their role. Although Lipsky does mention the issue of personal experience, he does not expand on it beyond providing an example of where rookie entrants to the profession are required to undergo further training before they are allowed to become fully fledged members of the profession and/ or have the necessary skills to deal with the actual variety of client interactions they are likely to be exposed to.

Lipsky discusses that the main reason for the perpetuation of the problem of inadequate resources relates to the fact that even when additional financial resources are directed towards street-level bureaucracies they may not in fact improve or alleviate working conditions as demand for the service simply increases to meet the supply, should the funds be allocated to expand SLB numbers. Extra funds may therefore in theory be used to increase the number of clients served or the number of services provided, however client services may not see any such changes as the funds may be allocated to the salaries of SLBs. Thus SLBs are ‘trapped in a cycle of mediocrity’ (ibid p38). Theoretically, Lipsky states that it may be possible to alleviate some of the SLBs working conditions and for example with teachers have smaller case loads i.e. smaller class sizes which would allow for a more time etc with individual pupils but the *cost* of providing such services would be exorbitant and are politically ‘out of the question.’ In summary, therefore SLBs work in



situations where the resource problem is seemingly irresolvable as demand always increases to meet supply as there is a great reservoir of demand for public services in general.

### **3.4.2 Goals and performance measures**

Lipsky posits that the SLB role is one that must deal with ‘conflicting and ambiguous goals’ (ibid p40). To illustrate his point, he provides an example of whether the role of the police is to maintain order or to enforce the law. He goes on to discuss that often the goals of public service are idealized and therefore also difficult to achieve and this is not aided by the fact that there are uncertainties regarding the effectiveness (i.e. what works?) of available technologies to reach the desired goals. He identifies three sources of goal conflict which arise when: 1) client-centred goals conflict with social engineering goals; 2) client-centred goals conflict with organization-centred goals and 3) goals conflict due to differing role expectations from multiple and conflicting reference groups. Each point is now briefly discussed.

#### *3.4.2.1 Client-centred goals vs. social engineering goals*

Here conflict arises when the SLBs concerns for an individual client are in contrast to the social engineering role of the agency in question. To illustrate his point Lipsky provides several examples of instances where this may occur. For instance, in the case of education he discusses the conflict and tensions caused by education oriented towards the individual and individual achievement vs. that oriented towards instilling broader political and social goals of citizenship and discipline.

#### *3.4.2.2 Client-centred vs. organisational goals*

Here the discussion relates to how the ability of SLBs to treat people as individuals, is compromised by the wider needs of the organization to process work quickly using the available resources. He states that the fundamental service dilemma for street-level bureaucracies is in essence ‘how to provide individual responses or treatment on a mass basis’ and that the study of SLBs may be seen as a study of *goal displacement* when the ‘norm of individual client orientation becomes subordinate to the needs for mass processing’ (ibid p44). The tension between efficient agency performance and attending

to individual clients is again compounded by limited resources and SLBs are challenged to find the best way of attempting to resolve these apparently incompatible goals.

#### *3.4.2.3 Goal conflicts and role expectations*

The final source of conflict stems from ‘the contradictory expectations that shape the street-level bureaucracy role’ (ibid p45). The differing expectations for the SLB role as discussed by Lipsky arise from three different groups: peers; other reference groups and the public and the extent to which these sources differ in their expectations. In relation to public expectations, he discusses how the role expectations of street-level bureaucracies can differ on the basis of public opinion arising from different locations or community sectors of the public. Hence the public does not constitute a uniform voice and demand a single approach, thereby producing role conflict. Peer expectations constitute the second dimension of role conflict or ambiguity and primarily arise from fellow ‘workers’ i.e. those operating under similar pressures. As a result, this is the only group that understands the need for SLBs to have goals that are aligned with the need to resolve their work pressures and consequently are a significant component in determining role expectations. Finally, despite SLBs’ desire to fulfil their attempts at a client-centred approach to their work, their clients are according to Lipsky *not* a significant determinant of the SLB role as SLBs do not think that clients ought to have a say in the nature of their street-level practice and at the time he notes led to vigorous opposition from various professional bodies to citizen involvement.

#### *3.4.2.4 Performance Measures*

Measuring the performance of SLBs and their work is according to Lipsky, extremely difficult. It is affected by factors already outlined such as: i) goal ambiguity; ii) the fact that the source of their work i.e. human interactions is complex and therefore difficult to measure; iii) as well as the fact that there is no mechanism to tell how on a regular basis client outcomes would be in the absence of intervention; iv) the baseline or starting point for assessment can vary from location to location as for example some clients may be more oriented and therefore compliant to the goals of the agency in question and hence produce better results but through no extra effort on behalf of the agency. The final factor contributing to the difficulty of measuring SLB performance relates to the fact their roles

are relatively free from (direct) supervision as their work is conducted in private and this situation is perpetuated by professional and peer norms of not questioning or criticizing the work of others. As a result of these factors, managers have little way of determining which individuals in their organizations are performing in relation to the desired standards. Despite such difficulties and the fact that SLBs attempt to resist their development and implementation, Lipsky highlights some of the 'crude' measures employed by street-level bureaucracies to control SLB activity, such as for example in the case of the police, a target for a number of arrests per month. Such measures however provide no indication of the quality of that interaction, in this case the appropriateness or manner of the arrest. Where such measures are in place Lipsky states that the behaviour of SLBs comes to reflect those measures and their associated incentives and/or sanctions and illustrates the general rule that 'behavior [sic] in organizations tends to drift toward compatibility with the ways organizations are evaluated' (ibid p51). At the time of writing, Lipsky noted that even where some indication of performance is available, clients are disadvantaged as they do not have access to such information which they may use to compare and contrast their treatment in one agency with another in the same field.

### **3.4.3 Client relations**

The SLB relationship with clients according to Lipsky is 'non-voluntary' and stems from the fact that street-level bureaucracies 'supply essential services which citizens cannot obtain elsewhere' (ibid p54). Government often holds a monopoly on such services and where private provision is available clients may not be able to afford them. As a result, clients are in a relatively powerless position to affect the work of SLBs and the agencies they work for have 'nothing to lose in failing to satisfy clients' (ibid p55). This Lipsky relates to the fact that in such agencies the situation is one characterized by high demand for their services and therefore the loss of any dissatisfied clients will only result in the space they vacate being filled by other clients in need. This relationship also helps explain why clients are not amongst SLBs' primary reference groups, but does not translate into their being completely powerless, as SLBs also require compliance; for example, Lipsky notes that teachers need to secure the cooperation of their pupils before they can begin to teach. Clients are however largely deferent to the SLBs who hold the position of power in terms of their ability to grant access to the resources the client

desires. SLBs and their agencies maintain this power differential by structuring how clients can access services via the use of queuing mechanisms or when, how frequently, and under what conditions, clients can approach them. Even within the actual client-SLB interaction, SLBs control the structure, content and pacing, by for instance, having routines of practice that expedite the interaction and allow them to move on through their heavy caseload. Lipsky provides the example of lawyers who wish to collate information relating to the specific case in a standardized manner that suits their need i.e. clients are shut off from discussing non-relevant aspects of their stories. In essence, SLBs effectively 'teach' their clients how to behave in accordance with their desired norms i.e. clients undergo a process of social construction. In addition to these more direct and coercive mechanisms, SLBs also attempt to gain client compliance by involving clients in the difficulties of their roles for example saying that they are just following orders. By invoking client empathy for the situation the SLB can help bring the client round to the agency perspective.

### **3.4.4 Advocacy and Alienation in SLB work**

#### *3.4.4.1 Advocacy*

In addition to being the 'rationers' or 'gatekeepers' to agency and wider resources, SLBs are also supposed to act as advocates for their clients i.e. to use their skills and knowledge of the system in order to secure the best treatments or resources as appropriate. The concept of advocacy is as Lipsky notes one instilled in the 'professional training and canons of lawyers, doctors, social workers...' (ibid p72). The conditions of SLB work however appear to act to undermine the ability of SLBs to act as advocates, as for example, high case loads and needs for mass processing precludes the devotion of dedicated time and effort to the individual. In addition, the street-level bureaucracies' public mandate to treat all clients equally acts against the advocate's goal of seeking special treatment for individual clients. Whereas Lipsky states that the organization seeks to limit access to its constrained resources, the advocates' actions would indicate that resources were limitless. Two further factors also appear to constrain the advocacy role of SLBs: 1) the client controlling aspects of SLB work place a tension on the ability to advocate for people and 2) the fact that clients may have to be passed on to other

professionals, mean that any deviations from the norm here would undermine the SLBs' credibility.

#### *3.4.4.2 Alienation*

Alienation is a term much used and originates with the work of Karl Marx. In Lipsky's analysis it is defined as a 'concept summarising the relationship of workers to their work, from which we may infer, attitudes arise' (ibid p75). The issue of alienation in relation to work refers to the central issues of the ability of workers to make decisions about their work and have some control and creativity over how they produce their outcomes. Production line workers have therefore characteristically been seen as 'alienated.' Lipsky discusses how certain aspects of the SLB role are 'unalienated', for example the discretion they possess in how they approach the individual clients as well as the fact that the source of their work i.e. human interaction is a source of variety in itself. However, he also discusses ways in which the work of SLBs *is* alienated, and is related to the product of their work i.e. clients.

First, SLBs only work on segments of the product and process. This is due to the fact that the pressures of processing their work i.e. people, leads to clients being treated as 'bundles of bureaucratically relevant attributes rather than as whole persons' (ibid p76). Lipsky states that the consequences of this approach leads to the likelihood that SLBs may miss aspects of the presenting problem. In addition, the drive for efficient approaches to resource use means that specialisation within agencies occurs. As a result, SLBs only work on part of the process. The cost to the agency however, may in fact be the reverse of the intended outcome i.e. inefficiency as divisions between intake and casework results in poor or inadequate data collection which subsequently affects decision making.

Secondly, and related to the first point, is the fact that SLBs do not control the outcome of the work, as specialisation and fragmented contact with clients means that they do not see the work through. In addition, clients' problems are not necessarily and often are not subject to closure, this leads to alienation when the SLBs experience this as a loss of control over scenarios they see themselves as being supposed to control. Again, here SLBs can develop new psychological modifications of their role in order to bridge the gap.

Thirdly, SLBs have on the whole an inability to control the input of their work and again this is due to the variable raw materials i.e. the diversity of people that they work in. SLBs are unable to affect wider circumstances of clients' lives.

Finally, SLBs are not in control of the pace of their work as they do not control the timing of their decision making as in order to ration resources, including SLB time, street-level bureaucracies attempt to control demand and predict demand by for example appointment scheduling. Lipsky posits that where SLBs are alienated from their work, they will be more willing to accept organisational restructuring and less concerned with protecting clients' interests and their own connection with clients (ibid p79). The issue for the agencies in which SLBs work is that alienated work leads to job dissatisfaction which can result in alienated individuals displaying low morale or absenteeism and thereby results in less than desirable levels of productivity. Should this be the case and should managers be inclined to address the problem, Lipsky discusses ways of reducing their workers' alienation by for example restructuring the work to make it less alienating, constructing new incentive or sanction structures for compliance or simply by increasing pay.

### **3.5 Conditions of SLB work: Consequences and coping mechanisms**

The conditions of work as outlined so far illustrate the difficulties facing SLBs, and for some, this results in them working in a manner that does not fit with their high ideals or personal preferences. This can result in them 'burning out' or leaving their roles, whereas those who continue, need to adapt and cope with the situation. The coping mechanisms (or patterns of practice) that SLBs develop in order to cope with their adverse working conditions as suggested by Lipsky are three-fold; first, SLBs develop patterns of practice 'that tend to limit demand, maximise the utilisation of available resources, and obtain client compliance' (ibid p83). The other two mechanisms both involve new psychological adaptations in order to narrow the gap between their personal and work limitations, the resulting service outcomes and the ideal service model. Specifically, they modify the concept of their job to narrow the gap between objectives and resources, as well as modifying the concept of their clients to render the inevitable gap between objectives and accomplishments more palatable (ibid p82–83). Importantly such adaptations are seen to

have a knock-on effect on the way that clients are processed and dealt with; the unfortunate result in some cases being that SLBs can give in to personal biases with some clients receiving preferential treatment over others. At the time of writing, Lipsky noted that SLBs were the focus of much public controversy due to the apparent observation of such unsanctioned biases. Finally, Lipsky also notes that, SLBs seek to simplify their tasks and develop routines and simplifications to aid in the management of the complexities involved in their work. Lipsky discusses how this may be seen by some analysts as being equivalent to bureaucratization whereas others see this as an inevitable response to a high demand and scarce resource environment. He suggests that SLBs develop their own patterns of simplification when official ways of categorising clients prove inadequate or act as a barrier to expeditious client processing, or indeed if they significantly contradict their personal preferences. These routines may at varying times be sanctioned or unsanctioned by the agency depending on whether or not they are consistent with agency goals.

### **3.6 Lipsky's predictions**

Lipsky made various predictions for the future of street-level bureaucracies and their frontline workers in an environment of 'fiscal crises.' In such conditions, Lipsky discusses how agencies must demonstrate accountability in order to avoid cuts in their budgets. The problem for managers in being able to demonstrate such accountability again lies in the nature of SLB work namely: 1) that they work in private therefore making it difficult to question the SLBs decision making; 2) they have control over the information or records they pass upwards to their superiors which facilitate the avoidance of scrutiny; 3) the nature of the policies and ambiguous or conflicting goals of the agency do not aid the identification of priority areas to which they may be held accountable; and finally, by attempting to challenge the performance levels of SLBs managers may in fact produce negative outcomes for service delivery. The main mechanism that Lipsky highlights and discusses in order to improve the accountability of street-level bureaucracies and their SLBs is the use of performance measures. He hypothesised that a valid set of performance indicators could in fact make the work of SLBs easier by the fact that they would provide goal clarity, in other words SLB discretion would be less necessary if there were greater regulation and control:

If discretion were constricted street-level bureaucrats would have less need for routines and simplifications to deal with uncertainty. If goals were clearer, workers could direct their energies with less ambivalence. If appropriate performance measures were available street-level bureaucrats could be made accountable for their behaviour. (ibid p199)

However, the introduction of such measures also leads Lipsky to make a series of predictions which highlights the problems he envisaged with their introduction. Firstly, he states that SLBs will “concentrate on the activities measured” (ibid p166). He discusses however how such a phenomenon had already been highlighted in earlier studies such as one concerning employment counsellors which reported that individuals increased their performance in relation to placement rate targets by ‘creaming’ i.e. focusing on those clients easier to place at the expense of what they perceived to be more difficult clients.<sup>202</sup> In essence, he predicts that workers will interpret such measures as a sign of management priority and therefore by virtue of their discretion direct their activity to those areas as required and improve their performance scores. Secondly, ‘fraud and deception can also intrude into performance measurement’ (ibid p167) i.e. manipulations of information and situations in order to meet targets and thirdly, there is the difficulty of relating quantitative indicators to actual service quality and he states that “the more discretion is part of the bureaucratic role, the less one can infer that quantitative indicators bear relationship quality” (ibid 167-8). In relation to the last point, Lipsky also highlights that it is difficult to measure the quality of SLB performances, as such measures do not represent all the work of SLBs and in particular it is difficult to measure the most important aspects of the service that SLBs provide. To illustrate his point he provides an example of the police force being given a target of the number of arrests to be made and whether or not “the arrests were made with care” (ibid p168).

Lipsky discusses how performance measures and the desire for accountability via the use of performance measures can have negative implications for productivity. According to Lipsky, productivity in the public sector ‘summarises the relationship between the utilisation of resources and the resulting public services product’ (ibid 170). In particular, he discusses how pressures to increase productivity can result in an erosion of services ‘qualitatively’ and that services undergo ‘debasement.’ However, he discusses that



attempts to measure the debasement of services is difficult due to difficulties in defining quality of the service. As managers are under pressure to increase productivity within the same budgets, they respond by asking people to do more or save money by substituting the usual professionals with cheaper para-professionals. The debasement of services in this way often results in negative outcomes for SLBs in terms of 'harder work, less job satisfaction and greater individual problems with clients' (ibid p171). However Lipsky does speculate as to whether the technology of performance measurement will improve in the future in order to allow the development of effective measures. The issue of performance measures is of particular relevance to the current work which seeks to assess the impact of the latest major contractual reform in general practice and its series of performance measures as contained within QOF.

### **3.7 Street-level services - improving the future outlook**

The last section of Lipsky's work looks at ways to mitigate the negative effects of street-level bureaucracies. He argues that the two best defences against negative outcomes are a strong ethic of professionalism and the increased involvement and empowerment of service users to scrutinise such services. He states that client contributions could be enhanced 'if street-level units accepted responsibility for group case loads rather than incorporating clients as the case loads of individual workers' (ibid p208). This move he argues would remove the isolation, pressures and competitive elements of working in an atomistic manner and encourage a more cooperative and supportive environment that makes the client the responsibility of all the SLBs not, just the individual SLB. In terms of the 'professional fix', Lipsky first discusses the prospects for the model before outlining the problems associated with this approach then outlining his vision of how the professional model may be enhanced in order to provide suitable solutions in order to get the type of desirable street-level services in the future. Lipsky argues that the attractions of the model for solving service dilemmas centres around the fact professionals (at least theoretically) are oriented and committed to a service orientation. New recruits enter their fields with high ideals and embody the spirit of the ideal service orientation. However, the problem of the professional fix he discusses arise from the fact that the organisation and control of professions and their interactions comes from within i.e. the professions are self-monitoring. High status professions such as law and medicine he argues, have been

shown to fail in attaining the high standards as advocated by their profession, by for example, seeking out higher-status clients at the expense of those with lower status and who presumably have greater need for the service. In order to support and facilitate future new recruits to practice in a manner that is more akin to the service ideal Lipsky suggests that: 1) additional financial support must be made available to provide some slack in the system in order to allow SLBs to organise themselves to be more responsive to the individual client; 2) financial resources would also allow for the creation of incentives to maintain and forge a career in the public sector. He also states that SLBs need rewards for effective and quality performance. This is of key relevance for the current work as essentially I am investigating the effects of this suggestion i.e. a new contract which contains such a P4P scheme. Finally, he discusses how there is a need for a new type of performance evaluation in order to determine the distribution of any rewards, one which is based on peer review and can take into account the qualitative aspects of case handling.

Having outlined the details of Lipsky's theory, I now briefly provide a flavour of where Lipsky's framework has been previously applied to professional practice within the wider non-medical academic literature, before focussing on its application in relation to the work of doctors and in particular that of GPs, the focus of my work.

### **3.8 Physicians as Street-Level Bureaucrats**

The focus of much of Lipsky's analysis and exemplars of SLBs centres on those professionals working in sectors such as social work, education and law enforcement. Indeed, in each decade of the thirty years or so since the publication of his work, scholars of these areas continue to apply Lipsky's work see for example.<sup>203-207</sup> Despite the fact that Lipsky often discusses how SLBs are professionals, he actually gives little attention to those who most stridently claim to be so i.e. doctors. Shortly after the publication of Lipsky's (1980) work however, some commentators suggested that the 'propositions embedded in the work are so important that they need to be tried on for fit in the health arena.'<sup>208(p969)</sup> Subsequently it appears that Lipsky's work has been applied to health workers and physicians, most commonly those working in US public health programs such as Medicaid or Medicare. For example, a recent empirical study used Lipsky's framework to illustrate how primary care physicians attempted to advocate for patients

with depression whom the physicians perceived, in a publicly funded health program, had little prospect of (and desire for) accessing specialist mental health care.<sup>209</sup> In such circumstances, the physicians who often were not directly reimbursed for mental health care, attempted to treat their patients' depression themselves, using the most efficient means they knew of (i.e. via a pharmacological approach) in order to process such patients within their limited appointment times. The authors showed how Lipsky's theory of street-level bureaucracy not only explained the advocacy behaviour of these physicians but that they also were able to rationalize this 'less than adequate care because of the Medicaid patient's status as a non-voluntary client' (ibid p156).

In the UK, to date, I am aware of only two studies which have employed Lipsky's work in relation to primary care physicians i.e. GPs<sup>132,196</sup> which I now outline.

### **3.9 GPs as Street-Level Bureaucrats – the literature**

The first application of Lipsky's work to GPs related to an ethnographic study that explored the process of service planning and health care commissioning for CHD in a PCG during the late 1990s.<sup>196</sup> The author discusses how concerns over rising costs in the NHS, led to the increased use of health economists and so called 'rational models' of decision making. The study aimed to assess the extent that rationality underpinned the decision making of the PCGs multidisciplinary group (which included GPs) who were given the responsibility of making recommendations for the care of CHD patients within the PCGs remit. The PCG's recommendations and actions were however to be made difficult by the fact that there was the difficulty of implementing new effective interventions which (based on the available evidence) would benefit CHD patients in a context where no additional funding was available. The author showed that in the face of multiple competing objectives, clinicians adopted behaviours which were 'in marked contrast to the rational model of decision-making that underpins health economic analysis' (ibid p134). Rather than following agency objectives and implementing the guidelines devised by the PCG team which included GPs, GPs continued to exercise their own clinical judgement and discretion and made decisions that would alleviate pressures on their own workload. Specifically GPs were acting as SLBs in that:

...the requirements for GPs to fulfil their street-level bureaucrat, client processing role conflict directly with the encouragement of a more explicit, proactive and systematic managerial perspective (ibid p134).

Indeed the 'client processing' aspect of the GP role has been shown to be a powerful factor in the implementation and enactment of another policy in general practice that are by definition explicit and systematic, i.e. NSF's.<sup>132</sup> This second study illustrated that a combination of factors such as 1) a lack of a structured implementation process or 'information process' and 2) the fact that implementing and complying with NSF's was not a compulsory requirement meant that GPs reacted as SLBs by rejecting some NSF's on the criteria of whether or not they made the practicalities of doing their job easier.<sup>132</sup> Specifically, concerns surrounded the size and complexity of the NSF's and such factors were cited as barriers to use in their patient processing role. This was in comparison to other existing guidelines which were adopted and used in practice as they were perceived as simple and an aid to processing their work.

In summary, both of these studies characterised GPs as SLBs prior to the introduction of the new contract in order to explain the responses of GPs to different policies. It appears that viewing GPs as street-level bureaucrats allows one to speculate how changes in policy may affect their care-giving or service practices. Indeed, as highlighted as the start of the chapter, one of the outcomes of the latter study was the suggestion that Lipsky's work may provide a useful way of understanding the impact of the new contracting arrangements and its P4P scheme or QOF on the work of GPs as they perceive it. As I alluded to earlier, this suggestion appeared highly relevant and on my reading of Lipsky's work as it resonated with key aspects of his theory i.e. discretion, which the substantive topic of interest i.e. QOF potentially affects. The next section discusses how GPs can and have been seen to fit Lipsky's definition of SLBs *prior* to the introduction of QOF before discussing the questions raised by the application of the SLB framework in the context of the latest major contractual change.

### **3.10 Conceptualising GPs as Street-Level Bureaucrats**

This section provides a discussion of the extent to which GPs and their work have been seen to fit Lipsky's main analytical points pre-nGMS and QOF. In addition, within each

section the available existing literature regarding the impact of QOF is related to each point in order to extrapolate and highlight the areas of investigation for the study.

### **3.10.1 Discretion and policy making**

SLBs are people who ‘interact directly with citizens in the course of their jobs, and who have substantial discretion in the execution of their work’ (ibid p3). Taking the first aspect of this statement, the central and traditional aspect of a GPs role (regardless of their status i.e. being a partner or salaried) is to attend to the presenting needs of a variety of citizens, who in the case of GPs are patients. In addition, the variety of patients and their presenting needs can be seen to correspond to the claim that the work of SLBs involves tasks too complicated to reduce to ‘programmatic formats’ (ibid p15), as well as the fact that judgements are required to be responsive to the needs of the individual client’s unique circumstances. Discretion, Lipsky notes is a relative concept. He states that the greater the degree of discretion the more salient his analysis is in understanding the behaviour of frontline or street-level public workers. Lipsky’s work therefore seems ideally suited to studying doctors who as archetypal professionals are considered to have wide discretion. However, wider social changes as described in the previous chapter, as well as the rise of EBP and subsequently SBM (i.e. concepts that appear to reduce complex medical work to ‘programmatic formats’ or rules), can be seen as a constraint on a GP’s ability to have discretion at least in terms of their clinical decision making. Whereas this may be true in comparison to the modern pre-EBP era, GPs have in recent times at least, not always perceived such ‘rules’ as restrictive. As already discussed, GPs exercised wide discretion with regards to a prescriptive policies such as the NSFs and other guidelines, utilising those aspects they perceived as ‘helpful’.<sup>132</sup> Earlier research also indicated that GPs’ positive attitudes towards professionally derived guidelines and these related to the fact that they perceived that they had a *choice* of whether to follow guidelines and that they need not to necessarily wholly adhere to them.<sup>210</sup> In other words, GPs perceived they had discretion, in terms of if and/or when to apply them, and in the case of the latter, how and who to apply them to. In fact, the GPs in this study perceived that many factors including their personal clinical experience influenced how they utilised guidelines.<sup>210</sup> A final point relating to the outcomes of these studies is that GPs appeared to ‘make policy’ i.e. the

policies or in this case centrally derived guidelines enacted on the ground, did not always (or if at all) resemble the official guidance.

The issue of personal experience is not discussed in detail by Lipsky. Experience however, may be a moderator of discretion e.g. it may affect how one perceives whether or not their personal discretion has been adversely affected or narrowed. It would seemingly affect how the individual had come to understand the nature of their role. In relation to the current work, those trained and socialised in recent times which have been heavily characterised by an EBP approach to care (i.e. individuals where such a model of care is the norm), would have perhaps a different perception in comparison to those individuals trained and socialised in the pre- or early modern EBP era. However, again the issue of experience may come into play, i.e. the tacit knowledge gained over time would indicate that up to a point, such people may be able to apply discretion in their use of these rules in ways in which those inexperienced would not. Furthermore, Lipsky expands little on its impact and implications for the types of routines, shortcut and mental modifications that SLBs are able to make. For instance, in the context of the current work, those practising for a long-time pre-QOF may have considerable differences in opinion and ways of working, to the mode of practice this advocates in comparison to those only practising in the post-QOF era. This is an area in which the analysis would benefit from further research and will be investigated in the current study.

Finally, the other major factor contributing to the fact that GPs have historically been able to enjoy wide discretion in their patient interactions, relates to the fact that their work is largely conducted in private. Although it is increasingly the case for GPs, their work and their practices, to be exposed to external scrutiny, pre-QOF GP work was still largely conducted in private and primarily involved seeing patients on their personal lists.<sup>132</sup>

The introduction of the new contract and QOF however, has resulted in a number of changes that would appear to suggest that GPs are less able to work to their own routines and in effect reduce the discretion of individual GPs in their practices. The evidence to date regarding the impact on individual GP discretion however, provides a mixed picture. The first factor that would appear to suggest that individual GP discretion may be reduced,

relates to the fact that the contract is at the practice level. The limited evidence to date suggests that GP principals have responded similarly by internally re-organising their practices teams in a similar manner around the needs of QOF, with some GPs becoming nominally responsible for delivering specific areas of QOF work.<sup>153,165</sup> In addition, studies have also shown that practices have developed internal surveillance systems which now make aspects of GP work visible to others within the practice.<sup>153</sup> Prior to these systems, the working practices (including the discovery of poor quality work) of other GPs would only be apparent via complaints or when dealing with other colleague's patients, whilst for example, providing cover for annual leave or other absences.<sup>211</sup> The introduction of standardised data entry templates for QOF requirements would also appear to suggest that any ad-hoc or prior ways of working would no longer be possible or more difficult to maintain.<sup>150</sup> Despite such changes however, research also indicates that GPs perceived that their discretion has remained intact.<sup>146,153</sup> This may be due to a number of factors: 1) GPs reported the ability to respond to the electronic templates flexibly;<sup>146,150</sup> and/or 2) GPs have reported that the templates serve as an 'aide memoire' in other words, rather than perceiving them as a device designed to constrain discretion, they see them as tools that 'made their life easier.'<sup>166</sup> However, other studies appear to suggest that GPs feel pressured into concentrating on QOF requirements within their consultations.<sup>157</sup>

Secondly, early studies appeared to indicate that GPs on the whole appeared to support and were positive about the clinical content of the targets contained within the initial 2004 version of QOF.<sup>153</sup> On a related point, both qualitative and quantitative research has also indicated that GPs claims that they were already doing the majority of work contained within (at least the initial version) QOF, appear to ring true. This is because prior to the introduction of QOF, standards of care were already improving, and QOF resulted only in 'modest' accelerations in care.<sup>167,212</sup> In other words, GPs may not feel that their discretion has been impacted upon as most were already meeting QOF targets, explaining why there was little resistance to QOF being introduced. However, later research appears to suggest that the later 2006 version of QOF was less well received, with GPs disputing the validity of certain indicators such as those for depression screening and CKD.<sup>157,158</sup> Despite the expressed reservations GPs held regarding the new indicators, 'no interviewee challenged the importance of these issues or stated their intention not to attempt to meet the

targets.<sup>158(p232)</sup> One study however, appears to offer a suggestion of as to why this may be the case.<sup>213</sup> It suggests that GPs, specifically GP principals, have limited opportunities to resist or disengage from the needs of the contract due to their responsibility to maintain practice income, or, as the author describes it (via the use of Bourdieu's concept of habitus), their 'economic capital'. GP principals however, do not necessarily have to do the work of the contract themselves, and research illustrates that PNs have been delegated many areas of QOF to deliver.<sup>153,157-159</sup> This is the fourth point which may have allowed GPs, or GP principals at least, to maintain a sense of no change. Finally, it must also be noted that there are large areas of work that QOF does not cover, for example acute work and estimates indicate that 75% of the population do not have any of the diseases in QOF.<sup>214</sup> Therefore, there are *a priori* still large areas of work for GPs to continue to work in line with the personal styles. Whether GPs perceive the work and discretion they have in terms of QOF vs. non-QOF areas differently is a question that appears unanswered in the literature.

The evidence to date regarding GP discretion and QOF is therefore a somewhat mixed picture and indicates that GPs are at least in some areas doing work that is not necessarily in line with their personal views or professional opinions. The current study has the advantage of assessing how GPs perceive the impact of the new arrangements now the contract has been in place for some time, and to assess the attitudes and perceptions of GPs to further changes which, as described earlier, appears to ask practices to do more work for less money and to do work that is less in line with their professional opinions. In addition, available empirical research to date has not particularly discussed or distinguished between the types of GP in terms of their status i.e. GP principals vs. salaried GPs and what implications this may have on areas such as perceived discretion. For example, one could hypothesise that salaried GPs, as employees, would be less at liberty to exercise their discretion with respect to QOF targets in comparison to GP principals who are also their managers/employers. SLB theory highlights that most analysts assume that lower level workers will conform to what is expected of them, but Lipsky states that often SLBs 'do not share the perspectives and preferences of their superiors' (ibid p16). It is therefore possible that salaried GPs, may in fact not share the



GP principal's goals unless they have been recruited and socialised into the GP principal's ways of working with and under QOF.

In terms of the policy making aspect of the GP's role, *a priori* one would expect the presence of standardised electronic templates to reduce the variability in the outcomes and work as related to QOF. Quantitative evidence shows that practices have from the first year of QOF achieved highly and continue to do so.<sup>154</sup> In addition most practices (99.6%) are participating in QOF,<sup>168</sup> indicating that centrally derived policy is being enacted as desired across general practice. QOF is *not* necessarily being conducted by GPs and therefore it may be that they see this function as remaining intact.

### **3.10.2 Conditions of work - resources**

As highlighted by the previous chapter, much of the GP work context has been characterised by limited and/or inadequate resources. Firstly, patient interactions occur within the limited time of the 'pre-planned appointment' (which in Lipskian terms can be seen as 'access limiting devices'). The finite resource of GP time has been a recurring theme with for example only 6 minutes per patient being allocated in the 1980s.<sup>54</sup> Just prior to 2004, the situation had improved with the average pre-planned consultation being 10 minutes.<sup>215</sup> However, the issue of limited time for GP-patient interaction and the pressure this creates for GPs to process their patients (accentuated by the pressures of a busy waiting room, or in Lipskian terms, a device to reinforce the image of the limited and precious nature of SLB time) remains characteristic of a GP's role. Secondly, there is the issue of limited financial resources. GPs are primarily independent contractors, and their contractor, the NHS, is a publicly funded system, which by its very nature has finite resources. In addition, the way that GPs have historically been funded has placed a limit on funds in relation to the number of patients GPs have on their lists. This left little provision for variations in GP workload and the fact that the demands on general practice have increased over time due to various factors as outlined in the previous chapter which has been neatly summarised by the RCGP as including:

...more patients presenting with chronic and multiple health problems, language barriers, a greater number of medical interventions, the preventive health care agenda and more complex administration. In addition, there is also a shift in

workload from secondary to primary care, resulting in a greater number of specialist services in family practices.<sup>216(p8)</sup>

The increase in demand is also demonstrated by the rise in the average number of consultations. For example, each person in the UK saw their GP on average 5 times during 2002, compared to 4 GP consultations per person per year in 2001.<sup>217</sup> Whilst it would be untrue to say that such demands are borne solely on the shoulders of GPs (other members of the PHCT e.g. PNs also share the burden), GPs are still the major point of contact and decision-making for presenting patients.<sup>218</sup> The picture of increasing demands against a situation of limited financial resources again resonates with Lipsky's analysis of the impact of limited resources on the quality of the services that patients receive.

The nGMS contract and QOF have the potential to change the situation of inadequate resources which may theoretically be used to alleviate the conditions that led to the low job satisfaction and morale amongst GPs prior to 2004. The issue of time (length of GP appointments) has been determined by QOF, as practices are incentivised to provide ten-minute appointments i.e. most GPs now strive to work within common time constraints. However, this does not necessarily translate to GPs having more time with patients post-QOF, as many already had appointments of this length.<sup>215</sup> In addition, QOF has created an extra administrative workload in terms of the need to attend to the data collection i.e. filling in of templates, therefore actual time for pre-QOF ways of working is reduced. In terms of financial resources, QOF has meant the influx of extra funding for general practice. Ultimately, GP principals decide how to use any of the additional funds and may use such resources to alleviate the conditions of their work and perhaps to deliver care in a manner consistent with their ideals. However, many principals appear to have personally benefited from the financial influx (as demonstrated by hikes in GP principal 'salaries' i.e. profit shares) and have not necessarily invested it into their practices in order to change pre-existing working conditions.<sup>169</sup> Other research however, indicates that practices *have* invested some of the extra finances into staff mainly administrative but also some clinical, often less skilled workers such as HCAs.<sup>147</sup>

### **3.10.3 Goals and performance measures**

#### *3.10.3.1 Goals*

In terms of GPs working in an environment of conflicting and ambiguous goals, one could argue that their position as gatekeepers to wider NHS resources, as well as their position as the patient's advocate, is potentially a fundamental source of conflict akin to the types of goal conflicts described earlier. Whereas this may theoretically be a source of goal conflict, the fact that GPs' referral and prescribing activities were unregulated for large periods of time, meant that in reality, there was little need for GPs to wrestle with such decisions. This situation contributed to the rising costs from general practice and was one of the reasons for increased management. A key decision reflecting this was the incumbent government's decision to cap prescribing in 1985 via the 'limited list.' Post QOF, research also indicated that there may increasingly be tensions or goal conflict (gatekeeper vs. advocate).<sup>146</sup> Specifically, tensions can revolve around GP requirements to balance PCT prescribing budgets whilst achieving increasingly difficult targets which potentially involve the use of more resources (e.g. diagnostic tests, prescribing more drugs etc). This will be explored where possible in the current study.

The GP's espoused focus on the individual and patient-centred, holistic care, has also been challenged by the direction of policy in the past two decades which encourages a more population approach to care. For example, in the case of GPFH, GPs were in the position of simultaneously commissioning and providing services within general practice, which may have created tensions (at least for lead fundholders) in terms of the needs of the patient vs. the needs of their wider patient list. Whereas most rank and file GPs did not have the decision making responsibility with regards to GPFH they ultimately would have to adapt and follow the local agreements made by their fundholding leads.

Another major initiative that went further towards moving GPs away from their traditional individual holistic focus was the introduction of NSFs which has been characterised as representing a departure in the way of practising medicine for GPs who espouse a focus on the individual.<sup>132</sup> QOF extends this approach to care and led to the suggestion that the future application of Lipsky's framework may also provide a way of analysing the impact of the nGMS contract which 'institutionalises this change further' (ibid p954). This is

because the underpinnings of the clinical aspects of QOF are derived from large scale population randomised controlled trials and therefore can be said to represent an approach more usually recognisable as being from a public health perspective. This is potentially a key tension for GPs regarding the ambiguity of goals in their work and is analogous to the fact that SLBs characteristically work in an environment with ambiguous or conflicting goals. For instance, Lipsky poses the question of whether ‘the role of the police is to maintain order or enforce the law’ (ibid p40). Similarly, one can see that the introduction of QOF may be seen to pose the dilemma of whether the role of the GP is to look after the individual patient or the population, in this case the whole of the practice population. In addition, as the contracts are held (and therefore QOF performance measured) at the practice level, one may also formulate the hypothesis that GPs may also face client-centred vs. organizational goal conflict. For example, within routine consultations there is now the possibility of conflicting agendas (patient vs. QOF).<sup>161</sup>

Furthermore, in striving to achieve highly on QOF, practices as described above have developed some processes that move general practice towards a more standardised and routinised approach to care. As such GPs may feel that their ability to treat the individual patient is somewhat compromised. Recent research suggests that as a result of QOF ‘groups of patients with similar conditions are assumed to require standardised appointments and follow-up, with little space for personalisation within an automated system.’<sup>43(p12)</sup> QOF however may mean that some GPs are able to resolve such goal ambiguity, as Lipsky predicted in that ‘If goals were clearer, workers could direct their energies with less ambivalence’ (ibid p19). Here the identification of QOF templates as ‘aide memoires’ would appear to provide such clarity as to what they are expected to achieve within their consultations. However, conversely it is also possible that the addition of the goals in QOF has created more ambiguity, specifically client vs. organisational, as prior to QOF, one could hypothesise that the goals of the GP were clearer i.e. simply attend to the patient’s presenting needs.

### 3.10.3.2 *Performance measures*

GPs have primarily worked in a context characterised by vague policy. GPs were in essence simply trusted to provide the necessary care to patients presenting problems and

there were no definitions or standards that represented good quality of care as medical knowledge was seen as too complex to distil down to simple formulae. Such a description resonates with Lipsky's discussion regarding the difficulties of measuring the performance of SLBs and their work (i.e. work is complex in nature and lack of ability to manage work done in private). However, since his writings, the 'technology' of performance measurement has advanced and proliferated and there has been an increasing acceptance and use of such measures across public services both domestically and internationally. An illustration of both of these points can be seen in the US health arena and The Joint Commission (TJC). The head of TJC recently wrote that 'the ubiquity of quality measurement and reporting makes it difficult to remember a health care landscape without them.'<sup>219</sup> TJC utilise performance measurements in their accreditation program to subscriber hospitals which ultimately decides their eligibility for state (Medicare) funding. The TJC website states that 'the history of the Joint Commission is rooted in performance measurement' and outlines the key stages undertaken in enabling their ability to performance manage.<sup>220</sup> Details of these stages are not provided here but it is suffice to say that they highlight the pivotal role of ICT. Essentially, ICT allowed TJC to collect and analyse performance data from disparate locations and collate it into a centralised database. In other words performance (or rather aspects of it) can now be more easily measured and monitored without a physical supervisory presence. This development as highlighted in the previous chapter is one of the key factors enabling successful implementation and achievement of the performance measures included in QOF in UK general practice.

In medicine, the ability to develop quality markers or performance measures has arisen as a result of the EBP movement. As a result, there has over time been an increasing acceptance within medicine that it is possible to measure good quality care, at least for some conditions and patients.<sup>77</sup> In UK general practice, QOF is to date the ultimate symbol of this (i.e. performance management) approach and represents a nationally and professionally agreed set of rules and standards against which the work of general practice can be measured. In addition, advancements in ICT plus its widespread implementation/use in general practice means that GP-patient interactions, traditionally beyond the gaze of outsiders, have been opened up to scrutiny and to influence by others.

Those in ‘managerial’ roles are therefore more able to monitor and attempt to align ‘worker’ activity with the desired targets. However, the existence of such systems does not ensure compliance as users can subvert the system, for example, by manipulating the information that is entered.<sup>163</sup>

Lipsky highlighted the difficulty of measuring performance when different agencies may be starting from different baselines. Similarly, QOF was introduced without any baseline measurements. Despite this, since the introduction of QOF in 2004, differences in the quality of healthcare delivered by practices initially thought to be at a disadvantage e.g. those located in areas of relatively high deprivation (compared to practices in areas of relatively low deprivation) appear small.<sup>221</sup> Whereas in Lipsky’s writing clients had no way to compare and contrast the treatment received in one agency or area in comparison to another, QOF results are available to the public. The publication of QOF scores of individual practices online allows for the possibility for patients to access information that allows them to compare and contrast how well their practice is performing in relation to others. However, given that most practices have and continue to achieve well on QOF, the information does not in practice allow for much discrimination. In addition, research has indicated that some GPs suggest that QOF is a limited measure of performance i.e. it only measures the measurable. Studies have indicated that important areas of care such as personal continuity and interpersonal care both of which are highly valued by patients, are not included within the measure and are seemingly suffering since the introduction of QOF.<sup>157,161</sup>

What of Lipsky’s predictions for the introduction of performance measurement? First, he predicts that SLBs will focus on the measured aspects of work. It appears that practices have become internally re-organised around the needs of QOF which exerts certain pressures on GPs to focus on QOF. At the individual GP level and in terms of their attitudes and approach to care within their consultations, some research indicates that GPs have become more biomedical in their approach overall as a result of QOF.<sup>43</sup> Other qualitative research suggests that *some* GPs appear to be more QOF-focused within their consultations than others;<sup>157</sup> although there is no consensus on whether individual GPs are focussing on the areas within QOF at the expense of those not included.<sup>161</sup> Recent

quantitative evidence however, appears to suggest that upward trends for non-QOF related activities (measured prior to QOF's introduction in 2004) have suffered a decline since the introduction of QOF.<sup>222</sup>

Secondly, evidence regarding predicted 'fraud and deception' is also limited but indicates that where GPs admit to QOF data manipulation<sup>157</sup> e.g. under-recording disease prevalence,<sup>151</sup> the 'culprits' appear to be in the minority.<sup>223</sup>

Finally, what of the evidence for the effect of performance measurement on productivity and the erosion of services in areas other than those measured? Although high QOF scores are being attained, there has been concern as to how QOF had impacted the *overall* quality of care received. An accepted definition of quality of care for individual patients defines quality in terms of access and effectiveness i.e. can individual patients access care when they need it and is it effective (clinically and interpersonally) when they receive it?<sup>224</sup> Whereas QOF is directed at and attempts to address the clinical aspects of care, there is little provision, other than the patient surveys for assessing the impact on the softer aspects of care such as interpersonal care. Quantitative evidence regarding the efficacy of feedback as a mechanism to improve the quality of interpersonal care however is limited and mixed.<sup>225</sup> Qualitative evidence appears to suggest that GPs have expressed concerns regarding the squeezing out of the soft aspects of care due to time limitations and pressure to attend to QOF templates.<sup>158</sup> Despite such concerns GPs have been reported as not perceiving patient concerns to be important measure of practice performance.<sup>157</sup> This may reflect Lipsky's view that clients/patients may not be a primary reference group for SLBs/GPs. However, practices are now increasingly incentivised on the basis of their survey scores, and therefore may react in future in order to re-coup any losses by being more responsive to patient feedback.

### **3.10.4 Clients and their relationships**

The nature of GP-patient relationships can also be seen to fit Lipsky's analysis. First, one can draw analogies in GP-patient terms in relation to the non-voluntary nature of SLBs clients. GPs remain the first point of contact for patients who wish to access wider health services, or indeed to get access to publicly funded prescription medications. To access

such resources patients have little choice but to attend and comply with GP decisions as in the publicly funded NHS service there is little alternative provision, private or otherwise. This point also illustrates the relative power differential between SLBs and their clients, in fact the doctor-patient relationship is characterised by the fact that it is intrinsically unequal.<sup>226 (p139)</sup> and that patients have in Lipskian terms traditionally not been a reference group for GP behaviour. However, as the previous chapter illustrates, the government has increasingly attempted to involve patients to make services more responsive. In particular, GPFH provided the first formal attempt and opportunity for public involvement.<sup>11</sup>

Post-2004 patients are still non-voluntary. Even though GP services can now via the APMS contract option be provided by private alternatives, this type of provision remains low.<sup>227</sup> In terms of the client-SLB relationship or GP-patient relationship, QOF can be seen as a device to plan access to services via the call/re-call systems. These systems also act to increase the non-voluntary nature of patients, by sending persistent reminders to enhance the likelihood of patient attendance. QOF also potentially presents a mechanism for GPs to control the pace and content of the interaction within the consultation. Little research and analysis has been conducted on the impact of QOF on the manner that GPs use QOF templates within their consultations. One recent study did just this and highlighted how GPs were able to utilise QOF templates within their consultations in order to minimise disruption and limit the opportunities for patients with long term conditions to introduce topics in to the consultation that GPs perceive they have little control over.<sup>228</sup>

### **3.10.5 Advocacy and alienation**

#### **3.10.5.1 Advocacy**

As identified in the previous chapter, advocacy is a traditional aspect of the GPs' role. There has however been seemingly little attention within the literature on this aspect of the GP role. An illustration of how GP advocacy can be affected by policy is in relation to GPFH. One study reported that GPFH raised ethical dilemmas for fund-holding GPs vs. those who were non-fund-holding with respect to prescribing, referral and investigation decisions.<sup>62</sup> Specifically, fundholding GPs were obligated 'to consider utilitarian principles when deciding about how justly to distribute health care within the doctor-



patient relationship' (ibid p 179). There has been no evidence to ascertain how this aspect of the GP role has been affected since 2004 and the introduction of QOF. One may expect from the evidence to date, that the various pressures on GPs to fulfil QOF targets, means they have little room or time to advocate for individual patients as QOF has encouraged a 'mass-processing' approach to patients and attempts to treat all patients equally by containing targets that represent national standards of care. Patients have ostensibly less choice about whether or when to attend the practice and have even been subjected to home visits and phone calls simply to collect QOF data.<sup>150</sup> One mechanism within QOF however does allow GPs to advocate for their patients, namely exception reporting. For instance, if the patient does not wish to take medication, the GP can respect their wishes and exception-report them. It may be therefore that GPs do not feel the need to attempt to advocate for individuals as they know they are receiving good care as QOF is largely evidence based and is reported as 'becoming synonymous with perceptions of good care.'<sup>164(p4)</sup> However, as noted earlier it may become more difficult for GPs to attempt to secure the best treatment for individuals in the face of increasing budget constraints.

#### 3.10.5.2 Alienation

Lipsky argues that certain aspects of the SLB role are 'un-alienated', for example the wide discretion they possess in how they approach the individual clients as well as the fact that the nature of their work i.e. human interaction, is a source of variety in itself. In these terms, GP work (as outlined in chapter 2) has historically clearly fallen into this 'un-alienated' category. Where it has been alienated however, relates to the inability of GPs to control the input of their work i.e. their patients. A GP can request a patient's attendance, prescribe etc but the patient must choose to attend and then comply in order for the GPs recommendations to be acted upon and be meaningful. GPs are also relatively powerless to affect the wider situation of their patients, for example their ill health may be due to poor housing and cannot be resolved by the GP. The ability to exception report means that practices are not penalised for issues largely out of the hands of GPs such as a patient's non-attendance. However, the nature of QOF i.e. inflexible rules and the manner in which it has been implemented can be seen to increase the potential for GP work to be more alienated in some ways and remain untouched in others.

QOF-induced organisational changes within practices to maximise the likelihood of meeting QOF targets, may mean that post-QOF some GPs feel more alienated from their work in various ways. First, the call/re-call systems and common pre-planned appointment lengths do not in theory allow GPs to control the pace of their work. Although GPs can spend longer than the planned appointments lengths with their patients, there are presumably personal incentives for them to attempt to stay within their allotted times e.g. to leave work earlier, attend to other aspects of work etc.

Secondly, in the drive for efficient approaches to gaining QOF points, GPs are experiencing changes in relation to how they work, as they are now less likely to deal with *all* of the patients' needs i.e. patient care is more fragmented. As a result of GPs delegating aspects of QOF work to nurses, they may now only deal with patients *after* they have already seen another practitioner. In other words, QOF has made it increasingly the case that GPs only form part, and in most cases the latter part of the patient care process. This resonates with one commentary which suggests that the statement 'the old adage that GPs treat 'the patient rather than the disease' may no longer turn out to be true, and 'general' practitioners may start to feel more like 'partial' practitioners.'<sup>133(p531)</sup> Whereas some GPs report this as allowing them to work in a manner they would consider less alienating i.e. them doing more complex work,<sup>150</sup> it has resulted in the loss of certain skills or 'de-skilling'<sup>161</sup> and decreased continuity with patients.<sup>157</sup> In other words, some GPs are now less satisfied with their work post-QOF. Lipsky posits that where SLBs are alienated in their work, they will be 'more willing to accept organisational restructuring and less concerned with protecting clients' interests and their own connection with clients' (ibid p79). Some research indicates that a substantial minority of GPs consider the standardized care as provided by QOF to be a 'box-ticking' exercise and felt their new role to be at odds with their professional training as generalist doctors.<sup>157</sup> It may be that GPs consider QOF template work to be alienating and therefore structuring QOF work in this stepwise manner allows them to avoid it. The benefits of such arrangements may make the loss of continuity of care bearable.

### **3.10.6 Consequences and coping mechanisms**

Lipsky argues that SLBs form routines and shortcuts to cope in the face of scarce resources. Similarly, GPs have been shown to use informal coping mechanisms in order to ration scarce resources.<sup>196</sup> They may also modify the concept of their job. For example evidence prior to 2004 suggested that GPs were re-configuring their identities due to the increasing demands they faced from complex and competing agendas (e.g. accept an increased volume of patients from secondary care and at the same time, manage demand within the practice).<sup>229</sup> This study suggests that rather than refuse to cope or resist, GPs modified their behaviour and professional identity via 'identity work' and re-framed themselves as biomedical specialists.<sup>229</sup> In contrast, post-2004 evidence indicates that GPs are continuing to frame themselves in their traditional rhetoric of holism (as they have delegated the biomedical/QOF work to their nurses) despite the nature of their work becoming more biomedical.<sup>43</sup>

### **3.11 Limitations of conceptualising GPs as SLBs**

Despite previous authors using Lipsky's framework, and the discussion so far illustrating that GPs fulfil many of the criteria for street-level bureaucracy, it must be acknowledged that there are some limitations to this analysis. GPs are for the most part not employees within the types of large agencies that Lipsky predominantly refers to in his analysis. They are for the most part owners of small organisations, which are run by the GP principals and their practice management staff. However, arrangements appear to vary locally, with the management of some practices being conducted for instance solely by the practice manager. Regardless of the local arrangements, there remains the theoretical ability for GP principals at least to alter the conditions and types of work they do by for example lengthening appointments times in order to alleviate some of the pressures they face in their practice. However, this has been discounted as a possibility by some, as the influence of demand 'makes this very difficult to achieve in practice.'<sup>132(p956)</sup> The author goes on to state that despite this difference, GPs (including GP principals) are seen to fit Lipsky's work as he 'defines street-level bureaucrats in terms of the characteristics of their work situations particularly the autonomy they enjoy in face-to-face contacts with the public' (ibid p956). In the conclusions the author re-visits the limitation of characterising

GPs, (at least GP principals) as SLBs and states that they can ‘in part’ be seen as SLBs. This was due to instances of behaviour that did not conform to expected SLB behaviour, and was more akin to behaviour that would be expected of ‘results oriented’ manager. In other words, GP principals can be seen as a SLB/manager hybrid. It would appear therefore, that any investigation of the SLB role in general practice must take into account the dual role of GP principals as workers in, and owners of, the organisation. In addition, the limitations highlighted here only apply in relation to GP partners and not to their employee counterparts i.e. salaried GPs, who are increasingly becoming a major sector of the GP work force and to date, have received surprisingly little attention within the literature.<sup>cf.230,231,232</sup> The difference in status between the two roles may have important implications for their respective perceptions of working under the new contractual arrangements. For example, Lipsky discusses the fact that most analysts assume that ‘lower level’ workers will conform to what is expected of them, but often in the case of SLBs they ‘do not share the perspectives and preferences of their superiors’ (p16). This proposition may explain findings which suggest that GP principals perceive salaried GPs as being less attentive to the recording of QOF data within their consultations.<sup>230</sup> It is possible therefore, that salaried GPs, may not share the GP principal’s goals or concerns, in this case the achievement of QOF targets. A suggested explanation for this difference is that GP principals have limited opportunities to resist or disengage from the contract due to their responsibility to maintain practice income (and their profit shares) or (via the use of Bourdieu’s concept of habitus) their ‘economic capital.’<sup>213</sup>

Despite outlining the differences between the two types of GP, common between them is their frequent interaction with the public and as a result they have a major client or patient processing role when doing their clinical work. In other words, unlike the managers in Lipsky’s analysis who are former SLBs themselves, but no longer see clients, GP principals are also still in the main processing patients and are therefore not entirely (if at all) removed from frontline services. Having identified the distinctions between GP principals and their salaried counterparts, the analysis in the current study will also distinguish between these two groups, which *a priori*, would seem to potentially affect attitudes and perceptions regarding the impact of contractual changes.

### 3.12 Critiques of and developments in SLB theory

In the thirty years since the publication of Lipsky's work there have inevitably been some critiques and suggested developments to Lipsky's analytical framework. Within the British public services context, it appears that much of the work has focused on whether or not Lipsky's framework is still applicable in light of the changing contexts found within modern public service agencies, in particular within the areas of social work and education. Specifically, the focus over the last decade appears to have centred on the central issue of discretion and whether or not discretion as Lipsky described it continues to operate within the types of organisations where SLBs operate. Analysts have tended to focus on three areas of change that have occurred since the publication of Lipsky's work and that *a priori* would appear to reduce the ability of street-level practitioners from operating with the type of discretion that Lipsky described.

The first relates to 'top-down pressures' and increased accountability stemming from the NPM movement. Here critics have in essence suggested that Lipsky's analysis belongs to a 'gentler age' of public service i.e. *before* the rise of managerialism.<sup>233</sup> For instance in social work, it has been argued that SLBs have less autonomy and discretion as managers control more of the content (technical and ideological) of practice;<sup>233</sup> thus, Lipsky's central analytical point no longer holds. This argument is *not* one shared by many contemporary commentators who continue to employ Lipsky's work in empirical studies which appear to illustrate that discretion is still in operation.<sup>e.g.234</sup> In other words, the increasing prevalence of managerialism does not necessarily nullify Lipsky's framework, as discretion is a *relative* concept. Such 'all or nothing' approaches are seen as too crude as they effectively close off the possibility and consideration of other types of discretion.<sup>235</sup> Some studies have utilised a typology of discretion comprising three aspects: 1) judgement in respect to the application of standards; 2) the final responsibility for making a decision (within the rules) and 3) discretion in the strong sense which gives the decisions and the criteria of decision making to professionals.<sup>236</sup> The suggestion is that 'all or nothing' approaches only focus on discretion in the 'strong sense' and pays little attention to the 'weaker' aspects of discretion i.e. the need for and creation of discretion by the act of rule interpretation. Rule interpretation is important for the study

of Lipsky's work as whereas some appear to suggest that rules are clearly laid out and therefore should be clearly interpreted,<sup>233</sup> others argue that this view is unwarranted and neglects Lipsky's view of policy as being voluminous and therefore open to interpretation.<sup>235</sup> In fact a key aspect of SLB theory is the ability of SLBs to interpret rules in ways that are not necessarily conducive to managerial policies/goals. In summary, they suggest that paradoxically, the creation of more rules leads to increased uncertainty and therefore need for more discretion and interpretation.<sup>235</sup> A recent study of a social services department illustrates this, reporting that when newly designed procedural manuals were introduced, they were seen as so elaborate that they created *more* discretion by requiring people choose what to follow and what to ignore.<sup>234</sup>

Another recent study of UK education, also 'unpacked' concept of discretion into three inter-related types: 1) rule discretion which is bounded by legal, fiscal or organisational constraints, 2) value discretion which stems from normative professional practice and 3) task discretion or the ability to carry out prescribed tasks.<sup>237</sup> The impact of various factors/changes (e.g. NPM reforms, national curriculum etc) were considered and then assessed for their impact against each of the identified types of discretion. As discussed earlier, QOF, a centrally derived (top-down) policy has the potential to reduce GP discretion and my work will also use this unpacked concept of discretion and assess the extent to which, if any, distinct aspects have been affected/eroded.

Recent attention has also been drawn to a particular facet associated with 'managing SLBs'. Whereas Lipsky assumes an intrinsically conflictual relationship between SLBs and managers (due to their differing priorities), it is now suggested that a more nuanced approach than this is needed.<sup>234</sup> Specifically it has been argued that Lipsky assumes managers to be a homogeneous group who act as 'policy lieutenants' committed to the implementation of organisational policy. Attention has been drawn to differences between layers of (or types of) managers i.e. 'managers' are not necessarily a homogeneous group. In the case of social work, it has been shown that local managers often still identify themselves as social workers who now have managerial roles, whereas higher 'strategic' managers view themselves as managers first and foremost.<sup>234</sup> Consequently, different 'identifications' have implications for the nature of discretion and

the way it is managed as the shared professional commitments transcend the distinction between local managers and practitioners. Local managers, in contrast to higher/strategic managers, worked together to promote professionalism i.e. a commitment to the needs of their clients and a freedom in their work role, rather than focussing solely on performance.<sup>234</sup> This study draws attention to the issue of professionalism and how this concept can shape the type of managerial approach and discretion that SLBs can wield. This again has relevance in the current work as the ‘managers’ in general medical practice are most likely to be practising GPs and not removed from being a professional. This may have implications for the way they manage their staff and GP colleagues towards meeting QOF targets.

In addition to ‘top-down pressures’, there is also the issue of ‘bottom-up pressures.’ Specifically, the government have taken various actions over-time in an attempt to increase the accountability of professionals to users, clients or patients of the service in question. As a result, bottom-up pressures have become a key characteristic of public service provision in recent decades.<sup>237</sup> For example one study focussing on education, highlighted the introduction of the Citizen’s charter in 1991 as strengthening the voice of the service-user.<sup>237</sup> This also resonates with the current work as QOF now provides incentives on the basis of the results of the patient survey. In other words, as a result of QOF general medical practice has been moved to a position of increased accountability from the ‘bottom-up.’ Whether GPs perceive this to have impacted on their discretion however, remains somewhat unanswered in the literature.

In addition to the ‘vertical’ pressures described above, the recent literature on SLB theory has also acknowledged that SLBs are also ‘horizontally accountable’ to their co-workers who may be peers within their profession or members of other professions.<sup>238</sup> It is suggested that these relationships also impact on an individual’s discretion and actions in relation to policy. Since the introduction of a practice level contract one would assume *a priori* that the accountability in the horizontal dimension has increased, and evidence to date suggests that this may be the case.

The final factor that appears to have significance for the exercise of discretion by street-level bureaucracies is the impact of ICT, something that Lipsky did not (and could not) have foreseen. The widespread implementation of ICT has meant that it is now an everyday feature of working life for many people including those operating within public service agencies. This has led some to argue for a change in terminology to reflect the impact of ICT which has changed the ‘street-level’ bureaucracy to a ‘screen-level’ bureaucracy and in some cases, depending on the service, a ‘system-level’ bureaucracy.<sup>239</sup> In essence they argue that in some agencies the impact of ICT has been to mediate client interactions and in some cases to fully automate (via decision algorithms) the decision making process. Whereas practitioners previously had the decision making power to determine eligibility of a client for the public services in question, the contemporary situation now removes this human interaction (unless the case is highly unusual or the client complains) and decisions are made via electronic forms. Decision making is therefore largely automated with little need for SLBs or discretion. As the authors state in their concluding comments however, it ‘remains to be seen whether similar transformations can be observed in non-legal, non-routine, street-level interactions such as teaching, nursing and policing’ (ibid p 180). These ideas have implications for the current work as ICT has a significant role to play in the data collection for QOF with likely impact on discretion

Lastly, there appears to be a focus on the application of Lipsky’s work to specific professions and/or contexts. Lipsky’s work concentrates on the *commonalities* that SLBs share in the nature of their work i.e. processing people and the conditions of their working environment. Whereas these generalisations have provided many useful insights, he gives little attention to the differences between the occupations/professions and the variety of agencies, functionaries (within those agencies) and the tasks those functionaries perform.<sup>238</sup> These differences have consequences however, for example the types of tasks may or may not be more or less conducive to becoming automated i.e. the extent to which tasks are regulated and structured by ICT (and therefore the level of discretion) varies across the types of street-level bureaucracy. It has been argued that Lipsky was not describing the ‘reality’ of all street-level bureaucracies but provided a ‘starting point’ or a ‘tentative framework’ that can be fine tuned to take into account the difference



contexts.<sup>240</sup> Consequently, there is scope for ‘in-depth’ studies of a range of occupations in the UK.<sup>237</sup>

### **3.13 Summary and Research aim**

In this chapter I aimed to provide an outline of the theoretical framework employed by the current study as well as to illustrate in detail its relevance to the topic of interest. In the first part of the chapter I briefly outlined the context and main points of the chosen theory, namely Lipsky’s theory of street-level bureaucracy. I then moved on to highlight how this framework had been successfully employed by various analysts from different academic disciplines before focussing on its application to general practice in order to explain GP attitudes and behaviours in response to previous primary care policies. The new contract, and in particular QOF, have however been seen by some as having the potential to fundamentally change the way that GPs work.<sup>241</sup> Evidence of the impact of QOF and the subsequent changes to date were discussed and related to Lipsky’s framework, in particular to the issue of discretion and performance measurement and management. The changes (as derived from the existing literature) appear to be wide ranging and appear to impact on several areas of Lipsky’s analytical framework. I then discussed the limitations of conceptualising GPs as SLBs but also indicated how further developments in SLB theory appear to strongly resonate with the remit of this research. I therefore seek to assess whether the conceptualisation of GPs as SLBs is still appropriate and useful to understanding GP behaviour and responses to centrally defined policy since the introduction of the new contractual arrangements, and in particular QOF.

As Lipsky himself stated, any changes to the conditions of work outlined in this chapter which not only allow for, but require SLB discretion, may make his analysis less appropriate. In the following chapters I explore the views and experiences of GPs in relation to the contractual changes. I investigate how QOF has been implemented within GP practices what subsequent impact, if any, this has had on the work of GPs, particularly in relation to the substantive element of GP work i.e. the consultation. In the concluding chapter I relate my findings to the existing empirical evidence and use the overall evidence in order to assess whether the key aspects of Lipsky’s framework still hold post-QOF.

## **Chapter 4**

### **Methodology and Methods**

#### **4.1 Introduction**

This chapter presents a discussion of the methodology and critiques the methods utilized in this thesis. I also outline the sampling approach, details of the sample; interview process and analysis are then discussed. The chapter ends with a brief discussion on my personal reflections relating to the research and interview process as well as ethical issues and how these were addressed.

#### **4.2 Research Design**

Convention and intuition suggests that the choice of research approach and associated methods should be influenced and relevant to the research questions. In this case, the research approach and methods were designed (prior to my involvement on the project) to answer the research questions of a wider project (see Appendix 1). However, the plans for data collection to address the project aims were congruent with addressing my own research questions. The formulation of these questions i.e. to assess the impact of the contract and in particular QOF was however adjusted slightly to reflect changes to the original design of the qualitative arm of the project. The original intention was to work within four health economies as fieldwork sites and to adopt a case-study approach i.e. recruiting whole organisations (GP practices, pharmacies and dental practices) and studying the impact of the contracts on the internal workings of the organisation and its staff via participant observation and interviews. Attempts to recruit in order to populate this framework proved very difficult and PCTs were identified instead as proxies for health economies based on willingness to participate, diversity of approaches to contracting and range of socioeconomic characteristics. The quantitative arm of the study provided data to identify such sites. Initially we attempted to utilise a maximum variation sampling approach to identify within PCTs, a variety of practices with respect to issues such as the ownership status, the size of the organisation and the level of performance against the contract. The task of recruiting whole organisations in accordance with the sampling strategy however proved too difficult to put into place and a decision was made by the Principal Investigator (PI), Professor Ruth McDonald (who is also one of my

supervisors), to change the design. Specifically, the decision was made to focus on interviewing individual primary care practitioners at multiple time points and where possible individual GPs more than once. Therefore the research topic I was to formulate also had to be one that could be answered by the chosen project methods i.e. interviews. However, this still left considerable scope as interviewing is the most common method of data collection employed in qualitative health research.<sup>242</sup> The research questions regarding the assessment of the impact of the changes on GP were therefore adjusted slightly to reflect the methods and are outlined below.

### **4.3 Research Questions**

This thesis aims to explore the perceived impact of the new contractual arrangements, and in particular the QOF, by eliciting the views and reported experiences of currently working GPs. I then ask, given the perceived impact, whether the prior conceptualisation of GPs as SLBs is still appropriate and useful to understanding GP behaviours and responses to centrally defined policy in the light of the reported results.

### **4.4 Theoretical considerations**

Much of the research concerning general practice has been grounded in a positivist epistemology. The doctrine of Positivism ‘advocates the application of the methods of the natural sciences to the study of social reality.’<sup>243(p12)</sup> The tenets of positivism have been summarised as: 1) only those phenomena and hence knowledge that is observable, is warranted as knowledge, 2) it is deductive and knowledge is advanced via hypothesis testing under experimental designs i.e. assumes a stable environment, 3) it is ‘value-free’ or objective 4) the approach provides predictive power 5) it assumes that reality is objective.<sup>243</sup>

In terms of the current work, the new contract and QOF could be seen to be an intervention designed to influence the behaviour of GPs and that of their practices. The application or uptake of this intervention however has not occurred across a uniformly organised context i.e. it has not taken place under stable experimental conditions as the environment in which GPs work is not stable or uniform. In fact contextual issues are likely to be of importance and affect how individual GPs perceived the initial changes and

those that have occurred since. Positivism would obstruct this exploration of complexity because it reduces rather than expands the horizon of inquiry. In addition, as the research involves eliciting GP views and perceptions of their experiences working under the new arrangements, the data will reflect attitudes and beliefs, rather than being observable. All in all, the positivist approach appeared to fall short when placed in the context of the research aims. The other end of the ‘epistemology spectrum’ consists of interpretive approaches. One type of interpretivism that has been adopted in relation to research interested in the views and experiences of patients as well as their practitioners (including GPs and nurses) is that of phenomenology (see for example<sup>244;245</sup>). This approach emphasises studying the experience of the issue of interest, from the ‘point of view’ of the subject. The problem with a phenomenological approach in this case is that it calls into question the very existence of social structures.<sup>246</sup> Specifically, the issue stems from the fact that ‘rather than accepting social structures affect the attitudes and actions of individuals, for phenomenologists the flow of causality runs in the other direction, in that social structures are creation of individual minds.’<sup>246(p414)</sup> In summary, both these approaches fail to take into account the influence that contextual factors have on individual experience of the intervention. As already highlighted, it is possible (and likely) that contextual factors and social structures such as the GP’s status in the organisation (i.e. salaried vs. principal), may affect the perceptions and experiences of such individuals with regards to the introduction, implementation of and subsequent impact of the contract and QOF on their day to day work. Having found neither ends of the spectrum to fit with the needs of my research aims, I therefore looked for a ‘middle-way’ and two viewpoints which appear to fit with my views and needs and which are broadly similar are subtle realism<sup>247</sup> and critical realism.<sup>248</sup> Both approaches take realist ontological positions (i.e. that the external world exists independently of our sense experience or observer) but have relativist epistemologies, in other words the epistemological dimension emphasises the fallibility of human knowledge and how it is socially and historically located. In addition, both views also acknowledge the influence of human agency is acknowledged whilst at the same time taking cognizance of the effect of structures on action.<sup>249,250</sup> The theoretical viewpoint taken in this thesis therefore tends towards that as advocated by these ‘middle-way’ approaches.

#### 4.5 The Research Approach

The current study is an exploration of the perceived impact of nGMS on general medical practice, and in particular the impact of QOF (and its changing nature) on the day to day work and practice of general practitioners. In order to assess the impact of this centrally derived policy, it is necessary to access GPs views and experiences regarding the new arrangements and how they may have and continue to impact on their day to day working lives. Many authors, emphasise the view that the purpose and context of research ought to determine which methodology is chosen.<sup>242,251,252</sup> In this section I briefly outline why the adopted methodology is appropriate for answering my research questions.

In the case of the empirical research on QOF, there is a growing literature which contains both quantitative and qualitative studies. The outputs of both types of approach reflect the types of questions that researchers have been interested to date. For instance, in case of the quantitative studies, researchers have been interested in assessing whether or not QOF targets have been achieved as well as how wide-scale factors such as deprivation or practice size characteristics may, or may not, have impacted on achievement levels.<sup>e.g.221</sup> This reflects the fact that in general, the goals of quantitative approaches are to enumerate the phenomenon of interest. The outcomes of this type of research however are limited (or provide a partial view) as they only tell us whether for targets have been met (or not), and not how or why. Qualitative studies on this area to date have attempted to address different types of questions such as ‘how’ and ‘why’ QOF has been achieved. For instance, some qualitative studies have revealed how practices have become internally organised around the needs of QOF.<sup>147</sup> Such studies illustrate the power of qualitative methods which allow more in-depth information to be collected that may be difficult or impossible to convey quantitatively,<sup>253</sup> and reflects the fact that the goal of qualitative methodologies is to explore and improve the understanding of social phenomena in a natural rather than experimental settings; emphasising the meanings, experiences and views of all participants.<sup>254</sup> The use of a qualitative approach will therefore allow me to answer my research questions by exploring in depth GPs views of how (and if) the QOF has affected their daily working practices and working lives. Furthermore, the longitudinal design (i.e. conducting second round interviews) allows for the examination of GP views over time, in this case over a one year interval. This was particularly

important for the current study as the substantive topic of interest i.e. QOF evolves on an annual basis. This allowed me to assess the stability or trends in GP views and experiences in addition to the usual ‘snapshots.’ It also provided a richer data set as I was able to explore certain areas of analytical interest in greater depth. This was particularly invaluable given the need to balance the data collection needs of the wider project and my PhD.

Despite the fact that qualitative methodologies are increasingly used in a wide range of research settings including the health services research arena,<sup>255</sup> there have been extensive discussions within the literature regarding the quality and limitations of these approaches. Criticisms typically reflect what researchers employing quantitative approaches (e.g. surveys) deem to be the ‘strengths’ of these methods. In other words, qualitative approaches are often criticised for being ‘unscientific’, open to bias, lacking in generalisability and reproducibility.<sup>256</sup> The application of such criteria arises from criteria acceptable within the positivist domain i.e. critics assume that by applying quantitative approaches they are able to measure stable phenomena in a ‘value-free’ manner. Even those attempting to measure phenomena and views via surveys are largely unaware as to whether those surveyed all uniformly interpreted the ‘questions, categories and language used in the questionnaire.’<sup>256 (p109)</sup> In other words although the instrument may be uniformly presented to participants and therefore data is presumed to be collected in a uniform manner, the results may reflect differences in interpretation rather than any ‘actual’ differences in attitudes etc. Such differences in interpretation are unlikely to be picked up by conventional ‘pre-testing’ of questionnaires.<sup>257</sup> However, by employing certain techniques, researchers have attempted to shed some light on this issue. For instance, utilising the think-aloud<sup>258</sup> approach (where participants verbalise their thoughts as they perform tasks) reveals how participants bring different meaning to information that is presented to them.<sup>259</sup> It appears therefore that irrespective of the chosen approach, the conclusions made depend upon the judgment and skill of the researcher and the appropriateness of the data collected.<sup>256</sup>

#### 4.6 Quality and Rigour in Qualitative Research

There is much debate regarding how to judge quality in qualitative research. Explicit discussions of quality in qualitative approaches ‘began from concerns designated with words such as validity and reliability, developed within the quantitative or scientific tradition.’<sup>260 (p465)</sup> One of the early responses to these concerns from within the qualitative research community was to write about issues of reliability and validity in relation to qualitative research but to imbue the terms with somewhat different meaning.<sup>243</sup> For example, some regard the key criteria representative of good quality research as being whether or not the interested reader can (should they choose to) replicate the study and confirm the findings (i.e. reliability).<sup>261</sup> However, other authors have questioned the validity of applying such criteria to qualitative research. Taking the example of applying the criterion of ‘replicability,’ in the case of certain types of qualitative research, it may be that the researcher is interested in the nature of change of for example a phenomenon or within an organisation. Fulfilling the criteria of ‘replicability’ in such cases is therefore simply not feasible.<sup>262</sup> Given this example of disagreement, it is somewhat unsurprising then that there has been a proliferation in activity around and publication of numerous different quality guidelines or criteria deemed suitable for assessing quality in qualitative research.<sup>263</sup> This was ‘in marked contrast to the quantitative tradition where a consensus around certain ideas (for example, the distinction between validity and reliability, or between internal and external validity) has been more easy to sustain amongst researchers.’<sup>260(p467)</sup> Despite the fact that there is no absolute list of criteria,<sup>264</sup> there do appear to be some commonly agreed areas, as most share a concern for trustworthiness and rigour i.e. all of them require such research to be both coherent and logical, as well as to show evidence of systematic and auditable work. Table 5 summarises these criteria along with a brief description of how the current study met the criteria.

**Table 5 Quality criteria (content adapted from <sup>242,265</sup> )**

<b>Judgement Criteria</b>	<b>Description</b>	<b>Methods used</b>
Transferability	Broadly corresponds to the notion of external validity or generalisability. The aim here is to give readers enough information ('thick description') for them to judge the applicability of the findings to other settings.	Provision of a full description of the sample characteristics (as well as comparative national figures where possible) and the findings
Dependability	Broadly corresponds to the notion of "reliability" in quantitative research. The reader should be able to establish via the work that the research process has been conducted with appropriate due care and attention i.e. there is enough of an audit trail.	Accurate interview transcripts were produced  Analysis of whole data set undertaken  Regular and ongoing discussion of analysis process with supervisors  Provide a clear account of the research process
Credibility	Akin to the notion of internal validity i.e. do the findings make sense?	The provision of sufficient information regarding the findings, study and other empirical literature.
Confirmability	Refers to the confidence the reader has in the findings.	Analysis of deviant cases and disconfirming data

## 4.7 Methods

### 4.7.1 A consideration of Semi-structured Interviews

Interviews are commonly defined as a conversation with a purpose.<sup>266</sup> They are the most commonly used qualitative method,<sup>242</sup> and have been described as 'the gold standard' of qualitative research.<sup>267</sup> There is however no single method of interviewing. Interviews vary in their form. On one side of the spectrum there are structured interviews which are narrowly defined conversations with a specific ordered set of questions. Those with positivist tendencies tend to employ such approaches in order to attempt to ensure the uniform asking and answering (in terms of order) of questions. This approach ultimately attempts to ensure a high degree of comparability between accounts.<sup>266</sup> In addition, such an approach is also assumed to minimise the role of the interviewer on the interviewee.<sup>267</sup>



On the other end of the spectrum are informal or unstructured interviews which rely on the spontaneous generation of data via natural opportunistic interactions within the field (i.e. they are often associated with observational methods) i.e. there is no pre-defined interview guide or schedule. These are often employed when the researcher begins with the assumption that they do not know in advance what the necessary questions are.<sup>266</sup> Interviewers are supposed to adapt throughout the encounter and explore, probe areas that arise spontaneously during the interview. Semi-structured interviews, the approach chosen in this work, lie in between these two extremes.<sup>242</sup>

The semi-structured interview has been described as being:

...conducted on the basis of a loose structure of open questions which define the area to be explored, at least initially, and from which the interviewer or interviewee may diverge in order to pursue an idea in more detail.'<sup>268 (ibid p106)</sup>

As the research aims to assess the impact of the new contractual arrangements and in particular QOF, this meant there were pre-determined broad questions, and hence, the semi-structured interview was deemed most appropriate. However, I also wanted to ensure that I wasn't imposing or restricting the issues that were discussed within the interviews solely to those I had formulated in advance. Again, the strength of the semi-structured interview was useful here as it allowed me to respond with flexibility in the interviews in order to explore emerging issues that were not necessarily anticipated at the start of the research.<sup>269</sup>

In terms of answering my research questions, i.e. assessing the impact of the introduction of the new contracts and QOF, I was in effect asking people to recall experiences, events, feelings when for example asking people (where appropriate) to compare their working lives pre- and post-April 2004. As QOF is designed to evolve over time, I was also interested in GP views on the nature and direction of changes. These requirements fit well with what some consider to be the advantageous properties of interviews:

We cannot observe feelings, thoughts and intentions. We cannot observe behaviours that took place at some previous point in time...we cannot observe how people have organised the world and the meanings they attach to what goes on in the world – we have to ask people questions about those things. The purpose

of interviewing then is to allow us to enter into the other persons' perspective.<sup>270</sup>(ibid p 196)

However, some highlight the fact that interviews record what people say, rather than what they may actually do or think, undermines their value.<sup>242</sup> Further criticism has been levelled at the reliance placed on memory in the construction of accounts i.e. there is the potential for recall bias.<sup>242,271</sup> Others discuss the issue of 'social performance' and 'impression management' (terms originating from Erving Goffman's<sup>272</sup> work) which may occur during the interview.<sup>266</sup> This point touches on a particular issue with regards to the way that data collected via interviews is treated and traditionally this has been seen in one of two ways.<sup>273</sup> The first sees interview data as a 'resource'. This approach views the data as reflecting (or a window on) the reality of the interviewees' outside of the interview. In this view language is largely unproblematic as it functions to provide 'facts.' An alternative view perceives interview data as a 'topic' which is (more or less) reflecting a reality that is jointly constructed i.e. between interviewer and interviewee. However, from everyday experience we know that language is not a neutral tool. For instance as highlighted above, during the interview, an interviewee may wish to present themselves in various ways and from this perspective the interview is an opportunity for impression management.<sup>272</sup> In the case of this work as I am interviewing professionals I may expect them to present themselves as being 'competent' and 'professional'. However, given that I was to interview a wide range of GPs, it is unlikely that all these varied informants will engage in convergent retrospective or impression management.<sup>274</sup>

Some analysts are wary of discounting the data from interviews due to the reasons outlined above.<sup>275</sup> They accept that the data cannot be treated simply as a representation of an individual's world and are shaped by the context in which they are produced. They insist that accounts from people who participate have special knowledge of interest and are therefore an important resource. Others state that interview data is valid 'so long as the interview is treated as a contextual account, not as a proxy representation of some other reality.'<sup>242</sup>(ibid p89) However, as in real life, the account obtained in an interview will have a mixture of the real and the representation.<sup>276</sup> I attempted to take this into account during the analysis by carefully examining the data and probing it in relation to any underlying tensions and apparent contradictions contained within.

#### **4.7.2 A consideration of telephone interviews**

The project's aims of collecting a large amount of data at repeated time points meant that I utilised telephone interviews in a small number of first round interviews (n=7) and for all second round interviews (n=24). Telephone interviews have been used extensively in quantitative research<sup>277</sup> but have not traditionally been a major way of collecting data in qualitative research.<sup>266,277</sup> Their use is considered to be advantageous within project settings as they permit data to be collected with minimal costs (e.g. no travel costs) and allow data to be collected easily from geographically diverse areas.<sup>266,278</sup> My use of telephone interviews was in fact largely due to such practical reasons however, some concerns have been raised regarding their use in qualitative research. The first appears to be the view that telephone interviews are an inferior mode of interviewing when compared to face to face.<sup>277</sup> A recent review of the use of telephone interviewing in qualitative research revealed that this 'biased' view (as the author terms it) is 'implicit both in the omission of telephone interviews in qualitative research texts and in the small number of articles on telephone interviews.'<sup>277(p394)</sup> This lack of presence in the qualitative literature appears to reflect doubts about the quality of the data gained via telephone methods, compared with face-to-face interviewing.<sup>278</sup> However, other researchers who having initially shared these doubts found that their use of telephone interviews produced unexpectedly rich data.<sup>279</sup> All in all, there appears to be little consensus on this issue, nevertheless the debate about face to face vs. phone interviewing was a point that I was careful to take into consideration when analysing those interviews conducted by phone vs. those conducted face to face. The other commonly cited disadvantage of telephone interviews surrounds the inability to pick up on any visual cues. There is however little research confirming these effects, and there is no clear understanding of how they might compromise qualitative data.<sup>277</sup>

Whereas there has been an apparent bias against the use of telephone interviews in qualitative research, there are in addition to the practical advantages of reduced cost other reported advantages. These have been summarised as 1) allowing participants to remain on their own turf, 2) permit more anonymity, 3) decrease social pressures and 4) allow participants to disclose sensitive information more freely. I also found the ability to jot

down notes (unobtrusively) on areas to go back and probe further on certain issues extremely helpful.<sup>277</sup> In addition, it has also been argued that qualitative telephone interviews are best utilised when 1) the researcher is employing either structured or semi-structured interviews and 2) when they are conducted among people with whom the interviewer has already conducted face to face interviews with.<sup>266</sup> My use of telephone interviews therefore largely fulfils these criteria as I was using semi-structured interviews and that most of them were utilised in the second round of data collection. In addition, I feel that GPs are in fact a very suitable group for conducting telephone interviews with, in that they are a natural medium for them as much of their day to day business is conducted on the phone, including telephone consultations with patients. Finally, both the face to face and telephone interviews were digitally recorded (and then professionally transcribed) and therefore the audio quality of the accounts was comparable.

#### **4.8 Sampling**

Appropriate methods of sampling are dependent upon the aim(s) of the research. Quantitative studies aim to produce a statistically representative probability or random sample (where each member of the population has an equal chance of being selected) of the whole population.<sup>242</sup> In contrast, in qualitative work:

...randomness and representativeness are of less concern than relevance...Does the sample produce the type of knowledge necessary to understand the structure and processes within which the individuals or situations are located?<sup>264(p346)</sup>

Furthermore the premise of the qualitative sampling approach has been described as:

...to identify specific groups of people who either possess characteristics or live in characteristics relevant to the social phenomenon being studied. Informants are identified because they will enable exploration of a particular aspect of behaviour relevant to the research. This...allows the researcher to include a wide range of types of informants and also to select key informants with access to important sources of knowledge.<sup>280(p12-13)</sup>

Thus initial sampling is usually purposeful or purposive i.e. it is guided by the need to select subjects that are able to provide relevant data or are “information-rich.”<sup>252(p203)</sup>

Some suggest that in order to achieve this, a number of different sampling strategies are

possible and include the technique employed in this study i.e. snowball sampling. I now discuss how the decision to adopt ‘snowball sampling’ was made.<sup>242</sup>

Given that the research aims to investigate the effects of the new contract and specifically QOF on the work of GPs, those approached to take part in the study were GPs. As described earlier, it initially was planned to recruit practices as a whole entity i.e. adopt an organisational viewpoint due to the fact that under the new contracting arrangements the contract is held at the practice level, as opposed to individual GPs. However, as this strategy was abandoned in the wider project due to the fact that it was not possible to engage and recruit whole practices and it was decided to focus on interviewing individual practitioners. Therefore, in order to collate the necessary participants and data it was decided to take a pragmatic approach based on ‘snowball sampling’ in view of the time (as project time had been lost in attempting to recruit whole practices) and resources available.

Snowball sampling involves identifying a few potential cases of interest, verifying their interest as well as eligibility, and accessing potential further cases via the initial participant’s social or professional contacts. It was developed and has subsequently been utilised by researchers as a solution to researching ‘hard-to-reach’ or ‘hidden’ populations.<sup>281</sup> Such populations are those which are ‘not validated by society’ and often tend to be small and attempt to remain off the societal radar.<sup>282</sup> They may therefore, be deterred from engaging in research due to the fear of legal sanctions, for example, sex-workers or illicit drug users. Although GPs are a socially visible group, I think they can be considered ‘hard-to-reach’ in that it is fairly well known within the health service research community that it is difficult to access GPs and to persuade them to take part in research. There are various factors that contribute to this such as constraints on their time due to clinical practice and the need to process their patient workload. In addition, it is virtually impossible to access them directly to discuss research which they may be interested in taking part in due to the fact that they employ staff which act as gatekeepers. Such factors therefore also led me to perceive GPs as an ‘elite’ group, because they are ‘relatively more powerful than the interviewer’ and culturally different if the interviewer

is a student...'<sup>242(p94)</sup> This of course applied to my own work and I presented myself as both a student as well as an employee on the wider project.

The difficulty with snowball sampling lies within the mechanism itself, in other words particular people may be included or excluded as a result of the initial participants who then refer the researcher onto other participants who may share similar viewpoints (which may in fact be atypical) as they belong to the same social network i.e. the sample may be too restricted and reflect a homogenised sample. In other words the accounts and in turn the research outcomes may be biased.<sup>281,283</sup> Despite the potential for this to occur, the approach employed did in fact produce a wide range of participants in terms of key factors of potential interest and importance such as status (principal or salaried), years of clinical experience, locations, practice size, and deprivation (see Section 4.10). Before discussing the recruited sample, I briefly outline the various strategies employed in attempting to access participants recruited in this study.

#### **4.9 Negotiating and Gaining Access**

I employed a number of strategies in order to access GPs. Firstly, given the fact that I work in a primary care research centre which has a number of jobbing GPs, it seemed a logical starting point to consult them and ask whether they or their colleagues would be interested in participating. This 'convenience sample' provided a small number of interviewees within the sample. Once this avenue had been exhausted, I then turned to other 'key informants' that I had encountered during the project research, namely PCT leads who were specifically commissioners of care within primary care and provider contract managers i.e. people who had access to the group of interest. After interviewing PCT leads for the wider project, I would then take the opportunity to ask if they had direct contact details in the form of e-mail addresses for their practitioners. Where PCT staff were willing to share this information I utilised the lists and individually e-mailed GPs in order to inform them of the research and ask them if they were willing to participate in the study. This tactic again produced a small sample of GPs which I was able to interview. Other attempts to contact GPs directly involved doing a mass mail out, which again produced a small number of participants. I also developed the tactic of speaking to the practice managers who were then interviewed for the project and asked to recruit any

willing GPs from their practices. I was directed by one practice manager to a local practice managers meeting which allowed me to speak to representatives of several practices in one go. This allowed me to present the aims of the overall project as well as to state my intentions to utilise the data for my own thesis. This again eventually produced a small number of participants. I also contacted one of the Local Medical Committees (LMC) who agreed to put an advert for the research project in their newsletter and as result some GPs actually contacted me voluntarily. The largest factor however that enabled both myself and the PI to recruit the numbers of GPs (and other participants) required was the inclusion of the project into the Primary Care Research Network (PCRN) portfolio. The PCRN portfolio is a subset of the National Institute for Health Research Clinical Research Network (NIHR CRN). The significance of this occurrence was the fact that we could now access support costs. Such costs are supplied by PCTs and are designed to cover the cost of the interviewee whilst they are undertaking research. This allowed us to contact practices with the carrot of funding and this significantly improved our recruitment. The other major asset that came with the project's inclusion into the PCRN portfolio was that the PCRN have specific contacts whose role is to aid the recruitment of suitable participants into the portfolios' projects. Such people, to whom I and the wider project team are extremely grateful to, were an invaluable resource. Finally, the inclusion of the project into the portfolio meant that the research moved from the immediate geographic setting i.e. the Greater Manchester area to other geographic locations.

#### **4.10 Participants**

In total I conducted 62 first round GP interviews (with have an average duration of 41.72 minutes and range of 26.09 to 62.81) between Feb 2008 and Sept 2009. A further 24 second round (R2) interviews also took place between November 2009 and January 2010 which in all cases was over one year after the initial interview (average duration of 21.3 minutes and a range of 13.2 to 30.3 minutes). The total sample comprised, 41 (or 66.1%) GP principals and 21 (or 33.9%) salaried GPs (see table 6). Just over half of all participants (54.8%) were male with the split between the two GPs groups in terms of status being: principal GPs 73.2% male and salaried GPs 19% male.

The composition of the whole sample in the study appears to compare well with national figures published in 2010 which report that in 2009, males comprised 53.9% (vs. 54.8% in the sample) of the overall GP workforce.<sup>284</sup> The dominance of the female representation in the salaried group of 21 participants also reflects the fact that it has also been reported that many women seem to have chosen to move into the area in the last 10 years, which has resulted in a 69.3% increase, changing from 32.6% of the workforce in 1999 to 43.7% in 2009.<sup>285</sup> In addition this trend i.e. the feminisation of the workforce appears to be continuing as in 2009 there was a bias of female registrars with 61.7% of registrars being women compared with 58.6% in 1999.

The average clinical experience of those in the sample was 14.5yrs (range = 0.5 to 35yrs) and principal GPs had an average of 19.1yrs experience in general practice comparison to salaried GPs who on average had 5.4yrs of experience. The difference here between salaried and principal GPs is also somewhat reflective of nationally derived figures which show that the proportion of practitioners aged 45 and above has risen from 49.2% in 1999 to 56.9% in 2009. In addition the numbers of under-35s are also increasing, rising from 11.9% in 1999 to 12.6% in 2009.<sup>285</sup>

**Table 6 Sample Characteristics**

Study ID	Sex	Date of Interview	Year medical degree gained (as listed in GP register)	Self-reported time (yrs) in general practice at time of interview	Status	Practice #	PCT #
1	F	11/02/08	1972	30	Principal	1	1
2	M	08/02/08	1996	4.5	Principal	2	9
3	M	07/03/08	1976	30	Principal	3	12
4	M	27/05/08	1969	32	Principal	3	12
5	M	19/03/08	1991	13	Principal	4	1
6	M	01/05/08	1980	24	Principal	5††	1
7	M	12/05/08	1986	17	Principal	6	1
8	M	17/06/08	1984	20	Principal	7	1
9	M	23/06/08	1983	20	Principal	8	5
10**	F	27/06/08	2000	1	Salaried	2	9
11	M	27/06/08	1998	5	Principal	2	9
12	F	22/07/08	1991	11	Salaried	9	5



13	M	23/07/08	1989	12	Principal	10	12
14	M	24/07/08	1983	20	Principal	10	12
15	M	31/07/08	1978	26	Principal	11	11
16	F	11/08/08	1984	18	Principal	12	5
17**	F	26/08/08	2002	2	Principal	13	8
18	F	26/08/08	1982	20	Principal	13	8
19	M	29/08/08	1967	35	Principal	14	12
20	M	10/09/08	1977	26	Principal	15††	5
21	M	18/09/08	1986	18	Principal	16	8
22	M	19/09/08	1983	23	Principal	17	5
23	M	29/09/08	1988	14	Principal	13	8
24**	F	10/10/08	1992*	2.5	Salaried	17	5
25	M	03/10/08	1974	30	Principal	18	11
26	M	10/11/08	1978	28	Principal	19	8
27	F	10/11/08	1988	15	Principal	19	8
28	M	11/11/08	1992	17	Principal	12	5
29	F	01/12/08	1978	31	Principal	9	5
30	F	08/12/08	1985	18	Salaried	20	2
31**	F	10/12/08	2002	3	Salaried	21	13
32	M	05/01/09	1998*	2	Principal	22	7
33	F	05/01/09	1984	21	Principal	22	7
34	M	07/01/09	1984	20	Principal	22	7
35	F	09/01/09	1983	25	Principal	22	7
36	M	12/01/09	1991	16	Principal	22	7
37	M	12/01/09	1991	16	Principal	22	7
38	M	14/01/09	1976	30	Principal	22	7
39**	M	14/01/09	2002	3.5	Principal	22	7
40**	M	16/01/09	1992*	3	Salaried	23†	5
41	F	16/01/09	2001	5	Salaried	23	5
42	F	20/01/09	1985	17	Principal	24	8
43	M	20/01/09	1990	12	Principal	24	8
44	F	20/01/09	1983	20	Principal	24	8
45	M	21/01/09	1990	25	Principal	24	8
46	F	21/01/09	1995	9	Principal	24	8
47**	F	30/01/09	1984*	2	Salaried	22	7
48**	F	10/02/09	2002	2.5	Salaried	25	13
49	M	09/02/09	1982	12	Salaried	24	8
50	M	13/03/09	1986	19	Principal	26	3
51**	F	09/03/09	2002	2.5	Salaried	27	8
52	M	09/03/09	1985	19	Principal	27	8
53**	F	06/04/09	2000	4	Salaried	28	6
54**	F	17/04/09	2000	3	Salaried	29††	10

55**	F	17/04/09	2004	1.5	Salaried	29	10
56	F	17/04/09	1995	5	Salaried	29	10
57**	F	28/04/09	2001	3	Salaried	29	10
58	F	06/05/09	1990	6	Salaried	29	10
59**	M	15/06/09	1994*	2	Salaried	30	7
60**	M	30/06/09	2000	0.5	Salaried	31	8
61	F	01/07/09	1990	16	Salaried	32	4
62	F	08/09/09	1992	10	Salaried	33	14

\* = previous career in hospital medicine before entering general practice  
\*\* = only worked under the new contractual arrangements (QOF) from April 2004.  
† = APMS practice  
†† = PMS practice  
R2 interviews indicated by shaded areas

Finally, an illustration of practice characteristics in terms of list size and deprivation are listed in tables 7 and 8. The practices in my sample had an average Index of Multiple Deprivation (IMD)<sup>†</sup> of 27.5, indicating that they were marginally more deprived (on average) when compared to the average practice nationally which has an IMD of 23.7.

**Table 7 Sample deprivation**

Index of Deprivation quintiles (1= most affluent and 5= most deprived)	No. of practices	No. of GPs
1	4	17
2	6	11
3	6	7
4	5	9
5	12	18
<b>Total</b>	<b>33</b>	<b>62</b>

<sup>†</sup> the IMD consists of a number of indicators, chosen to cover a range of economic, social and housing issues, into a single deprivation score for each small area in England.<sup>285</sup>  
Source: Constructed by: Social disadvantage research Department of social policy and social work university of Oxford  
Data obtained via GEOCONVERT : <http://geoconvert.mimas.ac.uk>

**Table 8 Sample practice size characteristics**

<b>Patient List Size (L)</b>	<b>No. of GP practices</b>	<b>No. of GPs</b>
L < 4000	5	7
4000 < L < 8000	15	27
8000 < L < 12000	9	10
L > 12000	3	16
Total	32	60

Note: Data for practice 13 (n=2GPs) unavailable as newly opened.  
Source: Copyright © 2004. Re-used with the permission of The Health and Social Care Information Centre. All rights reserved.

#### **4.11 The interview process and content**

All interviews began by reiterating the nature and purpose of the study, allowing the interviewee the opportunity to read the participant information sheet (see Appendix 2) and to ask any questions before obtaining consent (see Appendix 3). All interviews were conducted in the participants' own premises, specifically their offices. Each interview began with a set of general background questions such as 'how long they had been in practice for? What made them choose general practice as a career?' By asking such open-ended and non-controversial questions, it is suggested that a comfortable rapport between interviewer and interviewee may be built.<sup>242</sup> This type of questioning also encourages the participant to talk descriptively, thereby aiding in the collection of detailed data.<sup>252</sup> During data collection the topic guide evolved to include new areas that arose from the interviews as well to ask about contract/QOF changes during the data collection period. Examples of broad areas covered in the interviews were (See Appendix 4 for the topic guide):

- What effects, if any, the new contract and in particular QOF had on the participants themselves – at the time, over time etc
- What effects the new contract and in particular QOF had on others – colleagues, patients, relationships with the PCT etc
- What organisational changes had occurred as a result of or in anticipation of the contractual changes e.g. QOF teams
- What the differences were pre- and post- contractual changes (for themselves and others including patients)

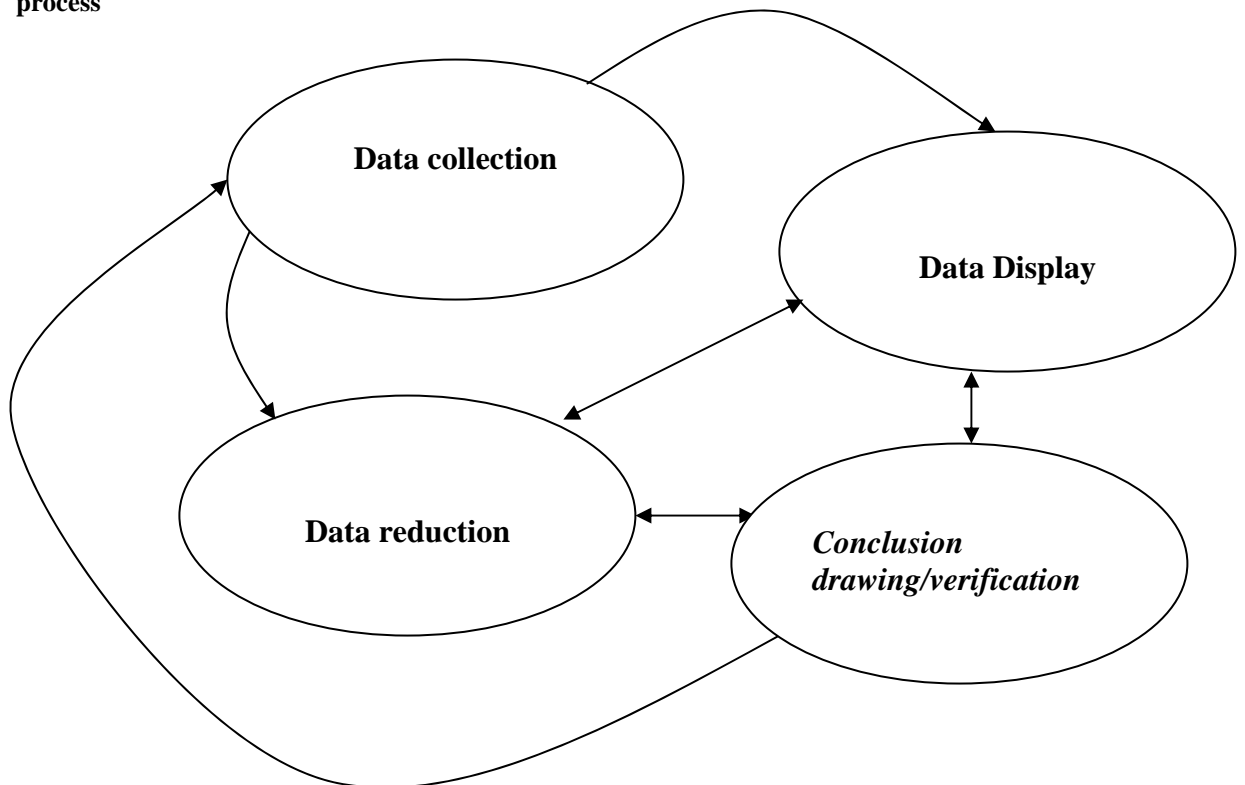
- How they perceived the changing nature of the contract and QOF content
- What they liked or disliked about the QOF

Second round interviews covered a number of topics of interest that arose in round one and through further investigation could provide further detail on the general phenomena identified in round one. Some questions were largely related to areas that arose specifically in an individual's transcript. For example, if in the first round the interviewee identified themselves as the overall QOF lead, I asked them whether all practitioners were equally good at fulfilling QOF requirements, how they dealt with under-performance etc. For this reason I have not included a generic R2 topic guide.

#### 4.12 Data Analysis

The analytical approach adopted in the current study closely followed that described by Miles and Huberman.<sup>265,286</sup> They suggest that analysis consists of three concurrent flows of activity: Data reduction, Data display and conclusion drawing /verification. A diagrammatic representation of the process is shown in figure 2. It illustrates the iterative nature of the analytical process.

**Figure 2. A diagrammatic representation of the analysis process**



The three main aspects of the process may be summarised as follows:

*Data reduction* - refers to the process of selecting and extracting information from the raw data (which in this case were interview transcripts) which reflects the topics of interest. In other words the process involves data fragmentation and labelling.

*Data display* - the organisation of the 'reduced data' in such a way that it enables a clearer understanding of it. This may involve the display of such data via use of tables or charts. The use of such 'cognitive devices' are intended to make the data appear more accessible as well as comparable in order to look for relationships and connections within the data.

*Conclusion drawing/verification* – essentially refers to the process of interpretation. Possible conclusions identified early on in the process via the identification of patterns and anomalies are tested, re-interpreted, modified and even discarded where appropriate as the process continues until 'final' conclusions are made.

It should be noted that although I have chosen the approach advocated by Miles and Huberman,<sup>265,286</sup> it is broadly similar to that also advocated by other analysts. For instance, those using approaches derived from 'grounded theory'<sup>287</sup> employ the technique of constant comparison, which also involves iterative data collection and analysis. The idea being that initial pieces of data (an interview or a theme) is taken as a starting point and subsequent accounts are compared in order to establish similarities and/or differences and therefore conceptualisations of the possible relationships between various pieces of data.<sup>288</sup> In fact, the three stages of constant comparison can be compared with that by Miles and Huberman<sup>265,286</sup> in the following way: open coding (data reduction), axial coding (data display) and selective coding (conclusion drawing).

#### **4.12.1 Process of Analysis**

Essentially the approach chosen involves segmenting the data and categorising it into themes. The process was both inductive and deductive in that I was interested in assessing the impact of the contract inductively but I also had Lipsky's theoretical framework to take into account therefore analysis was also deductive i.e. by looking for data that would fit or not into the main analytical points of his framework as outlined in the previous chapter.

First it should be noted that all interviews were digitally recorded and transcribed by professional transcribers. I then checked them for accuracy against the audio files. Transcripts were then uploaded into ATLAS.ti which was used specifically to aid in the data storage, management, and coding process.

Although I do not doubt that the actual 'doing' of the interviews and then checking the transcripts for accuracy started the initial informal analysis process in my head, the first active analytical step taken was the process of familiarising myself with the data simply by reading the transcripts at length. Notes were made during each reading, (using the memo facility in ATLAS.ti) of any points of particular interest. I then sought to 'reduce the data' by starting the process of coding i.e. attaching labels to pieces of in this case textual data.

Initial codes were assigned to the transcript text on the basis of the topic guide questions so as to provide a sensible descriptive 'framework' in which to retrieve segments of the transcripts that were comparable in that they were broadly talking about the same issues. Secondly I, then went through the transcripts again to code in the manner that shares some aspects of the 'open coding' employed when conducting a grounded theory approach, but as has already been described, the research was not being conducted in a theoretical vacuum as I had Lipsky's framework in mind. Essentially, these provisional codes were labels that indicated part of the transcripts that triggered an association in some manner with a particular category or idea. For instance I searched for data that related in some broad way to the concept of discretion.

The next stage involved the data display. The power of the computer package in this type of analysis meant that I was rapidly able to retrieve at the mere 'cost' of a few mouse clicks, all the data from all accounts pertaining to the same initial codes in order to form further codes that for instance linked the presence of phenomena. Data was kept in its verbatim form in order to reduce the likelihood of refining things too early and to maintain close contact with the raw data. I then produced charts of concepts (in Excel) with all data pertaining to the codes in order to allow comparisons across the participants as well as keeping key participant characteristics in mind. This allowed for data interrogation in relation to participants characteristics such as status or experience. From this stage I had regular meetings to discuss the emerging data both with my supervisors as well as the project team. In this way the themes identified in the early stages were able to be explored in later and even second round interviews.

The process of coding transcripts i.e. fragmenting the data means that the analysis essentially takes place within the selected data. This process however risks de-contextualising data.<sup>289</sup> In an attempt to avoid this, I utilised a spreadsheet (i.e. data display method) that I had produced and updated throughout the data collection, which listed all the main characteristics of the participants as well as a summary of key points from the account as a way of providing context to what and why the particular participant may have responded in certain ways. In essence, I was attempting to keep a broad 'narrative' of each participants or cases account. Most analyses adopt an either or approach to thematic and narrative approaches. However, the idea of adopting a narrative type approach (or aspects of it) in addition to a thematic approach is one advocated by some analysts *who* suggest that the techniques are in fact complementary and helpful to tease out different layers of understanding represented in the data.<sup>290</sup>

#### **4.13 An account and consideration of my role in the construction of the interview data**

It is acknowledged that within qualitative research, the researcher who conducts the research has an influence on the way that the data is collected and interpreted. This begins with the way that the aims of the work have been described to participants, how they were recruited (including by whom), and then how participants respond within the interviews.

Given that the participants in this study had been recruited via a number of different means and therefore may have received differing information and/or opinions of the research from those who had already participated, I felt that it was important to ensure that I presented myself and the research to the participant in as uniform a manner as possible. Firstly, I wanted to ensure that participants were aware that the project was funded by a body who produces ‘independent research about the organisation and delivery of healthcare for NHS commissioners, providers of health care, partner organisations such as local authorities and the voluntary sector, and for users of health care.’<sup>291</sup> In other words I wanted the participants to be aware that there was no conflict of interest in taking part (few participants however had heard of the National Institute for Health Research, let alone the Service Delivery and Organisation programme). In addition, I presented myself both as the jobbing researcher on the project as well as a PhD student.

Given that the phenomenon of interest (i.e. the contract and the contained QOF) is held at the practice level, I wanted to ensure that people felt that they were able to give their *personal* views, attitudes and experiences, whether they were positive or negative.<sup>n</sup> Therefore I stressed to participants that it was their *individual* views that were of interest and how *they* had perceived the impact. However, given that in many cases I was able to interview multiple GPs within a practice, in order to encourage participants to speak freely, I also stressed that I would not divulge any information pertaining to other individuals in their practice, or beyond. In addition, I guided the participants to the relevant section of the consent form which indicated that all interview data would be held in a secure manner and would be anonymised. Furthermore, I stressed that should they read any of the project outputs, that they the individual may recognise their own words, but that others would not.

Again to ensure uniformity of presentation, the interviews began by reiterating the nature and purpose of the study, allowing the interviewee the opportunity to read the participant information sheet and to ask any questions before obtaining consent. At this point, participants were given an opportunity to decline to be interviewed. I felt that this was

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<sup>n</sup> All interviews were conducted in the participants’ own private consultation rooms. Given that these are used to discuss confidential patient information, it should allow for a sense of privacy.



extremely important to stress, particularly in the case of salaried GPs who may have felt some pressure to comply.

During the interviews I attempted to convey my position as the interested and attentive listener. I was aware that the information disclosed to me was largely directed by line of questioning and also recognised that participants may have felt that they were expected to answer such questions in a way that they perceived and felt was acceptable and desirable by me the interviewer. However, as alluded to earlier I feel that in the case of GPs, an 'elite' group this was less likely to be the case as they were in fact the ones in position of having the knowledge that I was interested in. In addition, in order to avoid any 'researcher blindness' on responses, I regularly engaged in discussions with my supervisors on transcripts and throughout the analysis in order to get feedback on both my interviewing style and the analysis itself. Therefore I feel that what I present in the results chapters is as honest an account of the information I obtained as was possible.

#### **4.14 Ethics and research governance**

Multi-centred research ethics approval was granted from the Leeds East NHS Research Ethics Committee (REC; Application 07/Q1206/2). The University of Manchester REC ratified the study on the basis of NHS approval. In addition Research governance approval was sought and attained from each PCT as the research spread beyond the initial chosen sites.

#### **4.15 Summary**

In this chapter I have described the methodological approach that underlines the current work as well as a description and critique of the methods for data collection and analysis. The next two chapters present the results obtained from the data collection and analysis methods outlined in this chapter.

## **Chapter 5**

### **Exploring the impact of contractual change: the views and experiences of GP principals**

#### **5.1 Introduction**

In this chapter I explore the attitudes and experiences of 41 GP principals in relation to the contract introduced in 2004. Particular attention is given to QOF and its variants in the years since. I begin with an exploration of GP principals' attitudes to the overall structure and content of these arrangements as well as their views regarding the concept of QOF. I then move on to examine whether any practical measures were undertaken by participants in their practices in order to meet the demands of the new ways of working. The views of GP principals are then examined regarding the consequences of taking such practical measures as well as changes relating to the ICT systems, the repercussions of which appear to affect not only the principals and their wider practice staff but also their patients, in terms of the type and quality of care their patients receive.

#### **5.2 Attitudes to and experiences of contractual change: 2004 and beyond**

Participants were asked for their views and attitudes towards both the initial contractual change that occurred in 2004 as well as to the general direction and content of subsequent changes. Their accounts were largely ambivalent reflecting the fact that many saw it as an evolving 'package deal' which had both good and bad points, with the latter increasing over time. Participants identified four key areas in which they perceived the new arrangements as positive i.e. where 'gains' had been made in comparison to the previous version. Many of these gains however also often appeared to be interpreted as involving losses, some of which were unforeseen, but many of which were deemed as acceptable either for themselves, their profession or other parties including patients.

##### **5.2.1 Contractual change: the gains**

###### **5.2.1.1 Opting out: a good deal but for whom?**

The first and most cited gain, as well as the reason that many voted for the new contract, centres on their ability to opt out from out-of-hours responsibility. Many had been in general practice for a considerable period time prior to 2004 and recalled negative

experiences of having to provide out-of-hours care themselves. They described the situation prior to 2004 as 'unsustainable' as their normal surgery days were becoming more demanding due to the increasing complexity of work conducted in general practice. They perceived that the typical working day combined with on-call duties produced negative consequences for the quality of care delivered to their patients. By contrast they perceived that the new system was better for patients as they would not see tired GPs:

**Participant:** Some GPs [still] do out-of-hours. But after my 10 hours here, the last thing I want to do is out-of-hours....Would you really want to see me after I've been here 10 hours and brain-dead and you come in with a pain in your side that you are worried about and I'm thinking, are you male or female? **(GP5 - male, 13 years experience)**

Although participants warned of the dangers of working long hours under the old system, most participants also stated that they were in co-operative arrangements with other local practices to provide out-of-hours. Therefore their actual personal share of out-of-hours duties was small in comparison to the time when co-operative systems were not commonplace. However, despite the fact that co-operative arrangements placed less of an out-of-hours burden on the *individual* GP (i.e. they may have on been on-call a few times a month) most still wanted to opt out and had chosen to do so.

Even though most participants had actively chosen to opt, with some seeing this as beneficial to patients, a greater number expressed concerns about the type of care their patients received as a result of the out-of-hours changes. Concerns surrounded the use of doctors who had no prior knowledge of their patients. However, as the following quotes highlight, some rationalised and countered any concerns or 'guilty' feelings as (GP38) put it about the new service by arguing that patients often inappropriately used the 'old system':

**Participant:** ...We've lost the out-of-hours. Patients don't get as good a deal at now as they used to. But then again, they got too good a deal really. I think, they can stand that. We did get a fair amount of stuff that was unnecessary at night, which is a shame it's gone the other way now. **(GP7 –male, 17 years experience)**

**Participant:** out-of-hours had become such an abuse by many patients. I remember my last out-of-hours, I went in at 6:30am to see a kid with a runny nose

who'd had it for five days, and they had two cars parked in the drive and weren't bringing him out. I thought, "Right! That's solved it for me. I'm not feeling guilty about this. (GP38 – male, 30 years experience)

Many also highlighted that the cost of opting out was relatively small (approx. £6,000 per GP per annum). They felt the government had failed in their valuation of the level of service that they and their fellow GPs were providing:

**Participant:** ...one of the main reasons for me voting for the new contract was taking away of that obligation, because out-of-hours was becoming sillier every week, more and more, and busy. And you couldn't do a day's work afterwards. No, I wasn't sad to see that go...I'm quite amused that it was completely underfunded in the new contract, but then GP's have always said it was worth a lot more than the government recognized. (GP33 – female, 21 years experience)

Despite any concerns regarding the consequences of opting out, most were positive about the removal of out-of-hours care as it allowed them increased personal flexibility. For example they could cheaply trade a portion of income for decreased responsibility and increased leisure-time. As the following quote highlights for many the trade-off was deemed particularly attractive to those with family:

**Participant:**...and then when we decided we would opt out, it was brilliant from a personal point of view. It cost me money, but it was brilliant. Because I've got a two-year-old and that's great. But I could see from the community's point of view that it was crap. (GP35 – female, 25 years experience)

Despite most participants choosing to no longer provide out-of-hours care, a small number of participants continued to provide out-of-hours care as part of the service commissioned by the PCT. Some of these did so as they felt it was a core part of the work of general practice and their role as a GP:

**Participant:** I still feel the on-call vocational challenge, I suppose. I still see out-of-hours as part of our workload and therefore I'll do two shifts a month at the GP out-of-hours. And I've been involved with the administration of the out-of-hours. (GP37 – male, 16 years experience)

Others reasons for continuing out-of-hours care included the lack of external commitments (e.g. family) and the desire for extra earnings.

### 5.2.1.2 Improved income: the recognition of effort or under-estimation?

The second important gain related to the fact that most participants felt that the new monies on offer with the contract were a timely and deserved ‘pay rise.’ They perceived that they had already been providing a high quality of care. They described already following other evidence based guidance or policies such as the NSFs and as a result, many highlighted that their practice had easily achieved high QOF scores in the first year(s):

**Participant:** We looked at the performance indicators on QOF, and we thought, "This is a license to print money for us!" Because we were already doing... we didn't have to change. We had to change very little of what we did. In terms of medical management, we changed nothing. (GP22 – male, 23 years experience)

However, participants bemoaned the fact that in their view the government had underestimated the amount and quality of work that was previously being conducted in general practice and hence didn't expect such high achievement. They were also aware and troubled by the negative media reaction to their initial and continued success resulting in high earnings. They felt unfairly portrayed, citing that they were made to seem ‘greedy’, an adjective used by several participants. The line from the quote below ‘instead of being praised we just got slated’ sums up the sentiments in the accounts from many GPs who felt somewhat unfairly treated by both by the government and the media simply for performing well in what was after all a negotiated contract:

**Participant:** it was all agreed by the Department of Health, they'd agreed to the new contract...It was as if *we* were the greedy ones taking money off our patients...the pay scale [is] dependent on us jumping through numerous hoops, [it] had been agreed, and we managed to jump through those hoops. And our government wasn't very happy that we had achieved, which I found bizarre, really. They'd set out these targets for us and we achieved them and instead of being praised, we just got slated. (GP36 – male, 16 years experience)

Many therefore related that in some ways QOF had actually been beneficial as the achievement of high scores had provided a type of ‘evidence’ in that they were now able to demonstrate they (i.e. their own practice and the profession) provided a high level of service:

**Participant:** You've got this feeling of, "We know we're a good practice." And one of the ways of demonstrating it is to show that we hit all the targets. (GP18 – female, 20 years experience)

### 5.2.1.3 Improved recruitment and retention

A less cited gain related to the new contractual arrangements being more attractive to medical students and hence improving recruitment and retention into the specialty. Participants highlighted that general practice was less attractive to medical students than other medical specialties, and cited that both the improved pay and ability to opt-out of out-of-hours responsibilities would make general practice a more attractive option. They perceived that younger people were reluctant to work in the manner that the old system required:

**Participant:** I think, QOF-wise, it was a significant change, [it] needed to happen because in general practice people were leaving in droves...you couldn't get doctors into general practice...The trouble is that with the change in ...hospitals where you can be a consultant after five years, it was a lot easier to obtain the goals that you wanted. So people weren't interested in general practice. So they had to do something significant. Of course, that's what we have done. Now people are attracted by the salary. (GP5 – male, 13years experience)

**Participant:** I'm not sure that old-style general practice, with the practices particularly being responsible for night and weekend cover, was going to be sustainable in terms of getting younger people who were prepared to do it any longer. So, I think some things had to change. (GP26– male, 28 years experience)

Only four principals had recently entered general practice (having five years or less experience) and most cited factors such as variety of work and experiencing continuity of care with their patients as their reasons for choosing to work in general practice. Of these four, only GP32 cited the working hours of general practice as one of the key factors for her career change from hospital work.

### 5.2.1.4 QOF equates to improved and 'standardised' care

The final major gain cited by some participants did not relate to personal or wider professional gains, but to gains for patients and the quality of care they now received. Most perceived that since there was both a high uptake and achievement of QOF, the general patient population were now more likely to receive a good (as they felt that QOF

was largely evidence-based) and more consistent standard of care. Whilst most participants claimed that *they* were already providing high levels of care (claims they supported by citing their consistent achievement of high QOF scores) they also acknowledged that there had prior to 2004 been differences in quality of care provision across general practice. They felt that post-2004 the financial incentives contained within QOF had provided the impetus and motivation for those not practising appropriately to do so:

**Participant:** But the actual concept of QOF isn't a stress to me at all. It's just a more formalized way of what we were doing anyway. And we get paid for it, so brilliant! That's not a hardship. Where I would see QOF being a nuisance is if practices weren't necessarily doing all this stuff, then QOF was really going to give them a boot in the arse. But they need to get moving, and I think that's probably where the disgruntlement comes from. **(GP37 – male, 16 years experience)**

Despite many claiming to change little except to record their existing activities, it also became apparent during the interviews that many *had* in fact changed and/or improved their practice in some ways/areas. As this quote illustrates, this includes the fact that some felt that QOF improved health outcomes:

**SCS:** Do you think QOF has actually produced better patient outcomes?

**Participant:** I think quality-wise it probably has. Because certainly we're picking up a lot of undiagnosed, whereas previously maybe we wouldn't have checked blood pressure on everybody that came through the door, certainly not on a regular basis. We're diagnosing more and treating more, so I think from the patient point of view, that's likely to improve their outcomes. **(GP9 – male, 20 years experience)**

In addition to care quality, another motivating factor for practices to want to meet (and continue to meet) QOF targets related to the fact that GPs were now able to demonstrate and compare the quality of care their practice offered with other local practices. Some participants discussed how this triggered a competitive element to the doing of QOF which also contributed to improving and maintaining standards:

**Interviewee:** ..I like QOF, I like QOF even if we didn't get paid for it because erm in general especially in our area where there are six practices, erm you tend to be very competitive and you want, you know I want my diabetic figures to be the best

of the 6 practices here, if I can get 100% it's, I am sort of one up on next door sort of thing and I think what happens generally with this sort of thing is that it stimulates practices who may not have the enthusiasm lets to say, to have as good care other practices, it stimulated them to improve their practice. (GP5R2 – male, 13 years experience)

### **5.2.2 Contractual change: the losses**

Although many participants were largely positive about the new arrangements, many of these participants also pointed to specific areas where they considered there had been losses of some kind either to themselves, their wider profession or their patients.

#### **5.2.2.1 Locked in? On the contractual treadmill**

The vast majority of participants had voted for the initial 2004 version of the contract as it provided an attractive proposition giving them 1) the opportunity to remove their out-of-hours responsibility and 2) gain a pay rise. A small minority however felt that these gains had come at a considerable cost as they were now under a system in which they had lost a degree of control over the way they were able to work:

**Participant:** It's this new way of having to achieve targets. Audit everything and basically justify everything you do...suddenly, you are told this is what you have got to do, and you know you do get quite annoyed at being told what you should do. Maybe that's because we worked independently all these years and that's been taken away from us really (GP1 – female, 30 years experience)

The loss of some control due to QOF was also stated by others but some also felt that QOF was an acceptable and timely development. Many pointed to the fact that evidence-based practice was and had for sometime been the norm both in general practice and medicine more widely. Therefore they were now simply paid in line with what was considered to be 'best' practice:

**Participant:** I mean, sometimes we're our own worst enemies, really. I think, we're a really challenging group, probably, for...national government, because we're essentially used to being unmanaged...and we're used to getting our own way... And I think, some of us are really awkward about not being told what to do. And the reality is medicine has changed. And you cannot justify not following something where there's not an evidence base for it. And I think we sometimes shoot ourselves in the foot by talking about losing our autonomy and things...So,



I've no issue about following evidence based. (**GP23 – male, 14 years experience**)

Whilst QOF is voluntary, the importance of QOF to practice finances, combined with uncertainty over future funding were reported as being the major influences not only on their initial decision to choose to implement it but continued to be a major influence over time as I show below.

Whereas the initial version of the contract in 2004 was voted for by the majority of the profession and was seen as largely positive, later versions were perceived as being less so. GPs perceived that the contract was becoming more difficult for them to work under. Many felt that the 'goal posts' kept moving and that ultimately, this was as a result of their 'over-achievement' in the first year. A major change that participants were particularly negative and even angry about during the interviews was the introduction of the Extended Access DES in 2008. A good portion of the interviews were conducted around this time and therefore allowed for an in-depth discussion and collation of initial reactions and decisions regarding the contract amendment 'as it happened' so to speak. Participants did not feel that this DES was required or necessary and supported their perceptions by citing survey results that indicated high patient satisfaction with regards to access. In addition, many felt that they were being forced to accept the changes as otherwise they would be financially penalised i.e. they had little choice but to comply as the following quote highlights:

**Participants:** From an average practice they took £17,500 out of the contract and they said if you did extended hours -- for an average practice worked an extra three hours per week -- they will give you £17, 500 back. So it's no money. Yet we're at a loss because we have to pay an extra receptionist. There's lighting, heating, electricity, wear and tear. So we're actually losing. But we can't afford as a practice to take such a big chunk of loss, £17,500 and therefore our hands were tied and we've got no choice but to do it. (**GP13 – male, 12 years experience**)

The line 'we've got no choice but to do it' in terms of the financial implications summed up many participants sentiments regarding the DES and therefore unsurprisingly, most participants said that they had 'chosen' to implement it. Many were subsequently frustrated not only by this, but also that the new appointments on offer weren't being used

by patients that the government had argued needed them i.e. the busy working public. In particular, those located in deprived areas with high unemployment or areas with an older population (who could attend during normal surgery hours) cited this frustration. Such factors were also cited by the few participants who had decided *not* to implement the DES in their practice and to take the drop in income instead. In essence many regarded the DES as a mechanism for the government to increase its value for money or to 'claw back' monies. They again pointed to the fact that the initial contract had been negotiated by both the government and their professional body, and that the government was subsequently renegeing on that deal.

Participants also felt that QOF targets were also becoming more difficult to achieve. Some changes were seen as valid given that clinical evidence can change but other changes were viewed as a cynical ploy by the government to claw monies back as practices were year on year expected to expend greater efforts, for no additional compensation:

**Participant:** I think the 2004 one, the QOF aspect has been very good. I've been very positive for it. It's just that it's always changing. They're always trying to change it. It's OK, as long as the changes are attainable. It's when they try and make it as a part of a destructive scheme to reduce a practice's income, then that's when I don't think it's a good thing. **(GP8 – male, 20 years experience)**

The quote below highlights another example of a perceived cynical move, namely the incentivisation of the patient survey results.

**Participant:** QOF was meant to be evidence-based. So there's a reason for treating someone's blood pressure. There's a reason for lowering someone's cholesterol. We can buy into that. Start putting things into QOF that aren't evidence based but are politically-driven, Start putting patient surveys in which have got no validity, it's not QOF anymore... **(GP34 – male, 20 years experience)**

Furthermore, many prided themselves on gaining full QOF points year on year and such changes were seen as a barrier to this trend.

Many also described making additional investments in their practices around 2004 in anticipation of the additional QOF monies (for further details see section 5.3). Principals also stated that they had had other rising year on year costs e.g. salary increments. They all pointed to a continuing need to maintain their practice income and that continuing to achieve well against QOF targets aided this quest. They related that this need combined with the perception of a worsening financial situation placed them under increasing pressure and almost meant a scenario of 'no choice'. This appeared to extend to them pursuing targets that were not necessarily aligned with their professional and/or personal opinions. Many for example cited that the additions in 2006 of the CKD and depression indicators were not evidence-based; nevertheless most participants reported that their practices were hitting these targets and taking unusual measures to do so:

**Participant:** And then we have this sort of silly situation when you haven't got enough of them. We ended up one year having one of our practice nurses taking a couple of days out to phone people up to ask them if they're depressed or not, out of the blue. I wouldn't be terribly happy if someone rang me up at home for that, really, but that was what was decided had to be done. **(GP50 – male, 19 years experience)**

Only two GPs (GP28 and GP16 from practice 12) reported that they had collectively decided not to pursue certain areas of QOF as they did not consider them to be evidence-based. The quote below illustrates how GPs *do* have a choice but that they must be prepared to sacrifice income, in order to practise in a manner that was consistent with their personal and professional opinions:

**Participant:** So the quality indicators and the quality framework is to try and level the playing field a little bit, and maybe bring it up a little bit. The problem is it is herd medicine...So if you wish to deviate from that because of the individual need it is credibly possible to you. You have complete autonomy to, but there are financial implications to you because of that. So if you feel after consulting with your certain colleagues, looking at the evidence that one part of QOF makes no sense whatsoever. You choose not to do it and you choose to do something else, which may supersede it but is not being scored for, you will not get paid. So you still have autonomy, but you lose income. **(GP28 – male, 17 years experience)**

Participants also expressed concerns and uncertainty for the future outlook of the financial situation in general practice. For instance, there was some concern over the potential proliferation of APMS practices and the threat they could pose. Participants also cited

demands from the wider changes occurring within the health system. GPs were concerned as to how they would continue to manage given the recent lack of increase in finances:

**Participant:** I think that any [work] that is being taken away [by the nurse] is being replaced by just the greater numbers. By the fact that we've got greater demand, greater expectation.

**SCS:** Is that patient expectation?

**Participant:** Patient and political. We're now expected to deal with large groups of people who were treated in hospitals...all sorts of things... So all this is extra work, which means that anything that is freed up by us paying for extra staff or getting extras has been gobbled up. **(GP6 – male, 24 years experience)**

There was also concern as to how they could achieve tighter control of patient conditions in view of the fact 1) GPs cannot control their patients' actions/choices and 2) they were increasingly coming under pressure from PCTs to control their prescribing:

**Participant:**...[we ought] not to be penalized for not achieving because there are other factors into place. A patient might not want to take on board all the lifestyle advice. They might not want to take an extra blood pressure tablet. **(GP36– male, 16 years experience)**

**Participant:** Er, we, we have the tougher target that we try to adhere to and we get er, we get our wrists slapped because we're using too much mm, Atorvastatin as opposed to Simvastatin which doesn't bring the cholesterol below five in most cases.

**SCS:** Right, and when you say you get your wrists slapped, who's, who would be slapping them?

**Participant:** We er, well we get judged on it by all our targets mm, letters and testimonies from the PCT, we have the, we have a visit tomorrow by the management, the Prescribing Management Team to come out and discuss why we're not achieving our statin targets.

**SCS:** But you're trying to do the best, I guess, by the patient?

**Participant:** Well we're doing best for the patients rather than mm, what the PCT tell you ...they just want to save money. **(GP29R2 – female, 31 years experience)**

As a result of the various financial pressures many described making particular decisions which were motivated primarily by finance such as for example replacing staff with cheaper alternatives e.g. outgoing partners with salaried GPs. A small number however were less concerned, stating that even though the financial situation was worsening they were still well remunerated. Some described themselves as financially secure either due to holding other income-providing roles (such as GPs 28 and 16) or because they were nearing the end of their careers and had secured a good income and future pension.

Given that GPs perceived themselves to already be under increasing financial pressures, it is perhaps unsurprising that when asked about a future scenario of a more outcome based QOF, many were extremely negative. The following quote summarises the concerns raised by many GPs:

**Participant** I think one should not bring the payments and the outcomes into this. You have to see the effort. What are the efforts being made? What kind of work is being done? There are so many deprived areas and so many cultural issues, so many educational issues, in which the outcome is not necessarily influenced by the GP. There are so many other factors that come into it. **(GP25 – male, 30 years experience)**

#### **5.2.2.2 QOF and quality of care**

Despite many describing QOF as beneficial in terms of raising the general standards of quality across general practice for the wider patient population, many also felt that it was limited. Firstly, they pointed to the fact that general practice by its nature had a wide remit and that QOF only focused on a fraction of their work.

Secondly, they felt that QOF was limited to only the measurable aspects of their work. They reasoned that this was why QOF was largely based on the undertaking of specific tasks. It also meant that other aspects of their role that they considered as important e.g. being holistic or providing good interpersonal care were not included and hence not valued, by the government at least.

Thirdly, there was also a perception that there were various ways and means of scoring well against the targets and that high QOF scores did not necessarily translate into the provision of good quality care for three main reasons.

First, a 'tick-box' approach could also achieve high scores i.e. targets could be achieved by a cursory approach, one not consistent with their perceptions of what good GP care involves:

**Participant:** what they actually ask us to record, it's just like a tick-box mentality. I mean, in particular, the cancer one is ridiculous. You could spend hours and hours and hours talking to a cancer patient or you could spend five minutes. They just require that you discuss the diagnosis and the management plan. It's just ticking a box, so you could do it proper or you could do it very briefly, and you'd still get the same outcome for QOF. (GP29 – female, 31 years experience)

**Participant:** There are some surgeries who aren't as good as others who can still get good QOF scores. It hides them. (GP34 – male, 20 years experience)

Secondly, many were concerned that the focus on QOF targets meant that some practices were spending too much time and effort on their attainment at the expense of other areas and there was a risk of non-incentivised areas becoming neglected:

**Participant:** I think it's probably improved some care. I'm not sure, because of the emphasis it puts on some conditions, whether it may have improved some cares at the expense of others. I think that would be very difficult to demonstrate, but you just have your doubts a little bit.

**SCS:** You mean because people are focusing so much on...

**Participant:** Yeah. Because if you don't have one of the things that QOF looks at, maybe you get slightly neglected... (GP26 – male, 28 years experience)

However, others were keen to stress that their professional training and role was to attend to all patient needs and that their professionalism would act to combat such an occurrence:

**Participant:** it's just an insult to professionalism. The idea that if you're not a QOF scorer, you don't get through my door or I don't pay any attention to you is not acceptable. And I don't think that there is any evidence whatsoever that that has occurred (GP38 – 30 years experience)

Thirdly, some also perceived that it was possible for people to achieve well on QOF by ‘gaming’ the system. Many did not discuss this beyond recognising the potential for it to occur, or claiming to know of other practices where it did. However, one participant actually discussed changing blood pressure readings which were on the cusp of target levels:

**Participant:** Ah if it's 51 yeah I think you would record that as 50. I mean I suppose if - if the difference between 152 and a 150 makes no difference clinically and it's not appropriate to change someone's medication then you record a hundred and fifty. Erm is that cheating? I don't know. **(GP18 – female, 20 years experience)**

Finally, participants were also concerned as to what the population based approach meant for certain individual patients. Some perceived that it was leading to the ‘over-medicalisation’ of patients, particularly in the case of the elderly who may not want or benefit from medication but are now pushed towards it. They related this to the pull of financial incentives as the quote below highlights:

**Participants:** you have prescribing incentives and you have your statins being prescribed, what sense does it make for somebody who is demented and is 89 or 90 years old, and her cholesterol is six plus or five plus? That also requires prescribing statin because otherwise then I'm losing money. **(GP25 – male, 30 years experience)**

Many felt that this would become an increasing problem as the targets became tighter over time and highlighted the new HbA1c targets introduced in 2009 as being potentially dangerous if they were chased for all patients. They stressed the importance of practitioners utilising discretion with regard to assessing and treating the individual patient in view of target levels. It was unclear whether this would result in targets being unachieved but they highlighted the ability to exception report as an important mechanism to avoid inappropriate treatment.

## **5.3 Practical responses to QOF**

### **5.3.1 Organisational changes**

Despite the fact that many partners held ambivalent views on the changes, virtually all participants (n=39) reported wholly implementing QOF within their practices.

Participants described various changes that had occurred within their practices around the time of the introduction of the new contract in 2004 and beyond in order to respond to the needs of QOF. Three broad areas of organisational change were identified. The first area of change that participants discussed regarded staffing capacity.

### **5.3.2 Staffing capacity**

Most participants reported that prior to the introduction of QOF they had already been doing most of the clinical work required to fulfil the clinical targets. Some principals therefore reported that for their practice QOF simply required additional administrative efforts and therefore recruited additional administrative staff. Others however, *despite* claiming that they were already doing the required clinical QOF work, discussed the need to recruit additional clinical staff (or extend the hours and/or training of some existing staff) to do QOF related work, especially that associated with managing chronic diseases. The vast majority of clinical additions however appeared to be at the level of PNs and HCAs, not GPs:

**Participant:** The healthcare assistant has come in since the new contract.

**SCS:** Why did you make that decision?

**Participant:** Basically because the workload had increased particularly as goes monitoring-wise, with the QOF part of the contract. We needed to do an awful lot more bloods, and awful lot more monitoring of the routine measures. So the combination of that, plus the fact that our nurse had done the diabetes course and asthma course and a prescribing course, we felt that she could move on to something a bit more senior and someone else could do the routine blood pressures and bloods. **(GP9 – male, 20 years experience)**

Where participants had reported investing in additional staff capacity they noted that this had to varying degrees offset the potential financial gains that came with QOF monies. The following quote is from a GP in a small two-partner practice that had extended their PN time and also invested in additional administrative staff which had translated into a large increase in their wages bill:

**Participant:** For us it has cost us. Our wage bill has gone up from £4000 a month in general wages to £6000 a month, and our overall wages bill has gone up to £10000 a month from £5000 a month. It doubled our outgoing wages....Our actual



real term, *my* [participant's emphasis] wage increase has been negated by our wage increase just to make sure that the time spent doing all that crap does not impact on the time at the front desk and things. (GP28 – male, 17 years experience)

It was clear from such accounts that despite the additional costs that such changes represented, many felt that they were essential as they would have been unable to cope with pre-QOF arrangements, particularly in reference to the additional administrative work generated by QOF. In view of such changes, many complained that they had been unfairly represented in the media as having received large rises in their income and pointed to the fact they had in fact invested a good portion of QOF monies back into their practices and services.

**Participant:** We've made quite a significant increase in staff budgets. Our budget's gone up by 25% or something, within a couple of years. Where you get all the headlines, "Your evil GP earns X amount of money, and it's all about QOF money," where, actually, we've invested loads of it back into staffing, as most GP practices have. So yeah, we've increased our staff, definitely, the nursing staff. (GP39 – male, 3.5 years experience)

In contrast to those that had reported making such investments, a small number of participants reported making no QOF associated staff changes, stating that they had already invested in their practices prior to QOF and were doing most of the clinical work covered within QOF targets and therefore could cope with their existing arrangements. Many participants echoed these claims, citing changes as marginal (e.g. only taking on one HCA). Here QOF monies were seen as a much needed boost to practice and partner income.

**Participant:** I think to some extent it didn't overly concern us in this practice, because a lot of it was for things that we had been doing already. I think the majority of GPs who were reasonably clued-in would be watching a lot of these things anyway. As well as the fact that now we would be paid for what we'd been doing for years without pay was seen as a good thing. (GP9 – male, 20 years experience)

### 5.3.3 A focus on skill-mix – altered roles and responsibilities

The second type of organisational changes reported to have occurred in response to QOF regarded skill-mix in order to ensure that work was done by 'appropriate' practitioners within their practices. Many participants highlighted that there was already a trend for

delegating some chronic disease management (CDM) work to their nursing staff prior to the introduction of QOF. However, it was clear from the accounts that the introduction of QOF and the increased work that this entailed in some cases had increased the delegation of work previously conducted by GPs down to their PNs and subsequently a shift of 'nurse work' down to HCAs.

**Participant:** HCAs have taken on basically all of the bloods, whereas the nurses would do those before. And they've taken on quite a bit of nurse work in some respects. The nurse practitioners have taken on some of the doctor work, and the things the nurse practitioners would have done over the ordinary nurses, the ordinary nurse is now doing. So there has been a realignment of stuff. **(GP35 – female, 25 years experience)**

Much of the work that had been delegated down from GPs to PNs was perceived as being template-driven and participants felt that PNs were better suited to such 'task-oriented' work. They perceived that PNs were better at such work as they were less likely to deviate from the templates than GPs were:

**Participant:** [nurses] are doing a lot of the routine stuff, they are doing annual or twice yearly checks for people with asthma, COPD and diabetes and they have been involved, within sort of the guidelines they are managing high BP a bit, they'll refer back to the GP if they get stuck. ...

**SCS:** And what is their approach to the templates in comparison to yours, if any, do you think?

**Participant:** You might expect, nurses are better at it than GPs. Generally speaking one of us will probably have to design a template or tweak it, if it is an existing one, but the practice nurses are better at using them than we are **(GP26 – male, 28 years experience)**

Where increased delegation had occurred, many participants perceived that PNs had become increasingly important within their practices with respect to the doing of basic chronic disease work that comprise the majority of QOF targets.

**SCS:** Has the role of nurses changed with regard to the contract?

**Participant:** They are doing more work...you do feel that they've become a lot more important within the practice, rather than just being used for the peripheral stuff. They have become quite a part of the fundamental part of the work of the

practice. And obviously, regarding a partner's income, that practice nurse becomes worth her weight in gold. Absolutely. Also, when we have discussions about disease management, the nurses are always there. Whereas in the past, you might have had the GPs chatter about asthma or whatever. You have to have the nurse involved in all that. Which I think makes the nurse's position in a practice a lot higher. **(GP2 – male, 4.5 years experience)**

Some also highlighted that the ‘two-tier’ approach to patient care meant that they as GPs were now more able to utilise their skills better as they were spending less time doing simple tasks and more time on the many other aspects of general practice work and work suited to their skills:

**Participant:** It should leave us free to be more diagnosticians. Obviously, the chronic diseases are fairly specific things. There are plenty of chronic diseases that aren't in the QOF and there are plenty of acute conditions that become, not chronic, but have a time in which people need treating. It should leave us free to see those. **(GP45 – male, 25 years experience)**

It also meant that GPs could use their time to use the information collected by PNs within consultations e.g. medication reviews.

**Participant:** We tend to now have people who prepare the ground for us to then see the person, with all the information available to us. Someone with diabetes, heart disease and COPD would see the nurse for all the bloods, BP, urine, full check, spirometry. And then they come back a week later and all the results are back and we go through it from top to bottom. **(GP34 – male, 20 years experience)**

Despite any apparent focus on ‘appropriateness’ of who did what within their practice, it was also clear that many participants regarded the largely template related work now done by PNs as ‘routine’ and therefore undesirable. They also reported delegating ‘disliked’ areas such as the CKD and depression screening work to PNs. The ability therefore to ‘offload’ (GP14) therefore also had personal advantages:

**Participant:** There is a group of patients that just want to see the doctor. It is very difficult to get them to see the nurse. So our nursing appointments for this particular nurse are quite quiet. So we try to work on that and build that up and get her filled a bit better, and try and offload some of our routine stuff to them, which

is fine because I don't want to be doing a blood pressure clinic day in and day out.  
(GP14 – male, 20 years experience)

Finally, in a few cases, a focus on ‘skill-mix’ (a term used spontaneously by some participants) meant the replacement or substitution of some staff of a higher grade with ‘cheaper versions’ primarily using HCAs instead of PNs. For example, GP22 discusses the appointment of a HCA and subsequent redundancy of a PN after the introduction of the new contract:

**SCS:** So, was that at all in response to changes in 2004?

**Participant:** Yes because we found, by analyzing what the nurses were doing, that they were doing a lot of relatively low-tech tasks. For example, routine spirometry, a lot of blood pressure checking. But we cured that by buying a fancy automated blood pressure machine where the health care assistant monitors the results of that not the nurse, because it's not in their... and we pay our health care assistant half what we pay the nurse. And the health care assistant can do ECGs -- we found that nurses were doing ECGs, relative waste of nurse time, and once we started chopping out the things that nurses don't need to do, it became clear that we didn't need two nurses like we used to have (GP22 – male, 23 years experience)

The introduction of QOF therefore prompted increased attention to the notion of ‘efficiency’ within practices, not only in terms of matching roles and skills with QOF related tasks but also to financial efficiencies. A focus on financial efficiencies had in a small number of cases led to the introduction of ‘business managers’ in participants’ practices.

#### **5.3.4 Sub-specialisation**

Many participants described how the advent of QOF had led to increased sub-specialisation within their practices either as a result of PNs receiving additional training in a chronic disease or as a result of newly set-up disease specific ‘QOF clinics’. As described above, some PNs had been sent on additional training courses in order to be able to effectively deal with conditions such as diabetes but also to work ‘autonomously’ within these clinics. Participants perceived that PNs had benefited from such changes as they were able to develop their roles and were perceived as having improved job satisfaction and that patients received ‘better’ care as PNs were ‘specialists’ (who some

perceived knew more than they did about their specialist area) and have more focused time to spend with patients.

**Participant:** Well the nurses can spend longer. With us it is 10 minutes. And if they have got three or four problems it is going to be rushed. The nurses will see them for one problem only, and then call them back and maybe book double appointments if they have got other issues to talk about. So they actually get better treatment time wise with them. **(GP13 – male, 12 years experience)**

In contrast however, some participants perceived that PN-run disease specific clinics were not in fact an efficient use of resources (staff or time) and had scrapped them. They felt that they were better able to deal with a variety of patient needs in one appointment, which also meant that patients with multiple QOF-conditions were less likely to have to re-attend the practice for separate clinics.

**Participant:** Some practices will have a COPD clinic, and they'll come in once a year or whatever, sit them with a COPD nurse for 25 minutes, and she'll do their breathing checks. She'll check their medication. But they might have three chronic illnesses, and they come back to three separate clinics. That's over an hour of appointments, whereas I can do that all in one go. **(GP39 – male, 3.5 years experience)**

Whereas there may be some perceived organisational benefits from sub-specialisation, there were also some resulting personal concerns and perceived losses. Firstly, some participants were concerned about the possibility of becoming 'de-skilled' over-time as they were not regularly seeing chronic disease patients. Others reasoned that whilst this was a concern in theory, in practice, they still saw 'complex' chronic disease patients and that some patients still preferred to see a doctor over a PN and would therefore often book a separate appointment to do just that. Secondly, where PNs were seeing the stable and well-managed patients, this meant that their own workload had become more complex and demanding as GP35 put it, there was less 'light relief'. Thirdly, as a result of PNs increasingly seeing chronic disease patients regularly, there was some concern over losing continuity with their patients, which some perceived made their work harder. Finally, whereas some relished the opportunity to become more specialised, others felt that they were increasingly required specialised and were concerned about losing the variety in their work

**Participant:** Now you're no longer a generalist, you have to know a lot more about lots of other things and keep up to date with it. For example, if you have an interest in diabetes you're just pushed in the direction. And, yes, I do have an interest in diabetes, but I'm not a diabetologist. I don't want to be a consultant diabetologist and therefore you're seeing lots of different patients from other partners because you have an interest in diabetes. And you don't know them, you don't know the family history, you don't know the ins and out, you don't know the personality. They don't know your personality. I think that is a big difference.

**SCS:** Who's doing the pushing then? When you say you're being pushed.

**Participant:** The way we're organized now, in order to make it more effective and financially affective, it has to be structured in that way. So you do need someone who has an interest in diabetes, for example, to run the diabetic clinic and makes sure it's on top of things... (GP13 – male, 12years experience)

### 5.3.5 Internal QOF teams – QOF 'leads' and 'non-leads'

In addition to the type of sub-specialisation described above, there was also another type of specialisation within practices as a response to QOF. All participants described the formulation of internal 'QOF teams' who were nominally responsible for, and focused on, to varying degrees, the administration and the actual 'doing' of QOF related work to ensure that QOF targets were met. These arrangements resulted in participants holding one of three 'positions' 1) an overall QOF lead, 2) a partial QOF lead and 3) a 'non-lead' (Appendix 5 illustrates the sub-set of GPs who held overall lead positions and the participants they oversee within my sample).<sup>o</sup> Whereas the title of non-lead is fairly self-explanatory i.e. they held no nominated responsibility for QOF other than the expectation that they would conduct where possible the necessary QOF requirements on a day to day basis, the other two labels warrant more attention.<sup>p</sup>

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<sup>o</sup> This appendix was a useful analytical tool by allowing the comparison of accounts of those holding different QOF positions. It also affords the reader the opportunity to compare the data displayed in the thesis for participants in the same practice. For example on page 162 the quotes from GP23 and GP18 correspond closely, adding richness and confidence to the findings. Not all GPs are represented however as many were the only representative from their practice.

<sup>p</sup> As section 5.3.5 discusses the composition and range of positions that individual GPs can hold within their practice QOF teams, the GP identifiers are altered here to illustrate this. Subsequent sections in this chapter (5.4 onwards) utilise the standard identifiers employed thus far.

### 5.3.5.1 QOF Leads

#### 5.3.5.1.1 Overall leads: Who are they and why them?

Participants considered the role of overall QOF lead as one which had a large administrative element to it and therefore was considered time-consuming. Subsequently, a small number of participants reported that non-clinical staff, specifically practice managers who did not have clinical commitments and other partnership demands on their time would be most appropriate. In most cases however (n=33), participants reported a GP partner holding the role (as QOF is largely clinical) and seven GP partners in the sample identified themselves as being 'overall QOF leads'. Given that the role was seen as time consuming and additional to normal partner related duties, some overall leads had been given additional protected time. In other cases the GP simply had to absorb the new requirements on top of existing clinical work and other partner duties. In either case the overall leads bemoaned the fact that time allowed fell short of what the work required:

**SCS:** when you were doing the role full time did you have additional time for it, protected time or?

**Participant:** Yeah, erm, not enough! but the idea was that I did have protected time yeah. (GP34R2 – overall lead)

On probing for reasons as to why that one particular individual GP became the lead within the practice, participants reported various factors. The first being voluntarism. As the role was perceived as largely administrative and time-consuming, it was not seen as desirable by many participants and therefore those who came to hold the role simply volunteered.

**SCS:** Was it that other people wanted to do it [the overall lead role]?

**Participant:** I don't know, I think he [overall GP lead 43] was the lone voice. I used to do it when we were a small.., we amalgamated as practices and I used to do it when we were half the size erm but it is quite time consuming and I have other interests and it was ideal really (GP45 - non-lead)

Those that volunteered were also identified perceived themselves as having a particular personality type deemed suitable for the role as the following quote illustrates:

**Participant:** I quite like the number crunching, having done a PhD, a PhD in physics. It's quite nice looking at it, you do some changes and then you see what it is the next day. It's almost like a bit of research to be honest. It's an audited, number crunching proposal, which you sort of get satisfaction from. Even if you got no money from it I quite like doing it, because I'm a bit of a nerd as far as numbers are concerned. **(GP5 – overall QOF lead)**

Another lead GP, (GP34) described himself as having an 'obsessive nature' and was similarly described by another in his practice GP37, as someone who likes 'micro-managing numbers'.

The second factor in choosing a GP lead was that the overall lead came to the role as they were perceived by their colleagues (and themselves) as holding a particularly suitable 'prior partner role' within the practice, (such as being 'the business partner') and/or thirdly that they held particular traits and skills that would make them suitable to perform the role. In particular, participants related that the role required good ICT skills. Most overall leads were perceived as being the most ICT literate within the practice) and those who occupied such roles also identified this as a key factor in their 'appointment'.

**SCS:** I understand from the last interviews that you are the overall QOF lead for the practice.

**Participant:** Yes.

**SCS:** How was it decided that you would take on that role?

**Participant:** Erm, I've always been more of the, sort of the computer partner in terms of setting up templates and doing searches and things like that...and it just sort of tended to come my way erm, from the outset. **(GP34R2 – overall lead)**

#### *5.3.5.1.2 Overall leads: the role and remit*

All GPs overall leads were clear that their role was focused on the monitoring and administration of the *clinical* aspects of QOF and that the administration of *non-clinical* elements was the responsibility of their practice managers. Despite this similar remit, the amount of work and responsibilities varied amongst leads. Part of the variation in the lead role was as a result of the amount of delegation of QOF tasks and responsibility by the leads to their fellow practice staff. Some leads appeared to take the overall lead role and



did not delegate or devolve sub-clinical areas for other practitioners to be responsible for. They therefore have the sole responsibility of attempting to monitor and deliver all the areas of QOF in order to attain a good practice QOF score.<sup>9</sup> Other leads however delegated areas of QOF to their practitioners, who were then responsible for the day to day management and QOF work within that area, with the lead retaining the overall monitoring role. The role and responsibility of a lead therefore appears to be contingent on the locally chosen managerial approach. Where delegation was the chosen approach, it was usually done by the lead identifying and matching QOF area(s) with the individual practitioners' areas of interest or expertise:

**Participant:** The practice nurse has some clinical areas where she is responsible, I have some that I'm responsible for, and Doctor [name] has some that she's responsible for and they tend to be towards what we mostly do, so mine are epilepsy and mm, some of the, mm, the heart stuff and Doctor [name's] is the depression and the things like that. And mm, and they we, and so, so then we share the tasks. (GP28R2 – overall lead)

Although there were variations in the overall level of responsibility, there were some common features. All overall leads spoke of a need, in their role, to be aware of the annual changes happening within QOF and therefore acted as the practice “information lead.” In order to attempt to assure that their practice achieved well against the targets, they had a responsibility to not only be aware of the informational changes to QOF targets, but also to ensure that they passed on those changes to the rest of the staff via their ability with and control over the IT system:

**Participant:** Certainly I've tended to find that you know myself and [his GP partner] would be at the beginning - the head of the game because we would be making sure we're finding out and learning, and then we would be pulling people to catch up with us. And obviously we'd still be learning, you know, and we'd be finding out how to get to - even now, with the new QOF thing for depression, having to do a second HAD [Hospital Anxiety and Depression] score you know six to 12 weeks later, whatever it is, you know. We've all found that we've not really been able to keep up with that so we've all had to kind of encourage each other and bring it up on the meeting. So we've all been guilty on that one. So yeah, new - new things kind of takes a bit of time to kind of catch up with and get

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<sup>9</sup> In their R2 interviews, overall leads GP43 and GP34 reported reducing their overall lead commitments by appointing deputies (e.g. in case of GP34 it was GP32) as they no longer wanted sole responsibility for ensuring QOF success.

used to working like that, but once that happens it becomes your routine. (**GP2R2 – overall lead**)

Even though they identified the need for their role as ‘information leads’ and the difficulties and extra workload that annual QOF changes can bring, some also highlighted (as in the extract above from GP2) that once the initial system had been implemented, annual changes were comparatively easier to deal with and once in place they eventually become routine to practice work.

Finally, as they were usually the most ICT literate they were also ‘data leads’. This meant for example that overall leads would be responsible for ensuring that the templates used for data collection were fit for purpose and accurate by for example reflecting changes in QOF requirements. The quote below highlights the reliance of other practitioners within the practice on their overall lead:

**Participant:** And so we had one fairly recently about erm, you know, we need to ask patients about LARC [Long Acting Reversible Contraception] erm, so erm, and then when they come to add, change the templates for the letters etc he [the overall lead] lets us know as well. (**GP9 – non-lead**)

As data leads, such participants would also be responsible for the data monitoring, analysis and dissemination of that data analysis. Overall leads spoke of this aspect of their role in terms of monitoring progress against QOF targets and communicating that progress to the rest of the staff. The implementation and subsequent importance and the perceived impact of the role of ICT with regards to QOF work was discussed at length by many participants and is discussed in detail later.

#### *5.3.5.1.3 Partial leads*

This second group of GPs are also defined as ‘leads’ in the sense that they are also responsible for delivering QOF, but their individual focus is much narrower as they are responsible for delivering the results specific to their nominated area(s) of QOF. Sixteen of the forty one GP principals all described themselves as being nominally responsible for the delivery of their QOF areas (s) at QOF ‘year-end’ and are therefore classified here as ‘partial’ QOF leads. Some of these had an additional overall QOF lead whereas others

did not; however, all described being largely free to decide how to organise their own QOF related workloads.

Partial leads came to be responsible for their areas either via delegation from the overall lead or they simply divided it up amongst themselves. In either case most partial leads came to be responsible for areas in which they held particular clinical expertise or interest and for which as the GP below puts it they were ‘ultimately responsible for’ delivering:

**SCS:** Is there a sort of overall QOF lead ....

**Participant:** Yes, yes there is, one of my partners is a QOF lead but we got allocated certain areas to each partner and we are ultimately responsible for those areas. **(GP29R2 – partial lead)**

Whereas in most cases, GP principals acted as partial leads, some participants reported that salaried staff also held partial lead responsibilities. In the case of two overall leads (GP28 and GP2) they had delegated some areas of QOF to their salaried staff, a PN and salaried GPs respectively. Both referred to a perceived need to share the workload:

**Participant:** The practice nurse has some clinical areas where she is responsible, I have some that I’m responsible for, and Dr [name] has some that she's responsible for and they tend to be towards what we mostly do, so mine are epilepsy and mm, some of the, mm, the heart stuff and Dr [name’s] is the depression and the things like that. And mm, and they we, and so, so then we share the tasks. **(GP28 – overall lead)**

**Participant:** what I've done is I've decided, right, well, it's coming to April. We need to just check all the final bits. So I've dished out QOF areas to everybody so that we're not one big burden. **(GP2 – overall lead)**

The delegation of QOF areas to salaried staff was by necessity in the case of GP28 who worked in a small two-partner practice in which both partners were part-time. In contrast, GP2’s decision to designate his salaried staff as ‘partial leads’ appeared to arise from a need to ‘encourage’ them to attend to QOF elements:

**Participant:** I mean obviously myself and Dr [name] are the partners so we've got a quite a strong vested interest in making sure the QOF points are up. So erm, you

know, we've two salaried GPs and the practice nurse. So obviously they do sometimes need kind of encouraging [them] to be part of it...So we do distribute it evenly amongst the different people. And also just to raise the awareness of the requirements of that - of that area so people will start learning right, for epilepsy, if I see someone I know to make sure that I ask when their last fit was or, you know, for CKD make sure that they've had their last urine test and stuff like that. **(GP2R2 – overall lead)**

Although some partial leads were nominally responsible for their areas of QOF and this meant they were also doing most of QOF work in that area, for others the role simply meant overseeing QOF related work that the PNs or HCAs were doing:

**Participant:** You delegate what you can but you still have to have a doctor with an input into what's going on, really. So we have a lead GP for each of the areas, but you know, where possible, you get nurses to do it. So you have hypertension diabetes, whatever, I mean, we have nurses that run those clinics anyway. So they do produce quite a lot of the work, but you still have to have a doctor sort of keeping tabs on what's going on **(GP1 – partial lead)**

#### **5.4 The role and impact of ICT**

As highlighted previously, participants claimed to be doing the most of the clinical work required by QOF targets prior to 2004 and as a result many identified that the *most* significant change as the introduction and use of ICT. Participants described the initial ICT implementation phase and/or changes to the existing systems as a particular period of upheaval which required substantial additional administrative time and effort:

**Participant:** It was just data entry. All it was making sure that you read-coded with the right read codes. That's all it was...We had no problems. It was just data entry was the only issue. We weren't read coding properly...So we had to spend a lot of time, and that's where we invested in our administrators and our summarizers, to try and look at all of that for us and bring the notes to us and sort out the read codes and sort out the registers. **(GP13 – male, 26 years experience)**

Given that the ICT systems had been in place for approximately 4-5 years when participants were interviewed (and that previous research had examined this at a much earlier stage), I was keen to explore whether participants felt they had since adapted to the systems and what repercussions, if any, there were from these changes. It became

apparent from the accounts that the ICT systems were perceived as having both positive and negative effects.

#### **5.4.1 ICT: enabling and demanding a systematic approach to care**

Most participants perceived that the new ICT systems were beneficial for their practice population in a two-fold manner. First, the systems were perceived as improving patient records via the regular and repeated collection of accurate data aided by standardised templates. As a result participants felt they were now more able to audit and structure their work more effectively and that this had led to improved care:

**Participant:** you can see who is and isn't erm having appropriate treatment at the touch of a button instead of having to do a fairly long-winded search and then trawl through the list of patients. So I think the biggest change has been how easy the IT is and you can have alert on every patient afterwards that need a little thing doing, which I think probably it's the IT that's improved the patient care. **(GP18 – female, 20 years experience)**

Secondly, many QOF indicators required repeated measurements to be taken from patients and resulted in new patient call/re-call systems being implemented. Consequently, participants perceived this to be a positive development as this meant that fewer people 'slip through the net'

**Participant:** I think it's more when they look at recall and that side of it, there's some benefits. Less people slip through the net than used to happen. It used to be relying on the patient for having some responsibility for their care, whereas now we're very much responsible for it. We will make sure you have this test done. We'll make sure you've done that...before if people had diabetes and they didn't turn up, we often didn't chase them, which was bad in a way. In some ways, you've got to say, "That's part of the contract between doctor and patient and they should take some responsibility." **(GP6 – male, 24 years experience)**

Whereas the standardized call/re-call systems would mean that fewer patients would 'slip through the net' their rigidity also had negative implications as, patients with multiple QOF related diseases were required to make repeated visits to the practice, particularly where practices had disease-specific clinics. This was perceived by some as not only inefficient for the practice and the number of appointments that such patients required, but also inconvenient for patients who prior to QOF may have had more choice over when to

attend. Finally, some related that demand had increased as a result of the formal systems and the target system:

**Participant:** ....some of the quality markers about when you bring patients back and how often you bring them back, we do set our prescriptions up and other things around those, like the nine month and the twelve stuff and then what happens is, if a patient's come in the middle, you...it can be the wrong time for you... Mm, with QOF you tend to bring them back again because, because if it's inside the nine months you want, you want to see them two months later to be able to get it inside the next nine months. Mm, and that's, without a doubt, has increased our appointments and made patients feel we're a bit weird I think sometimes. **(GP28R2 – male, 17 years experience)**

The quote from GP6 also highlights another perceived change. He states that the new QOF systems were positive for patients as GPs now had greater responsibility for ensuring their patients received the necessary care. A small number were concerned that patients were now less able to exercise choice regarding management of their own conditions reducing responsibility for self care:

**Participant:** I've always felt some sort of responsibility should be given to the patients, that they should take care of their own health. It's a partnership. That's the way I view it. At the moment, it's more the doctor chasing them, which is wrong. I mean, nothing is wrong, but that's the way I feel it. **(GP4 – male, 32 years experience)**

Whereas many regarded increased data collection as beneficial, they felt it should be collected for a useful purpose, but some areas of QOF seemingly required 'unnecessary' data of little benefit for patients. Smoking indicators were an example frequently cited:

**Participant:** Having smoking data on everyone. Yes, that is very good health promotion, but health care for individuals what do you do with that information when you've got it? And theoretically, QOF isn't saying we want you to do anything with it. We just want you to collect it...QOF is very good, I suppose, in a way, on a population basis, but if you're looking as an individual, it's not that great sometimes. **(GP17 – female, 2 years experience)**

#### **5.4.2 ICT as surveillance**

As, described in section 5.3.5.1.2 those who were QOF leads within their practices, in particular overall leads (see Appendix 5 for those overall leads in the sample) also had a

responsibility to monitor QOF progress. They described regularly accessing the population manager system to identify deficient areas. As the extract below highlights, the data generated by the ICT system allowed for the identification of indicators that were below target levels, and these were often areas that practitioners did not like or felt were lacking in an evidence-base:

**Participant:** Yeah, yeah. I might as well speak to a brick wall sometimes but you know yes that's the way of it.

**SCS:** So do you like that aspect of your role? Is it something that works for you or do you just.....?

**Participant:** Its fine if I do it, bearing in mind its - that's fine, its getting people to do things because they're not terribly much in agreement with in terms of evidence based medicine. (GP22 – male, 23 years experience)

The system however could also be used to identify individual staff members whose performance was failing to meet the targets:

**Participant:** It was interesting because everybody thinks they're perfect and when you start looking at it, you realize that nobody's perfect, but some people are more imperfect than others. And there were a couple of things - you start going through that list of people who've missed one parameter and the same name keeps coming up. (GP34 – male, 20 years experience)

In addition to monitoring their own areas of responsibility, some partial leads appeared to extend this remit to monitoring to the work of other partial leads. In addition to the overt monitoring that overall leads conducted, there was also the possibility of both overt and covert monitoring by other partial leads:

**SCS:** When you say you have your own areas, do you do your own monitoring of the progress yourself within the area?

**Participant:** Yes I do, I keep an eye...fairly frequently on various bits of the system, certainly the bits I'm responsible for and sort of half an eye on other bits cos it's interesting to see where the problems are (GP26 – male, 28 years experience)

It became apparent that all participants were aware of the fact that ICT had made their QOF related work and performance regarding QOF targets visible:

**Participant:** within a practice, especially a large practice, ours isn't that big. But, for the large practice the doctors now can't hide and do their thing. They are accountable. Everybody is accountable to everybody else. The audit trails show that ...So, there is less room to hide for either under performance or over achievers. **(GP15 – male, 25 years experience)**

They were also aware that their individual actions (or rather lack of) could now impact directly on each other and that the demands of QOF required an increased team effort:

**Participant:** it's made us work more together as a practice. Prior to that, the way we operated we had more individualistic lists, whereas that's gone now. We all see each other's patients, and the assignment of a patient to a particular doctor doesn't really seem to make any difference to who they see. I think it's just made us generally operate much more as a team, because the entity that has to jump through all the hoops is the practice, not the individual doctors...we were operating much more individually before. **(GP50 – male, 19 years experience)**

Despite being aware of the visibility of their individual contributions, many participants were aware that within their practice, some practitioners were not as engaged in meeting QOF targets as others. Indeed some participants 'confessed' that they were not as enthused about the targets:

**Participant:** We all should be doing that in our respective areas, but speaking for myself, it's not something that I keep up with.....

**SCS:** But, you are still doing well as a practice?

**Participant:** Precisely. I think, it would be different if we weren't. Then, I think I probably would take a different attitude. So, I guess, I'm leaving it up to others. **(GP27 – female, 15 years experience)**

The introduction of ICT and the new ability to monitor each other's work therefore had the potential to cause issues within partnerships. Whilst participants acknowledged the potential for issues to arise, many did not feel that it worth causing any arguments over as disparities in effort were often not considered wide enough to address and cause bigger



problems within established partnerships and/or they perceived that people contributed to the practice in other ways as the extract below highlights.

**Participant:** Certain partners, if the alert comes up -- the BP or the smoking check -- they'll do it. Certain partners will. They just find they're busy enough to do [snaps fingers]. Which is understandable, really, with all the rest they have to do.

**SCS:** How's that managed, then? That sort of...

**Participant:** You have to be careful how you talk about it.

**SCS:** Yeah, exactly. Is it sort of done on an individual basis?

**Participant:** It's encouraged. We have a QOF meeting twice a year, and everyone is asked to do what they can. And pointed out what was short. As we're hitting the targets anyway, you know. That's the same with a lot of partnerships. People pull their weight in different ways. They're liable to be doing something else when they're not doing that thing. Otherwise all partnerships would split up. It's put partnerships under a lot more pressure, that sort of idea. **(GP14 – male, 20 years experience)**

In the case of participants from one practice, the overall lead described how formal legal measures had been taken to protect the interests of each partner in the event that one or more failed to contribute fairly.

**SCS:** I think there's been a worry, obviously with it being in practice-level contracts, that some people don't of pull their own weight.

**Participant:** The partnership agreement actually does cover that now. If someone is shown to systematically not pull their weight, then they can be financially penalized...It was something the new partnership lawyers introduced. It's never been to blows, but it's a good idea. **(GP34 – male, 20 years experience)**

Whereas such measures could be seen to be effective for GPs in partnerships, they do not of course apply to salaried staff who were deemed by some as being somewhat less motivated than principals when it came to attending to QOF. In an attempt to engage their salaried staff, some, as highlighted earlier, had designated their salaried staff as partial leads. Others however chose to boost the motivation of staff by offering a financial 'QOF bonus.' Although many participants had offered this in the first year and perceived that it had been an effective motivator, many had now ceased to offer bonuses for one of two reasons: they perceived QOF work as now routine general practice work and therefore

should be treated as such; they felt unable to, in view of the perceived worsening financial situation.

In addition to such tailored measures, there were some commonly employed tactics utilised by leads in order to attempt to motivate and direct practitioner activity towards the targets. QOF leads appeared to frequently utilise a form of ‘peer pressure.’ They chose the ‘public’ forum of practice meetings in order to communicate areas of QOF and therefore often by implication the practitioner(s), who were under-performing. Some adopted a subtle approach by simply presenting the data which they felt spoke for itself in terms of motivating those who needed to up their game:

**Participant:** we can see on pop[ulation] man[ager] where the gaps are and actually which patients are needing to be reviewed and where the clinical issues are and there’s a GPs name alongside that, it tends to become fairly clear to everyone and I find just by repetition and by demonstration in front of everyone of where we are and that I get the message out... **(GP23 – male, 14 years experience)**

In the case of GP23, this tactic appeared to work as one of his GP partners (in an all partner practice) describes in the following quote that she doesn’t want to be the one singled out as not contributing:

**Participant:** we’re so small we - we - it’s almost like if you see your name there you think, oh! no I need to go and sort that out. You know I don’t want to be the one that’s got - you know stopping it happening you know, the case you think oh gosh that’s my patient I’ have to look in and see what’s going on. **(GP18R2 – female, 25 years experience)**

Other overall leads however did not employ the subtle approach adopted by GP23 and adopted a more punitive style where they actively ‘named and shamed’ those not up to standard. A small proportion of those who were on the receiving end of such measures reported that they made little difference in changing their behaviour:

**SCS:** Some practices, they're naming and shaming people. Again, it's just interesting how practices have organized themselves to cope with the same demands....

**Participant:** Yeah. I believe I've got emails or Power Point of the lead tables of who we caught [not doing the] smoking or whatever. But it doesn't make any difference. (GP52 – male, 19 years experience)

In contrast to GP52, most participants described themselves as being on-board with such measures and doing whatever was necessary as they as it was to their collective benefit that targets were met.

Overall leads appeared to be aware of the burden that the perpetual *doing* of QOF caused as well as the extra effort required around QOF year-end when QOF-related activity within the practices appeared to be cranked up. In response to this some of the overall leads allowed for a 'QOF holiday' where they did not pursue colleagues over QOF targets:

**SCS:** Aha. And what are people's reactions when you know you're sort of having to remind [them regularly]?

**Participant:** brow beaten. We give them a couple of months off QOF a year but otherwise its sort of, 'oh well, okay yeah fine.' (GP22 – male, 23 years experience)

In addition, participants from one practice (ID22) had also structured their surgeries so that they had a combination of appointments and were not just doing a series of routine/repetitive QOF-related appointments e.g. medication reviews.

### **5.5 QOF and the consultation: concerns, consequences and solutions**

Whereas participants often claimed that the introduction of QOF had made little difference to the overall type and quality of care that they provided within their *practices*, many perceived that it had impacted on them personally in terms of the substantive aspect of their daily work i.e. conducting patient consultations. In order to provide some context, I asked participants to estimate the proportion of their consultations that were in some way QOF-related. The answers varied widely from 10% to 50% and although these estimates may not be accurate, they serve to illustrate the variation in QOF exposure that could arise as a result of for example, variation in the degree of delegation to PNs. Regardless of the estimates however, participants reported many similar concerns.

Prior to the advent of QOF, participants described how they were able to concentrate solely on the presenting needs of the individual patient. Many perceived however that this had become more difficult post-QOF. They described QOF as a ‘new agenda’ to consider within the consultation process and one which was often not aligned with that of the presenting patient’s. This posed an issue for some participants who felt that they were less able to practice in the manner instilled in them during their professional training:

**Participant:** I suppose I was anxious, and continue to be anxious, to some degree, that the focus on my agenda, when patients come to see me, is a big of a shift from when I started in practice. My training was all about eliciting the patient's agenda and pursuing and following that, and enabling them to sort of clarify what it was that they had come about. We still do that, but there are increasing elements of us having our own agenda, which may actually be quite distant to and different from what the patient has at the top of their list. **(GP23 – male, 14 years experience)**

The quote above also highlights what others described as a ‘discomfort’ when attempting to attend to QOF by asking patients to answer questions which were ‘inappropriate’ or seemed unrelated to what the patient was attending for and left many wondering how their patients interpreted such occurrences. When asked whether they thought patients had noticed a difference in the consultations, responses were mixed. Some reported that patients had not noticed a difference or at least had not commented on it to them, whereas others said that patients had commented on the fact that they were now being asked such questions as they were aware that this is how GPs were now paid.

The issue of competing agendas was highlighted by many and was exacerbated by the fact that the majority of participants had limited time (ten-minute consultation periods) to work within. In order to alleviate such QOF related tensions/pressures, 3 GPs in the same practice (ID13) reported increasing their consultation lengths (to approx. 12mins). These participants however were extremely unusual and most GPs still had their pre-2004 ten-minute consultation slots. These participants also described how QOF created additional, largely administrative work (e.g. recording data) which somehow had to be absorbed. This appeared to translate into the perception that the consultation was more pressured and had created new tensions and dilemmas over how to address the competing agendas. The

decision over which to attend to has different consequences as the second of these quotes highlights:

**Participant:** It does put us under a lot of pressure because the patients come in with their agenda, I look at the computer, the computer reminds me about all the things that we still haven't done on this patient. So, we're coming to two agendas which may actually be pulling us apart...and of course, that ends up with a certain amount of conflict. You either do it, or you don't do it. If you do tend to do it, it means that the 10 minute appointment is now being rushed because what you want to do, what I want to do, may take five minutes. And now obviously you're down to five minutes with the patient's agenda. That puts you under pressure. **(GP5 – male, 13 years experience)**

**Participant:** So that, you know, the patient might want come in and discuss the rash on their big toe or the fact that they're depressed, and actually you've got the hypertension review, the blood pressure due, HbA1c due, have had their eyes checked. And you're also thinking, well, what do I deal with? because you're aware that if there are these things flashing and you don't respond to them, then the practice loses income. And I guess you can be judged by your colleagues or in this case my GP partner and the nurse, as not doing my job properly. **(GP16 – female, 18 years experience)**

Many purported a desire to continue to practice in a manner they felt was in line with their professional training i.e. to put the patient's needs first. This preference however was seemingly in contrast to how the ICT systems they used were designed and functioned within the consultation. Participants described how various pop-up boxes would appear on opening a patient record that immediately drew attention to the outstanding QOF requirements for that patient. This appeared to shape the process of the consultation some:

**Participant:** we're on the EMIS system, so when they come in the population manager screen pops up and says smoking, blood pressure, X, Y, and Z. The problem with the system is that disappears as soon as you start the consultation. So you've either got to scribble down this list and try to remember it, or grab the patients and say, "Quick, before we do anything else, we've got to do X, Y and Z." **(GP9 – male, 20 years experience)**

A small proportion reasoned that many of QOF requirements represented good care and that they could be of greater importance than the patient's presenting needs.

Consequently, they described attending to QOF first, and perceived that this was best for the patient, regardless of whether the patient ‘liked’ them for it or not.

Although many described having a computer within the consultation room prior to QOF, the new requirements of attending to QOF pop-up boxes and templates appeared to increase the presence of the computer within the consultation. Many described how this translated into them having less eye-contact and time to talk with their patients, both factors that were important to their role:

**Participant:** Yeah. Medicine is like a second-hand car salesman. I'm watching the eyes, I'm watching to see whether people are lying to me. I'm going to throw out suggestions and watch their facial reaction. I'm actually, literally playing... I would liken it to being a second-hand car salesman. I'm looking for weakness, I'm looking for truth, I'm looking for tips to get the answer, and anything that actually distracts me from doing that is actually going to make me less effective at what I'm doing. It's as simple as that. **(GP37 – male, 16 years experience)**

In addition, the pressure of needing to fulfil the requirements of QOF in combination with limited time and the design of the systems in them becoming more ‘QOF-focused’ over time, i.e. consultations were becoming more doctor- rather than patient-centred. As the quote from GP35 puts it, the strains of attempting to meet QOF at times meant that ‘you don’t always see the person as a human being’

**Participant:** One of the problems with this sort of target-based culture and external pressure is that we've lost a little bit of the holistic type of medicine that I, as an old-fashioned sort of GP, like and I think patients like... To a degree, we're so busy with a consultation, trying to make sure that you've ticked all the boxes so that you can prove you've done what you said you've done, that you don't always see the person as a human being, if you like **(GP35 – female, 25 years experience)**

In the following quote, the GP not only highlights how one colleague in his practice is known for adopting this QOF-focused approach but that he had also experienced this first hand when attending another practice as a patient:

**Participant:** We've got one particular doctor in our practice who, sometimes the patients will mutter that they came in with a problem and all he did was ask a bunch of malarkey and take their blood pressure, weigh them, and they actually

didn't really get a chance to address what their problem was. That's definitely happening, and from my own point of view as a patient, when I went to my GP a little while ago, there was a locum there and I think he was under strict instructions. I went in to ask if I could see someone about my dodgy knee, and as soon as I sat down he said, "Oh, my God. We haven't checked your blood pressure! Put your arm out." (**GP50 – male, 19 years experience**)

Others reported that whilst this was a concern, or that it may be the case when it was approaching QOF year end, they felt that for the most part they were still putting their patient's needs first.

Given that the ICT systems had been in place for a number of years, many felt that their practice had largely adapted to the new ICT way of working with phrases such as 'ticking along nicely' being used. Many also described how they had become accustomed to weaving in QOF elements to their consultations by working in a flexible manner. They described judging each individual consultation and then adopting an opportunistic approach to fitting in QOF. Where they were unable to fully attend to both agendas, participants stated that they simply asked patients to re-attend.

**SCS:** I mean in terms of the computer, obviously, you've got the patients here and the computer there, and the computer's asking you for various bits of information. Yet, the patient's come in with their own agenda of - how do you sort of manage that?

**Participant:** Again, a case-to-case basis because they're coming for a simple cough and a cold and or for a pill check or whatever doesn't take you very long. Fine, then there's maybe a couple of things that you can do and that meantime, the smoking or the blood pressure. (**GP43 – male, 12 years experience**)

Whereas many participants highlighted the new concerns and issues described above, some felt that QOF and related ICT had in fact made their consultation work easier. They perceived that the templates were a useful 'aide memoire' and helpful guide:

**SCS:** So you feel like you've absorbed it all into your consultation routine, if you like, when someone comes through the door?

**Participant:** You kind of know what you're doing, you know what questions you have to ask, you know what test results you're looking for, you know what levels you have to achieve, that you're striving for. So it's certainly easier. (**GP36 – male, 16 years experience**)

In contrast however to QOF being perceived as helpful some perceived that the addition of another set of 'rules' merely served to cause confusion over which set of rules to follow. Participants commented on the disparity between the targets levels in QOF and those in other guidance:

**Participant:** Yeah. I mean, it is really confusing that there's no kind of consistency of guidance and I suppose, thinking about things like hypertension, particularly, and coronary heart disease risk, there's no consistent national guidance as far as I can see. (GP23 – male, 14 years experience)

Whereas some simply stated that any rules ought to be followed and adapted in light of the individual patient, others resolved any dilemmas that the disparities may cause by choosing to follow other guidance in preference to QOF, reasoning that it was more stringent and that one would hit QOF targets along the way anyway.

Finally, in addition to the general concerns regarding the addition of QOF, it was also clear that some aspects of QOF were considered more problematic within consultations than others. One area in particular that was disliked and perceived as difficult to accommodate within consultations was the requirement to use depression screening/assessment tools. The addition of such 'tools' was perceived an insult to their professional knowledge and that the fact that they felt they had been effectively diagnosing and managing the condition prior to 2006 when the tools were introduced. In addition to these 'professional objections', some also felt that the tools were amongst other things time-consuming, cumbersome and therefore impractical to build into a consultation, especially such a sensitive topic. However, they also felt under pressure to use them otherwise the practice would lose income. Many therefore reported simply doing it as a paper exercise but that in practice it had not altered the way that they personally diagnosed and managed the condition:

**Participant:** if somebody is mildly depressed, they're a 7, if they're moderate, they're 14, if they're bad they're 21. And really, I want to make sure they don't kill themselves while I'm sorting it out. What their score is academic! Do you know what I mean?

**SCS:** So you find it annoying that you have to do it?



**Participant:** No! All I do is intelligently bypass it. If I think something is wasting my time, in terms of getting through to the crux of what needs to be done for somebody, then why waste my time doing it? I'll fill the box. If I you want me to fill a box, I'll fill a box. I feel I'm bright enough to fill a box so nobody would know the difference, but I'll do it my way and I'll hopefully do it with the patients' best interest at heart. **(GP37 – male, 16 years experience)**

A few however felt that the addition was positive as they highlighted that depression was under-diagnosed whereas others were concerned as to what increased diagnosis would mean for demand on a system which already had inadequate resources. Finally, some participants, who initially disliked the tools, appeared to change their view over time as they found that patients liked them:

**Participant:** I use a PHQ9...I started to realize that patients are quite keen. I've had quite a few who were quite keen to take them away, and they actually check them and use them as a monitor of themselves and that's not what's in the guidelines. It's not how you should use it. But it's how patients sometimes find they're useful. And that was quite novel to me. I think GPs use what's given and modify in a way that suits them. And certainly I've sometimes found it's been useful for patients to say actually, "You are quite bad." Or maybe it's not that bad. ...So I have mixed feelings about PHQ9. To some extent, I feel deskilled in my routine questioning. But on the other hand, I've seen some patients benefit from it and use it in a different way. And seeing us score them, and getting them to think it's dropping and they're getting better can be quite useful. So I was quite surprised at that. It wasn't what I was expecting. **(GP18 – female, 20 years experience)**

## 5.6 Summary

The accounts of GP principals were largely ambivalent and reflect the fact that many saw the contract as an evolving 'package deal' which had both good and bad points, with the latter increasing over time.

The initial 2004 contract was well-received and GPs cited various benefits arising from it for both themselves and their overall patient population. They felt rewarded for providing good quality care and they perceived that the direct link between finance and clinical activity had led to the standardisation of *clinical* care for patients with the incentivised conditions. Furthermore, the financial incentives were directed at areas considered to be of clinical importance and for the most part rewarded what they considered to be evidence-based practice i.e. the goals of QOF were largely aligned with their professional

aims of providing high quality care. Despite these gains, many cited QOF-induced changes as detrimental to their personal relationships with and/or ability to focus on the substantive element of their work i.e. individual patients. However, much of the perceived negative consequences had seemingly arisen from the way participants had implemented QOF.

Participants reported undertaking similar actions within their practices in order to maximise the efficient use of their practice resources and importantly the probability of meeting their QOF targets. As a result the approach to patient care (for the conditions included in QOF) was now highly structured and resulted in patient care becoming increasingly fragmented. Whereas some of the internal changes were a continuation of those already happening prior to QOF, others arose specifically as a result of QOF, including the development of QOF 'teams.' The purpose and function of this sub-group of practitioners is to scrutinise and direct the work of their practice colleagues in relation to QOF targets. As a result, many related that they were now working in a less atomistic manner but for the most part this was not seen as a negative.

Finally, the issue of finances was something of a recurring and significant theme within the account of these participants. Many described how post-2004 versions of the contract, in effect, asked them to do more work without recompense that was not necessarily in line with their professional opinions. However, rather than reject those areas that were not in line with their professional or personal opinions, the vast majority of participants reported pursuing them. They reasoned that they were in a position of increasing demand on practice finances and that in the face of a worsening financial situation they had 'no choice' but to comply.

## Chapter 6

### Exploring the impact of contractual change: the views and experiences of salaried GPs

#### 6.1 Introduction

As highlighted in chapter 3, only two studies have attempted to ascertain the views and experiences of salaried GPs directly post-2004.<sup>230,231</sup> Of these, one focused primarily on the educational support needs of ‘sessional’ (locum and salaried GPs) and does not discuss salaried GP work specifically in relation to the contract and/or QOF.<sup>231</sup> The other study reported the post-2004 experiences of salaried GPs as far less positive than their principal counterparts who reported positive changes to their working lives.<sup>230</sup> The evidence suggests that salaried GPs experiences are dependent upon their principals,<sup>230,231</sup> specifically regarding the type of work they were allowed to engage in with many being delegated ‘the left-over or discarded jobs, mopping up the less complex and perhaps less professionally satisfying or challenging work.’<sup>231(p914)</sup> These findings are in contrast to an earlier study who found ‘early-career’ salaried GPs (interviewed early in 2004) as reporting high job satisfaction and doing what they considered to be ‘nice-work.’<sup>232</sup> Although this latter study did not explore the views of the eighteen participants specifically in relation to the new contract, the difference in findings appear rather drastic given the relatively short intervening period. In this chapter I hope to shed further light on the diametrically opposed findings of these studies by providing an in-depth analysis of the attitudes and working experiences of 21 salaried GPs in relation to the nGMS.

#### 6.2 Attitudes to, experiences of and consequences: contractual change

In contrast to GP principals, most of the salaried GPs (n=13) had in fact *only* worked under the post-2004 arrangements. They therefore obviously had no basis for comparison to perceived differences in ways of working pre- and post-change in 2004. In addition, these participants had also not been in a position to vote either for or against the changes they now work under. Despite these differences, and the differences in status between the two groups the attitudes of salaried GPs to the overall structure and content of the contract as well as QOF showed many similarities to their principal counterparts but with some

notable exceptions. Accounts were again largely ambivalent with most perceiving that where gains had been made in one area, they also translated into losses in others.

### **6.2.1 Contractual change: the gains**

As well as asking for their unprompted attitudes towards the new arrangements, I was also keen to assess whether any of the gains identified by GP principals were similarly perceived by salaried GPs. For example in the previous chapter, most GP principals cited the two main advantages of the new contract as 1) their new ability to opt out of providing out-of-hours care as they found the old system ‘unsustainable’ and 2) the increased monies on offer as a result of QOF. In addition, they felt that these factors had in-turn, positively impacted on recruitment into the profession. As a large proportion of salaried GPs had recently entered general practice I was keen to assess whether any had chosen to do so in light of these specific changes.

#### **6.2.1.1 Opting out: a good deal but for whom?**

In contrast to their principal counterparts, salaried GPs’ attitudes to the ability to opt out of out-of-hours care seemed largely apathetic. Their views appeared to be influenced by their perception that the pre-2004 out-of-hours workload was not in fact particularly onerous as they highlighted that out-of-hours provision had predominantly occurred via local co-operative arrangements. As such many reasoned that their actual *personal* responsibility would have been of an acceptable and manageable level had the 2004 changes not occurred. In the following quote GP31 reasons that being on-call for one day per month (as she perceived the old local system to be) would not be too onerous and acceptable should there be a return to the previous system:

**Participant:** Before, they had [a] co-op, so it was all the practices in the area got together to run the co-op. Some people didn't do it. Some people did...But, basically the practices were allocated a share, and I don't think it was too onerous, anyway. So, if it went back to that system, I think that would be fine. And I think it just worked out that you did one a month or something like that. **(GP31 – female, 3 years experience)**

Despite this apparent apathy, many participants cited the working hours in general practice as good and preferable to those in hospitals. For some participants it was one of the major reasons cited for choosing general practice and it was *the* main reason for two of the three GPs who had chosen to transfer to general practice after having a ‘first career’ in

a hospital environment. Later on in the interviews I attempted to assess the importance of the 'new' ability to opt-out to their career decision making by asking participants whether they still would have chosen general practice if the ability to opt-out had not been introduced. Many said that ultimately, it would not have affected their decision, assuming again that the old co-operative system was not in fact too demanding. They also cited other additional or compensating benefits in choosing general practice such as experiencing continuity of care with their patients and/or variety in their work. One participant however who had transferred over from hospital medicine did say that he would have chosen to continue to work in hospitals and *not* transfer to general practice, had the change not occurred.

All but two participants stated that they had chosen to opt out of providing out-of-hours care and cited a variety of reasons including: wanting a good work/life balance; they held other demanding posts for example within PCTs or had had young families as in the case of several female participants including GP53 below:

**SCS:** What are our thoughts on that [out-of-hours] not being a part of general practice anymore?

**Participant:** It's nice in a way, because I've got a young family. So for me, that suits me just fine. I'm at the moment opting out of doing that, which I can do. But I know the two full-timers opt in because they also take registrars with them. I suppose you do miss a bit of critical care, and it's lovely for patients if it's your own doctor who is coming to see you in your hour of need (**GP53 – female, 4 years experience**)

Where participants cited any *personal* benefits they may have gained under the new 'opt-out' system, they were for the most part, like some GP principals, also concerned as to the impact on patient care as under the new system. They perceived that patients were now less likely to receive good quality care and/or care from doctors they had no prior relationship with.

**SCS:** when [the contract] came in there was also the 'removal' of out-of-hours. What were your thoughts on that? Do you think that was a good thing..?

**Participant:** Yes, course I did!! I don't know, in some ways it is good, I mean I think the idea of having an on-call cooperative is a good idea; I mean I think

different PCTs handle it differently, and I am not sure if I rate it too highly the way that the PCT here has done it. I think how it was beforehand, where it was local GPs, and you all to do your share, I think it was probably a better idea you know...I think standards have slipped a little bit because it is not local GPs, that are doing all the sessions. (GP48 – female, 2.5 years experience)

#### **6.2.1.2 Increased income – a gain, but not for us, at least not for now!**

Participants were all aware of the increased monies since 2004 due to the high levels of QOF achievement across the country. They perceived (and assumed in the case of those not in practice prior to 2004) that most GPs had already been providing good quality care and that the increased income was therefore deserved. Few however, discussed income rises as a reason for choosing general practice and again cited other motives such as continuity with their patients and having a wide variety of work. All were aware that any financial gains made were primarily for principals and that this had created large disparities in earnings between themselves and their principals. Some perceived that this disparity fairly reflected the differences in responsibility between their employers and themselves and felt they were fairly rewarded for their work. Others were more resentful of the differences as many thought that the largest aspect of both their and principal counterpart's role and workload was largely the same and as GP49 put it created 'two-tiers' of GP:

**Participant:** I think because I've got my own list, I do sometimes feel that I'm there always doing almost as much work. Clinically, yes, I do all the patients that are in my name, I have to deal with. And I have the same amount as the partners. And I get half the pay. Literally half the pay. So yeah, that starts getting a little bit frustrating. I mean, obviously I don't have the extra admin side to it, but I don't know how it's worth half pay. Do you know what I mean? (GP55 – female, 1.5 years experience)

**Participant:** There are lots of good things of being salaried, but equally you are.. I will get paid less than the people who do the same, the guy next door who is the partner and will have more responsibility because of the way they run it and it is a norm is that we have a pecking order of which clinics get filled first, so salaried will get filled before the non-salaried, and sort of extra home-visits you, will get the extra home-visits, than the partners etc...So in a sense it is a two-tier, probably it is inevitable. (GP49 – male, 12 years experience)

As the quote from GP49<sup>f</sup> above also highlights, as well as their negativity towards the disparities in pay, some participants also felt that they were more likely to have to do less desirable work or work that partners did not want to. Certain duties, such as doing more home visits or working in extended hours clinics were included in their contracts of employment and therefore some felt unable to complain or that the situation was fair as they had agreed to it upon signing their contracts. Others felt that they were fairly treated with regard to the sharing of ‘undesirable tasks’ and perceived themselves as ‘equals’ to their employers. However, even in such cases some went on to describe frustration they held that although they may be included in practice or GP-level meetings, their views and opinions expressed within such fora were not necessarily acted upon or taken on-board.<sup>s</sup> Having asked all the various participants about their experiences and treatment as a salaried GP, their accounts suggest that their experiences were somewhat dependent on the individual practice:

**SCS:** Some people have said things like they end up doing more visits or their surgeries will be the ones that are booked first...

**Participant:** You know, that's that doesn't happen here, and where I trained, it did. Where I trained it was salarieds [sic], trainees and registrars, who basically took the brunt of all the rubbish! ...But here, actually everyone does an equal amount of stuff, I think... So I think it is really quite fair here compared to other places. And on the visit screen it's obvious who's got which visits that day. And everyone does a pretty similar amount, actually. So, yeah, that doesn't bother me. **(GP51 – female, 2.5 years experience)**

A factor that appeared to mitigate the strength of feeling concerning the perceived disparities regarding pay and their treatment appeared to relate to whether or not the individual wished to become a partner in the future. Some had actively chosen and sought a salaried post and were largely pragmatic about the differences in pay, stating that such differences came with the territory. In these cases, participants acknowledged the difference in earnings but felt fairly rewarded for the work they did and that being salaried had other compensations as for example it allowed them to pursue other roles (as in the case of GP49) or priorities such as spending time with their family. The quote below is

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<sup>f</sup> GP49 was a principal in another practice prior to deciding to become salaried in order to pursue an additional career.

<sup>s</sup> Some e.g. GP62 however did not work on the days when the practice had their meetings and felt more excluded.

from a GP who had once been a partner in her current practice and switched to a salaried role in order to pursue her interest in academic research. She describes that despite the 'poor timing' of her decision, the trade-off for her was worth it:

**Participant:** I stopped being a partner in August 2003. And GPs got a 25-percent pay raise in April 2004. So that was the worst financial decision I ever made!! However, it didn't really matter because it was the best clinical decision, or life decision, I ever made. **(GP30 – female, 18 years experience)**

Whereas some had actively chosen a salaried post, others took one with a view of eventually becoming a partner at some point in the future, either in their current practice or elsewhere. Others described their current salaried situation as acceptable for the time being whilst for example they had young children or because they wanted to concentrate on clinical work:

**Participant:** I think it's changed because over the years people went from qualifying, from a GP registrar into a partnership. So then I think due to change of contracts and things like that, partnerships started drying up...It could lead to partnership in a few years. Then I know some people have definitely wanted partnerships quite early on, after qualifying but I felt quite happy really getting a salaried post first and just consolidating what I know. Also building up my knowledge and learning about more about management and a bit more before moving on to partnership. **(GP55 – female, 1.5 years experience)**

### **6.2.1.3 Improved income but fewer ways of accessing it – consequences for the future?**

The section above indicates a significant degree of agency in terms of GPs choosing to be a salaried GP; however, it was not clear as to how much of this was simply rhetoric or how much was an active choice. For some, as in the case of GP30 and GP49, there was clearly an active choice as both had rejected their prior principal status. Some also stated that the salaried option suited them for the foreseeable future. Others however stated that they would have preferred to have moved from training to a principal position or at least have the option when they felt ready to take on greater responsibility. As the previous quote from GP55 illustrates, at the time of conducting the interviews partnerships were perceived as being in short supply and that the new contractual arrangements had influenced this situation. Most were aware of this situation but many who wished to



progress to a principal role hoped that the situation would resolve itself as eventually they would reach a point where they would become dissatisfied with their salaried posts. The main reasons cited for wishing to move into a principal role related to a current inability to affect practice policy and a desire to exercise more control over their own destinies. The first quote below indicates that this GP is nearing that point whilst the second is from a GP who had reached it:

**Participant:** I think so. I'm at that stage now where there are certain things that start to irritate you a little bit, and because you're not a partner and you don't tend to have the say - you can nag people and say, "We need to do this," or "This needs to be sorted out." There's only so much nagging you can do. You get to the point where you start to get a little frustrated, thinking, "Oh, if I was a partner, I would have more say in this happening." And those sorts of things. So I think I'm getting to that stage in the next year or two as well. **(GP61 – female, 16 years experience)**

**Participant:** if you're salaried, you don't really have a huge say in practice policy. The partners decide...whether you're allowed to see 10 patients or whether you have to see 30... I felt like I was stagnating a bit in a salaried job, so that's why I wanted to move on to a partnership, because I thought it would just give me a little bit more insight and ability to change and mold a practice and help my patients a lot more. **(GP41 – female, 5 years experience)**

GP61 along with most of the other participants who expressed a desire to eventually become a principal appeared content (or felt they had to be) to wait out the situation out (for many hoped that the situation would resolve itself). However, GP41 had taken decisive action and moved on from her old practice to her current post. She related that at that time she wished to move onto a partnership there were few opportunities within traditional partner-run practices. As a result she decided to take a post as the lead clinician in a new privately-owned practice which had recently won an APMS contract.

She appeared to have no qualms over working for a private company reasoning that all practices were profit-making organisations, privately run or not. Throughout the interview she was critical of traditional practices and her attitudes appeared to reflect a sense of rejection from her old practice and the lack of opportunities currently available. For example, she criticised the professional uproar and traditional practices who were not offering extended hours relating that they were shirking their professional responsibilities

as ‘when you enter the healthcare profession, you're offering a 24 hour service, because people don't choose when they get ill, you know (GP41).’ She reasoned that her new practice was offering a ‘better’ service due to their longer opening hours. However, her move had been instigated by a desire to gain influence and control over practice affairs. Although she was the lead clinician in her new practice, her desire to gain control over the practice was seemingly not realised. Whereas she described being able to influence action by for example the company taking her concerns on board regarding staff (highlighting the subsequent removal of a member of staff who she deemed ‘compromised patient care’), in the quote below she also describes how she has no real ‘powers’ or control relating to the running of the organisation. This is however not stated as a negative by her, in fact she relates it as being as positive as both she and her GP colleague are on a level-playing field:

**Participant:** So, there is a hierarchy to some extent. But, the good thing is, it's much more uniform. Because I don't have the power to hire or fire. I don't have the power to manipulate people. I don't have the power to say, "Well, you're working these hours, and I'm working these hours." In that sense, you're working for a company, and there are guidelines for all the employees who work for that company that are very similar. So, you're kind of autonomous, but you're part of a company. You're given responsibility for certain things. But, equally, you can't use that position to abuse others **(GP41 – female, 5 years experience)**

Both GP41 and her colleague GP40 (who also took his post due to a lack of available partnerships) however were unusual cases as they had both had wholly positive attitudes towards privately-run general practice and were currently working in them. In contrast, most of the other participants working in traditional partnership arrangements were far more critical of privately-owned practices, despite having no experience of working in such organizations. They perceived that patient care was less likely to be of the standards in traditionally run organizations. They posited that unlike traditional partner-run practices who were of course partly motivated by finances, privately-run counterparts were *only* motivated by profits and therefore they were more likely to compromise professional standards in order to pursue money. Some felt that as professionals, the staff in such organizations would not let standards slip, at least not intentionally but that they may eventually hold more of a worker (‘9 to 5’) mentality; i.e. there would be less effort or will to go the extra mile and less loyalty towards the organization. In addition, whereas within

traditional partnerships they as employees were managed primarily by other doctors, the idea of being managed by non-medically trained staff was also less attractive:

**Participant:** If I was working for Virgin and I did my hours eight to four three days a week, and then went home and this money just went into a big pot and it just got paid, I don't think I would get the same job satisfaction for one. I just don't think I would want to do a good job for them, to be honest. Whereas I know my partners and I know that they are decent people and so I want to do a good job for them as well. But maybe that's me being naive. That's how I feel. (GP56 – female, 5 years experience)

**Participant:** I think [as] doctors we do like to be able to make certain management decisions, as well. And I don't know if you know all salaried working for bigger practices. Private...how much of those choices and decisions would be able to make as salaried doctors. Some of the decisions are clinical as well, and maybe out the realm of someone who is just trained in purely management. (GP55 – female, 1.5 years experience)

#### 6.2.1.4 QOF equates to improved and standardised care

Many perceived that most practices (including their own current practice) had prior to 2004 already been providing good standards of care and reasoned that this was why QOF achievement had been high overall. The quote below is from a GP who recalls minimal disruption (except for the administrative effort to implement the ICT) during the introduction of QOF to her practice (during her training) as she perceived it to be 'evidence-based':

**Participant:** ... the nice thing was that this practice was already so well organized, the bits that QOF put in were already happening ...I think, for the surgery here it was relatively easy, except for the computer point of view, to put all the data in, because it was already there...It's a very evidence-based surgery. It does things because it makes sense. And so regular blood pressures on people who have got a diagnosis of hypertension is a logical thing to do. So that was already there. (GP53 – female, 4 years experience)

Many related that QOF was therefore in line with the way they *ought* to practice, claimed to have already practised and/or that this was the way they had been trained. It was apparent that EBP was of key importance and that their views on QOF were affected by their views that QOF was also largely evidence-based:

**Participant:** ...on the whole, if you read about it [QOF], and then you go back, and you know it's evidence based, this is good. Evidence based medicine basically is what's important at the end of the day (**GP24 – female, 2.5 years experience**)

However they also believed that QOF had been largely positive for the general patient population who were, post-QOF, more likely to receive better and/or more uniform standards of care as outlying practices/individuals were more likely to be motivated (via financial or competitive drivers) to improve their standards:

**Participant:** Unfortunately, there are pretty appalling GPs out there. So I think QOF is making them think about I haven't taken a blood pressure for five years and this diabetic I suppose should have retinal screening, shouldn't they? ...It was being missed and it was poor care for people...so patients from their point of view it's much better. (**GP56 – female, 5 years experience**)

Some identified that as QOF evolved, it would continue to improve standards as well as being a useful educational tool. Some related that although they did not like the depression tool, they felt that its inclusion was important as depression was a prevalent and under-diagnosed condition. They also highlighted that medicine evolved, hence QOF should evolve and that QOF effectively kept practices up to date. However, some also highlighted that QOF did not match the latest available guidance, particularly those that had only recently entered practice. This group felt the most up to date with current guidance as a result of their recent examinations and training. A small number suggested that 'older' GPs may have stagnated in their approach and knowledge and that QOF was helpful in keeping their practice relatively up to date:

**Participant:** I suspect probably a lot of us are more, even more up to date with guidelines than, than some of the older GPs, because we've, we you know we've had to learn them for our, for our exams and learn the new evidence and things. Erm so no, I think, I don't think it - no I don't - no I don't think it's certainly more important for us erm than it is for older GPs...they're a little bit more set in their ways really (**GP31 – female, 3 years experience**)

Finally, a small number related that the widespread introduction of a single set of standardised targets and guidelines for all practitioners to work towards was positive for patients who were now likely to see a number of different professionals within their practice. They perceived that patients were now being told the same message:

**Participant:** I actually quite like the fact that we're all - and again, we're all trying to do the same thing together. That means if patients go and see [GP name] first of

all and then come to see me, they'll get the same treatment rather than us all trying to approach things from different angles and doing our own sort of thing. At least if you've got some sort of a protocol there, the patients get sort of standard care.  
**(GP61 – female, 16 years experience)**

### **6.2.2 Contractual change: losses**

Many salaried participants felt that the overall structure and content of the new arrangements had been beneficial, but primarily for GP principals and in particular those that had been practising for some time prior to 2004 and now no longer had 24-hour responsibility for their patients. Many participants were largely positive about QOF as a concept as 1) they felt that it had improved patient care and 2) it was largely evidence-based and therefore in line with the standards of care they ought to provide. However, they also had some misgivings about the P4P system.

#### **6.2.2.1 Locked in? On the contractual treadmill**

Participants were aware that the contract was reviewed annually and that were working to an evolving agenda. As discussed the evolving nature was perceived as being positive for patients as standards of care would continue to rise and improve. A small number, however were more cynical about the nature of the changes and like many of the principals, they perceived the continuous ‘goal creep’ as a way of clawing back monies from the profession. They also felt that the government had under-estimated the amount and quality of work being provided by general practice and that ultimately many of the subsequent contractual changes were not for clinical but political purposes. For example, on asking about their thoughts regarding the extended hours DES many perceived that these changes were unnecessary in terms of patient satisfaction with practice access. Many related however that despite the perceived lack of need for the DES, the decisions of whether or not to implement the DES actually came down to the perceived financial implications. Some stated that their principals had ‘no choice’ but to implement the DES as it would represent a financial loss. Others said that their principals had decided against it (again due to financial factors) and they were prepared to ‘take the financial hit.’

**Participant:** Cost was one of the main things. Especially going into our elderly population, we didn't see a particular demand. That was proven by our previous Saturday surgeries. There were people who could have come any time during the week.

**SCS:** So for all the people who said "Oh, this isn't really a choice, it's being imposed on us," that doesn't really resonate?

**Participant:** We were prepared to take that small financial hit, because we would still lose money even if we did take it on and get the money, it would cost us more to implement it. **(GP60 - male, 0.5 years experience)**

In terms of the direction of QOF changes, many felt that in contrast to the 2004 version, many of the 'new' (post-2004) changes were not evidence-based, highlighting for example the 2006 introduction of indicators requiring the use of depression tools. In addition, the patient survey<sup>1</sup> and the new diabetes indicators introduced in 2009 were considered as very controversial targets, the latter was considered by many to be potentially dangerous to some patients:

**Participant:** I mean I think, yeah really it always has to evolve because the evidence always changes anyway. I think the HbA1c is a particularly difficult one I think because... there's controversy about that because the studies are actually showing now that we try to progress in the controls are really very low on HbA1C's, the mortality rates are actually higher....So, so I think that's - that's a particular one where erm it's a very specific controversial one **(GP31 – female, 3 years experience)**

Approximately half of the salaried participants were interviewed around or after the time of the introduction of these new indicators. I was keen to ascertain in later interviews whether or not these controversial targets were being pursued. It appeared that in most cases however they were not considered problematic enough not to pursue despite any reservations that they as individuals may hold:

**SCS:** When new indicators came out in April, what happened?

**Participant:** We had a practice meeting. The details were gathered together... and we had a meeting with the doctors and the nurses, and went through everything that we needed to be doing essentially. To make sure we're up to date.

**SCS:** What were people's views on these new indicators?

**Participant:** Fairly ambivalent, really. No one had any particular concerns or problems.

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<sup>1</sup> Some perceived that this was in fact a perverse incentive as practices may score well by patients valuing a 'nice' but incompetent GP.

**SCS:** What about the value of them? Do you see any good clinical reasons for them being in there?

**Participant:** Some of them. I think, definitely most of them do seem to have a reasonable clinical benefit. I think some of the targets are too aggressive, I think. Diabetes would be a good example. HbA1c targets, they're going lower and lower, which I think a lot of people would disagree with. And certainly I think the evidence would disagree with. So that'd be one where I'd be worried about. **(GP60 – male, 0.5 years experience)**

Participants however, related that in order to avoid being too aggressive in the pursuit of targets and potentially pushing individual patients too far (or to dangerous levels), individual practitioners would need to continue to apply discretion and assess each case as they presented. Participants highlighted the importance of exception reporting in allowing them to exert their professional judgement and thereby reduce the potential for inappropriate patients to be pushed too far. When asked their views regarding a QOF without exception reporting, participants related that this would not only be unfair to patients who may be pushed into having unwanted treatments but also to practitioners/practice performance. Furthermore, some related that that local population factors would come into play and make it more difficult for those working in more deprived areas to hit targets.

**Participant:** I mean...a small proportion will never have a smear no matter how many times you ask them. There will be people who are asthmatic who will never stop smoking ...so it's not always about purely about the doctor activity, I think find out that they made the effort, but if we made the effort, and it is not beyond their ability and because the patient tries, or patient health or whatever, then there shouldn't be penalized for that. **(GP49 –male, 12 years experience)**

**Participant:** Obviously we're coming from a lot further back with our patients than some other people. Some other people have got patients who are your nice, wealthy patients that want to have all the screening done and want to have their cholesterol checked. Some of our have got much bigger issues, and cholesterol is not of any significance. They're trying to survive today, not get through 20 years to find out what their cholesterol is. **(GP61 – female, 16 years experience)**

In addition to concerns over the pursuit of controversial targets, there was also a general perception amongst some participants that the perpetual and focused pursuit of targets in principle was problematic. Some felt that their principals were too focused on the continual need to achieve against the targets in order to maintain practice income:

**SCS:**... what do you think, you know, are the main differences between before and ... and now? I mean do you think things are better, worse or a mixture ... I mean....

**Participant:** for the patients or for the ...

**SCS:** For both.

**Participant:** I think it's ... well I think it has put a lot of strain on the partners and practice to get all QOF points. And the same as the contract, I mean when it came to get all these points just to get more money, I think ehm it's put more strain on doctors and it has lost ehm the ... just normal care for patients, taking them as a patient rather than as another points ... object to get points. **(GP62 – female, 10 years experience)**

This perceived focus on achieving targets and the transformation of patients into as GP62 puts it an 'object to get points' was echoed by some other participants. Even though GP10 had only been working for a year, she also felt that this was the case:

**Participant:** [QOF's] all I've ever known, basically...it's making sure that you concentrate on specific things. So, it's at least monitoring that you achieve things, like blood pressure, for example, things like that. But, it does make you just kind of, in a way, go for points, if you see what I mean, rather than looking at patients as whole. Things you really just go 'oh, I've got to get that,' to get the points. You see what I mean?... It's not like it's something I really agree with, in a way, because I think it makes you focus on the wrong thing because you're not aiming for targets, you're wanting to look after patients. **(GP10 – female, 1 years experience)**

Being an employee appeared to provoke different views with respect to their need to focus on QOF. Whereas some participants felt that they were *obliged* to meet QOF targets (even though some disagreed with QOF or aspects of it e.g. GP62 saying 'her heart wasn't in it'), others felt that they were (or could be) less focused than their principal counterparts who they perceived had (or should have) the main responsibility and pressure of achieving QOF:

**Participant:** This is one of the benefits of being in that under-tier of a salaried GP. It's the partner's job to sit all worrying about who that mail... send an email and say can you please keep an eye upon blah, blah, blah when they are coming in. It's something that doesn't have to make any difference to me **(GP49 – male, 12 years experience)**



Others felt a strong sense of attachment to their practice and had seemingly been socialized into their practice's way of doing things, including meeting QOF targets:

**Participant:** I do my share of the game. I tend to... I trained here, so I've got a lot of attachment to this practice. And I tend to do things just like a partner. (GP59 – male, 2 years experience).

#### 6.2.2.2 QOF and quality of care?

Whereas many considered that QOF was largely evidence-based and had led to improvements in care standards for the overall patient population, they were also aware that it was a limited measure and could have negative consequences. There was a perception that a large proportion of practice time and effort was directed at achieving the targets. Whilst included areas were considered important, they related that they often took a large amount of time and attention away from other important areas of work, particularly in relation to *their* specific practice population or individual patients:

**Participant:** I just feel as though we're spending a lot of time doing a few of these things. I think because of our population here, sometimes there are bigger issues than screening for depression, actually. They're being abused or something else is going on. You feel that you have to do those sorts of things and then try and cover the other things or try and help them with their social problems or whatever else as well. (GP61 – female, 16 years experience)

In addition, some related that due to the focus on QOF there was a risk of other areas of work being somewhat sidelined, particularly towards QOF year end where the practice activity was particularly geared towards QOF targets:

**SCS:** So you think that the areas that aren't in QOF aren't necessarily done as well in general. I'm not saying here, as such.

**Participant:** I would say so. If you had just a short period of time, you're likely to stress more on areas that are likely to be economically yielding as opposed to areas which are not. You'll still do them at the end of the day, but when it comes around January or February, everybody is now busy and trying to look at the areas that they need to improve on. So I would not have any particular citing that this one probably has not been managed as well, but the presence of QOF I think is likely to improve the quality of service that patients get [in those areas]. (GP59 – male, 2 years experience)

Finally, many related that although the achievement of high QOF scores may mean that on the surface good quality of care is being provided, it did not necessarily translate into high quality care *actually* being provided overall or to individual patients. Many perceived that it was possible to achieve well on QOF by simply being good at ticking boxes and in some cases by gaming the system:

**SCS:** Is it equivalent to good care, do you think, a high QOF score?

**Participant:** I'm sure that isn't a direct correlation. I think it probably shows the vigilance and hard work, but not necessarily. If all you diabetics have got blood pressures under a certain level and they are all having their retinal screening every year, it tends to suggest that their diabetes is going to be better controlled than people who aren't having those things done...Because a lot of what's good general practice, it's not ticking boxes really. **(GP56 – female, 5 years experience)**

**SCS:** Do you think that if you get a good QOF score now that necessarily means that you're providing good quality care?

**Participant:** No, I don't think so, because there is evidence out that that surgeries, on the day before QOF is due everybody has had their blood pressure done and it's 120/80. So there's real scope for falsifying. And unfortunately nobody is willing to address the surgeries that falsify, because the PCT has been approached and said that it's a police matter and the police say it's a PCT matter. So it doesn't happen. So, no. Good QOF numbers doesn't necessarily mean you've given good care. **(GP53– female, 4 years experience)**

## **6.3 Practical responses to QOF**

### **6.3.1 Organisational change?**

Although salaried GPs were not in a position to actually decide to implement changes in response to the new contractual arrangements, I was keen to assess whether salaried GPs had experienced changes akin to those that principals described making in the previous chapter. I was also interested in what their thoughts and experiences were as a result of such changes.

### **6.3.2 Staffing capacity**

Some participants were not in post when the contract came into play in 2004 and therefore were unable to discuss whether or not changes to the staffing levels had occurred. Of those that were in post a mixed picture emerged, with some stating that no changes had

occurred and others stating that additional staff members (both clinical and non-clinical) had been taken on. Any participants who had joined their practice after 2004 were asked why they had been recruited. None related their appointment to QOF work, but cited other factors such as the practice was expanding or they were a replacement for outgoing partners:

**Participant:** I think when I came in here, I think two of the partners were retiring and they were basically looking in for a salaried post because Dr. [principal] had turned from a part-time to a full-time, and I also was looking for a salaried post. (GP47 – female, 2 years experience)

### 6.3.3 Skill-mix: altered roles and responsibilities

Many participants were unable to answer questions regarding whether any changes in skill-mix had occurred specifically in relation to the 2004 changes. However most described that within their practices, PNs had a significant role in CDM, particularly in relation to areas that were included in QOF. Some highlighted that their PNs had already been doing this type of work pre-QOF, but others stated that there had been an increased shift of work previously done by GPs to PNs since 2004:

**SCS:** Yeah. So just thinking about what happened to the nurses roles when ... when this came in. Did, did their [nurse's] roles change?

**Participant:** They did ... yeah more put in charge to do CDM. Because a lot of the points probably come in through keeping a tighter control on chronic illnesses. And because we don't have the time to ask all the questions, they are doing our main monitoring of like asthma reviews and therefore yeah their involvement in chronic illness was increased a lot, which I think is a good (GP62 – female, 10 years experience)

Regardless of whether or not QOF had been responsible for PNs doing more CDM work, most perceived that PNs were the best or most appropriate people for the role. They reasoned that most of QOF related CDM work involved routine and/or template-driven work. PNs were deemed as being ideal for this type of work as they were 'good'/'better' than GPs at following protocols. Whereas many perceived these arrangements meant an efficient and appropriate use of practice resources, it also meant that they were now more likely to see the more 'complex' patients and therefore the working day was now more intense with fewer breaks:

**Participant:** I do think sometimes... I think having more defined roles is a more efficient use of your time because me testing someone's urine or doing an ECG, you know, they're paying me a lot of money to do something that's so simplistic. So, I do think your skills would be better employed in dealing with more complex patients But, equally, you need a balance, because they're exhausting, the complex patients and it's nice to have a break in between doing bloods or doing a pill check or something. **(GP41 – female, 5 years experience)**

### **6.3.4 Sub-specialisation**

In the previous chapter, some principals described a trend towards increased sub-specialisation within their practices, primarily due to PNs receiving more specialised training and dealing more exclusively with chronic disease patients or with the development of PN-led, disease-specific QOF clinics. Others stated that this situation had already been in place prior to QOF and some did not have such arrangements as they perceived that GPs were more able to deal with a variety of needs in one appointment. The accounts of salaried GPs also reflected this mixed picture. Some related that the 'sub-specialist approach' to care was a positive development for the specialist PNs who they perceived as now having increased job satisfaction by working autonomously in their clinics. Some also perceived that patients received 'better' care under these arrangements as PNs were trained and focused care on providing specialised care for the patient's specific condition. As GP59 also highlights, this arrangement also meant that patients were now more likely to experience continuity of care with their 'expert' PNs:

**Participant:** I think it's been a good development both for the nurses, for the doctors and for the patients. For the nurses, it's a new area. They can develop themselves and do the work. For the doctors, it's less work, work taken off your hands. And that gives real time to concentrate on other things. For the patients you get to know one person. You are being seen by one person all the way through. **(GP59 – male, 2 years experience)**

**Participant:** I wouldn't know whether they had been doing it before, but they've certainly been doing it since and they're very effective. And it's my impression that they enjoy having an area of clinical responsibility, as well. One of the nurses is an expert on COPD... And the other nurse is a diabetic expert. **(GP12 – female, 11 years experience)**

A repercussion of this arrangement however, as highlighted in the quote below, is that some participants felt they were less familiar with certain areas of medicine than their

specialist PNs and in some cases felt de-skilled. As GP12 stated, this meant that at times she may have to seek advice from her PN colleague, something that some of the more recent entrants also described doing.

**Participant:** [nurse name] is probably now better -- the practice nurse who's the respiratory nurse -- was certainly better at spirometry than I am because I have to go back and look at the numbers and interpret the graphs again. But she does all the spirometry so she can easily say, "This means this." So she's certainly better at that and she's more on top of current prescribing recommendations. And the diabetic nurse is similarly good at that. I sometimes ask [nurse name's] advice or send patients to see her for an opinion. **(GP12 – female, 11 years experience)**

### 6.3.5 Internal QOF teams – QOF ‘leads’ and ‘non-leads’

All participants described the presence of an internal ‘QOF team/QOF leads’ within their practices. Most participants however were not part of these teams and were ‘non-leads’ with no nominal responsibility for an area(s) of QOF. The quote below typified the type of arrangements that most participants were subject to i.e. being monitored and directed by their QOF lead(s).

**Participant:** we have got a main partner, he looks at all QOF stuff for both surgeries, and like myself and the nurse practitioner here keep an eye on it here too. But I mean, most of it, I don't do that so much so [name of main partner] will tend to do that and he will let us know basically, whatever we are falling behind in, and what perhaps we need to look at...generally, the guidance comes from higher up, and it just gets filtered down, and say look...we need to catch up on some mental health reviews, and then we will implement that and do what we can. **(GP48 – female, 2.5 years experience)**

Four salaried participants however, did hold a nominated responsibility for an area or in the case of GP41 all areas of QOF.<sup>u</sup> GP41 was the lead clinician but also shared the duties of an ‘overall QOF lead’ as identified in the previous chapter with her practice manager and described the tasks required by the lead role as needing a team effort.

**SCS:** So, in terms of such a progressing against QOF targets, is it you who monitors them, or is it [name] the practice manager?

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<sup>u</sup> Whereas this was unusual for a salaried GPs to hold the ‘overall QOF lead role, her employment in a private practice meant that any GP who held the post would be salaried.

**Participant:** It's a team effort, really. We all do. I will tend to keep quite a close eye on QOF, but then, so did [name's practice manager]. We'll holler out things to each other. So, it's really a team effort, QOF, to be honest. Even our admin have helped, in terms of auditing patients. I've just made up spreadsheets for the information that I need and when they've sat in reception doing nothing, they've gone through the patients and collated the information for me, which highlights what's missing for which patients. **(GP41 – female, 5 years experience)**

However, this GP was working in a newly opened practice (having only been open for three months prior to the interview), with few clinical staff and it was unclear whether this arrangement was of a temporary nature.

The other three 'leads' could be classified as 'partial leads' in their practices. GP61 said she had volunteered for the role, whereas GP10 and GP31 had each been delegated an area of QOF by their respective overall leads. GP61 and her salaried GP colleague had been delegated the shared responsibility for two areas of QOF, mental health and depression. She described how the depression indicators in particular required a substantial effort during the period of its introduction. This included deciding which tool that practice staff would use, as well as doing the extra administrative work to collate and prepare the necessary patient record information:

**Participant:** the first year we did it as neither of us knew what we were doing we used to get together and come in on our day off and look at our parameters and look at what we had and work out a plan of what we need to do, sometimes what we needed to do was go through all the patient records and check that they have got depression, and whether it was a new episode or whether they need a review or something like that. So usually we would meet together and from that meeting we would then say between now and when we meet again in 4 weeks time this is what we need to do, we'd split it up between the 2 of us and he'd do the first half and I would so the second half. **(GP61 – female, 16 years experience)**

GP61 also described having to monitor and 'chase' other GPs (including her principals) in relation to her QOF areas and indicated that it was difficult for her to do so, particularly in the case of certain 'repeat offenders' who did not correctly comply with the (PHQ-9) tool:

**Participant:** if we go back through them again and it hasn't been done...and there were a couple and to be honest they tend to be the same Drs that don't use them, so you chase them and say "well did you do a PHQ9?" and sometimes they give them the patient the PHQ9 and they document them given to patient but the patient

doesn't bring them back and so they document PHQ9 given to patient but there is no score as the patient never brought the PHQ9 form back... (**GP61 – female, 16 years experience**)

GP61 appeared somewhat frustrated by her lack of ability to influence these 'repeat offenders' and seemed somewhat disillusioned by her efforts which had not resulted in the financial bonus she hoped for. However she appeared to find solace in the fact that she believed that the 'extra' QOF monies had been reinvested into the practice and had not gone to the principals.

**Participant:** It is extra work and I volunteered to do it in the first instance, I think almost in the hope that we would get a bonus or something as in the first stages it was we would get extra money and you know it will be dished out between the people who do the work and this that and the other and it never was, it didn't go to the partners, but was put back into the practice funds (**GP61 – female, 16 years experience**)

It should be noted however, that (as highlighted earlier) this GP was looking for a partnership in the near future. An unspoken future benefit for her volunteering to be a partial QOF lead may have been to gain kudos with her principals and enhance her chances of being offered a partnership should an opening become available.

In contrast to GP61, the other two partial leads had substantially smaller areas of QOF (epilepsy) to deal with both in terms of the prevalence of the condition as well as the workload involved. They also perceived their contributions as small, particularly in comparison to their GP principals:

**Participant:** We each have... Well, mainly the partners have specified sort of QOF areas given to them. I mean, I do epilepsy, but the salaried doctors don't do an awful lot of it. It's more the partners that do it. So, epilepsy's my thing. (**GP31– female, 3 years experience**)

**Participant:** I mean, [the practice manager] obviously does all the organizational bits of it, but I think, [GP11] and [overall QOF lead GP2] probably take responsibility, if you like, for the rest of it. And I think [overall QOF lead GP2] basically was the one to allocate us all in the area, and then he would keep checking it. And then, we were supposed to do our own area, but he would check

on it. So, other than the organizational bit, I think [GP partner] and [overall QOF lead GP2] probably focus on it a bit more. (GP10– female, 1 year’s experience)

Despite the smaller areas of QOF responsibility, both described having to do ‘extra’ work themselves in order to ensure that their areas were on track to achieve target levels. In particular, GP10 said she was not happy about having to do such work which often required staying late beyond her usual hours. Earlier in the interview, she had in fact described herself as being less QOF-oriented than her principals (GP2 and GP11) which concurred with a view in the in the previous chapter that salaried staff needed ‘encouraging to be a part of it’ (GP2). It appeared however that GP2’s delegation of an area of QOF responsibility had increased not only her awareness of QOF requirements but also the likelihood of her doing QOF elements:

**Participant:** it was at that time that I was given part of QOF to look at. So, I did spend a lot of extra time doing it, just going over things and checking with people and asking people to come in and things like that at that time. But, that's the only... and obviously, that was only a couple months ago. Since then, I've been a bit more aware of it than I was, because I haven't even been noticing these things before then. Since then, maybe if I see something I might think of it. If I do a medication review and they've got epilepsy, I might include more of QOF things than I had been doing before, if you see what I mean, because I'm more aware of what you need for that (GP10 – female, 1 years experience)

#### 6.4 The role and impact of ICT

Of those that had been in practice prior to QOF, most stated that their practice that had already been ‘paperless’ for some time and were positive about the use of ICT (vs. paper notes) viewing QOF-related ICT as increased coding which was considered good practice. One GP who had recently moved over from Ireland (where they did not have QOF and in this GP’s case even use ICT) also spoke of the benefit of having these systems:

**Participant:** most of it's paper, back at home, you'd have to trod through pages of notes, which is much more time consuming. So even though I think people go on about QOF in terms of time and workloads, I should think it simplifies things much more (GP57 – female, 3 years experience)

Most participants felt that the systems had improved care due to the standardization of quality and improvements in patient record keeping and therefore an improved ability to



audit their work. Not all areas of QOF however were deemed important, indeed some thought certain areas were unnecessary e.g. CKD especially as they were not actually required to do anything with that data. Such areas were therefore perceived as a distraction or time away from doing other more important work. GP61 described how much practice time was spent ‘de-bugging’ patient records, an activity that didn’t necessarily lead to improvements in care:

**Participant:** But, you know, things have definitely changed since QOF came in. And a lot of it is time actually not spent with the patient; it's time spent going through the records and finding why does that code keep coming up, and why does it say we need to do this with the patient. Which actually isn't improving patient care. So that's the problem. I'm not sure if it's a good test of how well we care for our patients. **(GP61 – female, 16 years experience)**

#### **6.4.1 ICT as surveillance**

All participants were aware that the ICT systems were used within their practices to monitor QOF progress and identify areas that required increased efforts. They were also aware that their work, at least in relation to QOF, was visible to others in their practice particularly at their practice meetings where QOF leads would present QOF data. There again seemed to be a variety of approaches that their QOF leads took with respect to ‘encouraging’ their practice staff and practitioners as the following quotes illustrate:

**Participant:** In the management meeting, they discuss... QOF plays a big part of it. So, it is the partners, but we are there as well as salaried GP's are around. And we are always asked for ideas. And it was found that some people were missing out, actually going through and getting those points, so that's brought up. And sometimes, name and shame is the only thing that works, unfortunately, but it does. **(GP24 – female, 2.5 years experience)**

**Participant:** It's on a rolling agenda item on the practice meetings. And it generally gets a nod in the direction of most of the time and perhaps just before the -- well, it has to go about March time, doesn't it? He [QOF lead] might say we are not up to our percentage of recording people who could, there's a highlight box, could everybody make sure that do it. So it's no more than that really. It's no wagging fingers. **(GP12 – female, 11 years experience)**

The prospect of being named and shamed or standing out appeared to be an effective motivator for many, including compliance with areas that were not thought to be representing ‘good medical care’ (‘that other stuff’):

**Participants:** For QOF I think because I've got my own patient list and just I'm just quite aware that I don't want to be the one with really bad QOF results because every now and then we get sent round lists of our patients who need a bit of QOF catch up on X, Y and Z. As much as you can, I try to do bits and pieces as they go along for my patients. Some of it is general good medical care. And that other stuff as well. You have pride in your work. You don't want to be the one who is really got really low QOF points, compared to someone else in the practice. **(GP55 – female, 1.5 years experience)**

Despite the surveillance, many participants did not feel that they were put under any particular pressure to meet QOF targets. Some reasoned that it was primarily their principals' responsibility:

**Participant:** I don't feel any pressure, right, partly because we've got 14 partners. So, you know...one of them does all the mental health QOFs, someone else does all the stroke QOFs...they've all got their own responsibilities. And because they're partners they do, do QOF, because it's their business. No, I never get leaned on. I mean, we get sheets sent around saying these last 10 patients all need their blood pressures. And I look through them and I'll see if they've had a blood pressure done at the hospital and it's just not made it on to a read code. I'll do it that way. **(GP54 – female, 3 years experience)**

In contrast to most participants who did not feel closely scrutinised or under pressure to achieve QOF targets, two participants working in their former training practices appeared to undergo an unusually high level of scrutiny, despite now being fully qualified. Rather than perceiving such scrutiny as negative they perceived it as being positive both for their own continuing development and for patient care. In addition, both claimed to do more than the 'average' salaried GP which could be beneficial for moving onto a partnership:

**Participant:** very often the principal doctors at some point will go through everybody that's been seen that day to see if there are any points left undone. And that's partially because of the teaching role being so big here. Because it is part of good care. It should have been in their own diary of notes anyway, that something needs updating. And so you do get pulled up if you miss some of the things. **(GP53 – female, 4 years experience)**

**Participant:** It's just training really. Because it's only now two and a half years since I've completed my registrar. So, it's good. If I do get into a partnership later, which I would like to eventually I suppose, though we don't know the future of

General Practice at the moment, it'll help, because you know how things are done.  
(GP24 – female, 2.5 years experience)

Finally, as described, GPs were aware and accustomed to being under regular surveillance *within* their own practices GP41, was subject to subject to *daily* surveillance from external sources, specifically the company holding the APMS contract:

**Participant:** I can get a phone call from [Company] saying, "You've got some new blood tests that you've not looked at today." So, you know, it's something that I've got used to. It's not something that's nice because you do feel like people are invading your privacy at times. (GP41 – female, 5 years experience)

#### **6.4.2 ICT as communication from a distance**

Most of the salaried GPs only worked a limited number of sessions. Some did not work on the days that QOF/practice meetings were held on. As a result a small number of participants described the undesirable situation of being uninformed about changes to the targets. As a result some were only informed of changes by the ICT of new work they were required to do for their practice:

**Participant:** This is the problem with working part-time is that all QOF meetings happen on the day that I don't work...So I'm trying to find out about it. But at the moment, all these obesity things keep popping up. I don't actually know whether any QOF points are going with that or whether they're setting up some sort of obesity register. (GP56 – female, 5 years experience)

#### **6.5 QOF and the consultation: concerns, difficulties, consequences and solutions**

Despite most participants having only worked post-QOF, many of their views and experiences mirrored those of their more experienced counterparts as well as the principal GPs. Many described how QOF had affected their consultations and for the most part not in a positive way. Participants were asked about non-QOF vs. QOF related work. Those in practice prior to 2004 were asked how their consultations compared pre- and post-QOF. The less experienced GPs (i.e. post-QOF only experience) were asked about non-QOF vs. QOF related consultations. In either case, non-QOF related consultations were seen as comparatively less pressured with one main focus, the patient's presenting issue:

**SCS:** During that year when you were working without QOF, what would you say your consultations were like in comparison to now?

**Participant:** I would say that they were more relaxed. The concentration and attention was more on patients rather than on boxes. You would have more time for a patient to spend on say, examination rather than taking height, weight, and whatever [laughs] (**GP58 – female, 6 years experience**)

Participants felt their ability to focus on the patient was somewhat compromised. QOF was seen as ‘another agenda’ in the consultation and one which was not necessarily aligned with that of the patient. Given that participants’ appointments were limited to ten-minutes this created extra pressure within the consultation:

**Participant:** I suppose it just puts more pressure on you time-wise. But I think you just have to manage it, you have no option. And you've got the proper examination done first. Then you have to try to quickly move through what you need to get done. ...But, yes, time pressure is a little bit of an issue. (**GP57 – female, 3 years experience**)

The GP above described how post-QOF she simply had ‘no option’ but to adapt to the new ways of working. Her view was echoed by many and was seemingly derived from the fact that there had been no additional time added on to the ten-minute consultation post-QOF. They somehow therefore had to find ways of working in the new requirements.

Where a patient attends for a ‘simple’ issue (that could be dealt with quickly) there appears to be little conflict as they described usually being able to attend to both agendas. However in ‘busy’ consultations where the patient for example brought multiple problems, they described dilemmas as to which agenda to attend to and that often something had to give. In most cases they described that often this was time for things like communication regarding non-presenting or non-QOF related problems and/or interpersonal care. As these quotes highlight, ‘medical’ i.e. clinical care may be improving but at the cost of other types of care:

**Participant:** when patients come in you also, they’re looking at the contents of the screen and you’re looking at what the results are and where to put that and trying to fill up all the templates rather than, I think you hardly have your contact with the face contact really, or...Contact with the patients, so. Erm yes I think you look, you sort of like you’re trying to fill up all the boxes, you’re trying to do everything for QOF rather than looking at the patient and taking time to talk to the patients. (**GP47 – female, 2 years experience**)

**Participant:** ...you lose all the time to chat and build up relationships with patients...that's a completely different part of general practice that the government just can't see and doesn't understand. And so you chat about... You know, everything else that's going on in their lives. You just don't have time for that because you're too busy going, "Do you smoke? I know I asked you that last time, but believe it or not that was 15 months ago and I've got to ask you again" and all that sort of business but I think it gives better medical care to patients. (**GP56 – female, 5 years experience**)

Many expressed concerns that such consultations were not reflective of the type of approach that they had been trained to provide. Some participants such as GP58 who expressed a dislike for the 'QOF-focused' approach felt that over time or at particularly busy periods (many referring to being pressured by busy waiting rooms) they were becoming more QOF-oriented in order to get through their workload:

**Participant:** [QOF] changes the concept of consultation. For instance, when I started, I was trained to look at a patient. Look at the patient: did I have a good contact, and smile, and nod, or whatever? And then I went to see my GP, and I was shocked that my GP wasn't... I mean, I have changed my GP since then, but he wasn't interested in me, he was just looking at the screen. And I try not to do that with my patients, but then I'm running late everyday by half an hour, and then patients complain. It's a vicious circle. Or, they give you a comment, like a sarcastic comment: that every time you're here, their appointment was like 20 minutes ago. So I'm finding myself more, now, turning to the computer. So, it's a big, big change for me. Although I hate it, I hate it. I changed my GP a long time ago because of that... [laughs] (**GP58 – female, 6 years experience**)

A small number went on to express concerns regarding the future of their consultations as they felt that the consultation was already crowded and that new additions to QOF would simply reduce the non-clinical aspect of their role even more. Given that non-clinical aspects of care, e.g. continuity of care, was one of the main reasons cited for participants choosing general practice, the reduction of time with their patients may have negative future consequences for job satisfaction. As GP54 puts it, such a situation would take the 'fun out of the job':

**Participant:** So we're always going to reach a limit where there's only so much you can do. And I guess they just keep creating more amendments that we have to get everything crossed off in. It just takes the fun out of the job, really... you haven't actually spent time getting to know the patient and what the patient actually wants. (**GP54 – female, 3 years experience**)

Whereas many identified with at least a significant proportion of their consultations being very template-oriented, others felt that overall they had a more 'adaptive' approach. They described this as consisting of 1) eliciting the patient's needs and judging how much time this would take and 2) assessing how important any of the missing QOF elements were and 3) making a decision as to which agenda to deal with. Many reasoned that often some or all of QOF elements were not that important and could be dealt with in a separate appointment. If the missing QOF requirements for that particular patient were deemed to be of 'urgent' clinical importance then participants described taking the opportunity to attend to those whilst the patient was present. If they were *not* deemed important and could not be fit into the consultation then some participants stated that they simply asked the patient to book another appointment, thereby removing any pressures they may have felt in attempting to both agendas:

**Participant:** I tend to wait and see what the patient is coming in with, because I think you know, some things are appropriate, some things aren't appropriate. You know, if somebody is coming in to tell me that they just found out they have been diagnosed with terminal cancer, it is not appropriate to start quizzing them about their smoking status and wanting to check blood pressure... So I think, I mean it can be difficult if you have got things flashing on the screen saying, please check this, please do that; but I think there are ways and means of doing it. **(GP48 – female, 2.5 years experience)**

**SCS:** Do you have a QOF routine?

**Participant:** A lot of it depends on how much time we've got. If you don't have any time, then you just ignore it. You don't have time to do it every consultation...But, if you're running on time and someone just comes in with a sore throat or whatever - something that's quite quick to deal with - then you've got time to do it. So, I don't think you do feel pressured because you don't have to do it there and then. It just completely depends on whether you're running on time or you've got time to do it. And like I say, when you're doing the searches anyway, they'll pick up the people who need reviewing. So, you can bring them back in for a specific appointment. **(GP31 – female, 3 years experience)**

The term 'appropriate,' as used by GP48 was used by many participants in relation to how they individually judged each consultation with regards to the doing of QOF elements. Many however also described a sense of awkwardness when asking patients seeming 'inappropriate' questions within their consultations:

**Participant:** So yeah, sometimes it can be a little bit hard. I think the whole smoking thing is just a bit of a nightmare because if we have to ask every six months if they were still smoking or something odd like that. So I kept on asking the same people again, and obviously they hadn't given up smoking yet. But you have to tick the box. And I think sometimes when you know the patient, that gets to be a bit awkward. Because you know they're not going to give up smoking. It's not really the time for them to give up smoking because they're going through various other stresses and things like that. **(GP55 – female, 1.5 years experience)**

In order to deflect any discomfort that may arise from the need to ask 'inappropriate' questions to the patient, some participants described adopting a tactic of blaming the computer:

**Participant:** I ask questions like, "What's your ethnic status?" And stuff like that. They're just like, "For goodness sake." You can wrangle a blood pressure into a conversation or into consultation OK, but how do you ask somebody where they're from? How are you going to get to that? But I blame the computer for that most of the time. **(GP56 – female, 5 years experience)**

The preceding account suggests that the addition of QOF often made the consultation process more difficult due to the fact that they had dual and often competing agendas within time-limited consultations. However, many also related that the addition of QOF templates was helpful as they now had tools which guided them to areas that were mostly regarded as being clinically important for the care of individual patients:

**SCS:** OK. What about working to the templates, protocols, and guidelines?

**Participant:** Yes. I like that. It is a good thing.

**SCS:** Do you think it makes your job easier that you have these things to follow?

**Participant:** It makes it easier, although the doctor should have what it is in his mind, but you know, you might forget things. If you have it in template - OK, I will ask her for this, I will ask for this, 1, 2, 3 - it is a good thing. **(GP40 – male, 3 years experience)**

**Participant:** It certainly, initially it does put a bit more pressure on you, because you're not used to them. In another sense it makes life much easier because instead of trolling through notes at home [Ireland], you have no pop ups or anything like that, and here you see it pop up. You know what to do, and it's easily done **(GP57 – female, 3 years experience)**

Not all 'templates' however were perceived as helpful. The depression tools were described by many as difficult to incorporate into their consultations and were not

perceived as being evidence-based or effective enough to replace their professional ability to assess their own patients. As a result, many participants described using the tools in a cursory way and that the output did not really affect the way they chose to manage their patients.

**Participant:** But I use them. I don't really see them as being that valuable. Although I did go to a talk by [name] saying that they did pick up, so they were slightly discriminating. But I don't monitor my treatment on them so I wouldn't do one at baseline and then, six months later, do a follow-up one, particularly. Because I've found there are other ways of monitoring the treatment, you know, talking to the patient and asking them how they're feeling. I've monitored the treatment that way more. So I suppose they're a little bit irksome. **(GP12 – female, 11 years experience)**

**Participant:** One that just springs to mind, just because I was doing it this morning, was speaking to someone who's horribly depressed. Then the idea of having to bring a questionnaire into -- I tend to ask them the questions and then fill out the questionnaire after. So I suppose a lot of it doesn't seem directly related to what we've seen, like your instinct that was important as a doctor. **(GP51– female, 2.5 years experience)**

Despite many disliking the tools they still felt that they had to use them (in some way) in order to fulfil QOF requirements. One participant however bucked this trend and described herself as a 'conscientious objector' to their use and routinely refused to use them. She reasoned however that she was only able to do this as she had previously been a partner in the practice and that her abstinence did not actually cost the practice overall a great deal financially.

**Participant:** Absolutely not under no circumstances will I ever use the screening tools. [laughs]

**SCS:** Does that cause any issues?

**Participant:** Yeah it does, particularly me being salaried. It's an instance where being salaried is more complicated because if I were a partner I would persuade my partners as a practice to have a policy that we wouldn't use them because I think they are positively detrimental. I think they can actually interfere with the way you manage patients with depression. Being salaried, I have to make my case and periodically say, "Well I'm not just doing it." And at the end of the year luckily the amount of money attached to the screening questionnaires is not very big. **(GP30 – female, 18 years experience)**



## **6.6 Summary**

The views and experiences of this group of GPs largely reflected those of the GP principals, with regards to the perceived gains and losses resulting from QOF, particularly the impact on quality of patient care and the impact on the consultation. This reflects the fact that regardless of status or clinical experience, GPs share a common professional ideology underpinned by their professional training as well as the fact that the common substantive aspect to their work is face-to-face patient care. However, despite the broad congruence between the accounts of the two groups of GPs, this group reflected that really only GP principals were the immediate and direct beneficiaries of the new contract. In particular, the perceived pay disparity created an impression of ‘two-tierism’ within the profession. Furthermore, the contract had led to a situation where it was increasingly difficult for this group of GPs to move up a tier as their GP principal counterparts were not offering partnerships. The level of resentment around this situation was somewhat contingent on the personal circumstances of the salaried GP, but in the long-term it appeared to create the potential for increased tensions between members of the profession.

## Chapter 7

### Discussion and conclusion

#### 7.1 Introduction

Large scale quantitative studies constitute the majority of the empirical research regarding the nGMS contract and specifically the impact of QOF on general practice. Studies have focused on associations between target achievement levels and, for example practice traits<sup>292-294</sup> or individual diseases.<sup>295</sup> Such studies however tell us little in relation to how achievement levels have been attained, why targets are pursued and any unintended consequences of the P4P scheme. Qualitative studies such as this allow us to examine and answer such questions by revealing some of the underlying complexities. The findings outlined in the two previous chapters illustrate some of these complexities. They suggest that the perceived impact of the nGMS contract, and in particular QOF, on the work of GPs was variable and complex. Despite this, there were many common findings between the two groups of GPs particularly in relation to the perceived impact of QOF, and in many cases these reflect but also supplement the existing empirical literature. There were some differences in views between the two groups regarding the broader contractual (i.e. non-QOF specific) benefits and losses. Such findings add to a small number of post-contractual change studies which have placed a focus on the differences *between* GPs.

In this chapter, I examine the available existing empirical literature on the impact of the nGMS contract in combination with my findings and in relation to my chosen theoretical framework. For ease of presentation and understanding, I discuss the combined evidence within each individual aspect of Michael Lipsky's SLB framework as outlined in chapter 3. I end the discussion by providing a judgement as to the continuing applicability and usefulness of Lipsky's work to GPs, as well considering my study's strengths and weaknesses before providing some overall concluding comments.

#### 7.2 Discretion and Policy Making

In chapter 3, I described how discretion is at the heart of Lipsky's work and as a result has received the most attention by analysts seeking to apply and test the framework in other UK professional contexts. Accordingly, this sub-section forms the largest portion of my

discussion. This reflects the fact that many of the nGMS and QOF associated changes reported in the existing empirical literature (outlined in chapters 2 and 3) suggested that discretion was an aspect of GP work that was subject to significant change. In line with recent developments in SLB theory, I have moved away from the broad concept of ‘professional discretion’ employed in the only study to have assessed the issue of post-QOF GP discretion directly.<sup>146</sup> Furthermore, I assess the issues and impact of both multiple accountability and ICT on GP discretion. Consequently I am able to provide a more nuanced view of GP discretion and illustrate how various post-QOF factors can act to constrain certain aspects of discretion whilst leaving others virtually intact. The extent of QOF’s impact on GP discretion is somewhat contingent on the approaches taken by the individual GP and/or their practices. This reflects the mixed evidence on GP discretion reported in the literature. I start with a re-cap of the factors cited by Lipsky as giving rise to the ‘substantial discretion’ SLBs are seen to have.

Lipsky posits that SLB discretion arises as a result of: 1) the complex nature (and subject) of their work, which is too complicated to reduce to ‘programmatic formats’ and 2) a lack of capability to scrutinise SLB work which is normally conducted in private. However, as I outlined in chapter 3, both of these conditions have somewhat changed over time within public services more widely as well as in general practice. To briefly re-cap, the EBP approach to medical knowledge has become prevalent and this has seemingly led to changing views and attitudes within medicine more widely. It seems to be accepted that a portion of medical professional knowledge can be reduced to various sets of accepted rules for the measurement and standardisation of professional practice. General practice is no exception, as there has been an increasing acceptance that quality of care can be defined and measured.<sup>77</sup> Ultimately this acceptance and drive to improve quality has led to the development of QOF. Secondly, post-contractual research has identified convergent organisational changes within practices that would appear to make it easier to scrutinise and direct GP work, specifically the emergence and widespread presence of QOF leads or QOF teams.<sup>165;153</sup> Although my findings and the existing empirical evidence indicate that the exact form of these ‘teams’ varies at the local level,<sup>52,153</sup> they *all* have a common function. QOF leads/teams are charged with supervising and directing QOF-related work of their practice colleagues. They do so by utilising the new performance monitoring

capabilities provided by the ICT systems.<sup>153</sup> This new level of scrutiny means that clinician-patient interactions, traditionally beyond the gaze of outsiders, have been opened up to scrutiny and to influence by others.<sup>296</sup> I return to this development later in this subsection as it has significant implications and warrants a more detailed discussion. For now the salient point is that aspects of GP work are now visible and open to scrutiny from others. Despite these changes, the only post-QOF study to assess the issue of GP discretion directly, found that GPs did not perceive the contract and associated changes as stifling their discretion.<sup>146</sup> This conclusion is also reflected in my findings as many participants who had been in practice prior to 2004, claimed a scenario of ‘no change’ for a variety of reasons. However, as I go on to outline, it is also clear that in comparison to working under the old GMS contract, GP discretion has been affected and continues to be so as the contract evolves.

### **7.2.1 Post-QOF: A scenario of ‘no change’**

Participants’ cited various reasons to support their claims of ‘no change.’ Firstly, many GPs reported that they had already been practising in an evidence-based manner i.e. they claimed to be providing the levels of care required by the initial version of QOF and that the main impact of QOF was simply the formalisation (recording) of this work.<sup>cf.157</sup> Other empirical research also reported that GPs made similar claims,<sup>158</sup> and is supported by quantitative evidence which suggest that the introduction of QOF only led to a short-term boost in the rate of quality improvement for some included conditions.<sup>167,212</sup> The authors of these quantitative studies suggest that the limited impact of QOF on quality, may be due to various reasons including the fact the conditions assessed had all been subject to various pre-QOF quality of care improvement efforts (e.g. NSFs).<sup>167</sup> Therefore even though the introduction of QOF represented another set of ‘rules’ to work within and towards, GPs already appeared to be aligned behind the goal of quality improvement. Indeed, early empirical research on QOF conducted in 2005-6 suggested that professional priorities were aligned with the clinical targets contained within in the 2004 version of QOF.<sup>153</sup> Despite the passage of time, my findings also suggest that GPs are still aligned behind the majority of the clinical content of QOF and view it as leading to improved and/or standardised care for their patient populations. The evidence would so far suggest therefore that value discretion has remained intact.

Secondly, GPs reported that it was practice nurses, not they, who were doing the majority of the determinate (or low discretion) QOF-related template work. GPs perceived nurses as the most ‘appropriate’ practitioners for this. This resonates with research which suggested that pre-QOF, general practice was undergoing a transformation due to a re-distribution of work via a ‘hierarchy of appropriateness’<sup>156</sup> in which, prior to 2004, those further down the clinical hierarchy were increasingly doing work previously considered to be medical. Similarly, some of my participants reported that their PNs had (prior to 2004) already been doing the CDM work for many of the conditions included in QOF. Other GPs however spoke of how the introduction of QOF had led to altered roles and responsibilities within their practices. They reported that post-2004 PNs were now doing work previously conducted by GPs. In some cases, this also instigated a further shift, with former ‘nurse work’ being delegated downwards to HCAs, many of whom had been recruited specifically with this transfer in mind. The newly widespread use of standardised electronic templates had seemingly aided this shift, as these templates provide a clear outline of the tasks required for chronic disease patients. PNs were perceived by GPs to be better suited or more ‘appropriate’ to the routine task work required by the templates and felt that PNs were less likely to deviate from them than GPs.<sup>v</sup> As a result of these shifts, participants described that they were now free (or freer) to deal with the more complex/indeterminate work for which they perceived their GP training and skills (e.g. in diagnosis) more suited. Taken together, these findings support the existing empirical evidence which indicates that QOF has accelerated the trend for nurses to be the front-line providers of chronic disease care for the included conditions.<sup>52,153,157-159</sup> As a result, it appears that the task discretion of PNs and *not* GPs has been most significantly impacted. Research regarding the impact of QOF on nurses supports this, stating that templates were perceived to be ‘particularly constraining by PNs, who had less discretion than the doctors over their use.’<sup>153(p1358)</sup>

Thirdly, various commentators raised concerns about QOF-approach, specifically fearing that it would lead to the mechanisation of care provision.<sup>297,298</sup> Early empirical work

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<sup>v</sup> An added benefit of this arrangement for GP principals, (one which largely unspoken, but alluded to) was that this increased the likelihood of meeting their QOF targets.

reported that whilst these concerns may exist, GPs felt that their own personal practices were not reflective of a ‘Fordist’ or production line approach.<sup>153</sup> This view was also prominent in my findings. GPs reported that QOF rules were not simply mechanistically applied to *all* patients, but that there was a continued need to interpret the guidelines for each individual patient. They described discretion in choosing which set of guidelines to follow, as well as the fact that not all patients were eligible for certain QOF targets. Furthermore, the inclusion of the exception reporting facility exemplifies that QOF ‘rules’ are not intended to be applied in such a way and its inclusion was to allow professional judgement to continue to be exercised.<sup>299</sup> Indeed, GPs in my sample viewed exception reporting as an important mechanism to ensure that the rules set out on QOF were not strictly followed in *all* cases. They also perceived that exception reporting served to decrease the likelihood of the over-medicalisation of certain patients or patient groups (e.g. the elderly).<sup>w</sup> Therefore, GPs perceived that there was still space *within* the rules for discretion to operate in. This reflects the idea that discretion is a relative concept, and highlights that post-QOF both ‘weak discretion’ or ‘rule discretion’ remains in operation.<sup>236</sup>

Fourthly, it appears that GPs still feel that they have wide task discretion within their consultations. Prior empirical research described how on accessing a patient’s record, the ICT systems generate pop-up boxes to attract the attention of the clinician to highlight any missing QOF data.<sup>150</sup> Clinicians are however, able to dismiss these pop-up boxes and do not *have* to enter the information.<sup>150</sup> Therefore the system is built to allow user discretion. As existing evidence suggests, GPs utilise this capability and their discretion to respond ‘flexibly’ to the needs of QOF within the consultations.<sup>146</sup> This was also reflected in my findings, as *all* participants described being able to choose when and if to attend to QOF in their consultations. As a result, GPs in my study and elsewhere<sup>158</sup> felt that they were able maintain claims to a holistic approach to care. Furthermore, even though QOF templates are designed to be used in a uniform way, participants described various approaches to their use, particularly in relation to areas they personally disliked e.g. many found their own ways of using the templates.

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<sup>w</sup> Specifically, it has been suggested that the failure to make an allowance for age in QOF means that doctors are ‘encouraged to over-treat hypertension’ in elderly patients who are then at increased risk of fractures arising from falls.<sup>297</sup>

Lastly, my findings support existing empirical evidence which suggests that some GPs perceived the templates as helpful aide-memoires which facilitate the completion of required tasks.<sup>296</sup>

### **7.2.2 Post QOF: ‘no change’ but...**

Thus far the evidence presented would suggest that GP discretion has been largely unaffected by the contractual change in 2004. However, it was also clear from the empirical evidence and my data that GP discretion had been affected in comparison to working under the old GMS contract.<sup>x</sup> Furthermore, GPs are over-time increasingly doing work that is not in line with their personal and/or professional opinions.<sup>158</sup> Specifically, it appears that both task and value discretion *have* been somewhat affected by the introduction of QOF.

#### **7.2.2.1 Post-QOF: ‘no change’ but extra work required**

Given my participants’ own claims of ‘no change,’ any quality improvements were suggested to have occurred as a result of ‘other’ practices/practitioners now being motivated (by the financial incentives) to work in a ‘quality’ manner. However, during their accounts GPs often made reference to areas where changes had occurred in their *own* practices, both at a practice and consultation level. For example at the practice level, GPs spoke of how the new ICT systems meant that they were increasingly re-calling patients. As GP6 put it, prior to QOF “if people had diabetes and they didn’t turn up, we often didn’t chase them.” Furthermore, both the existing evidence<sup>147,157</sup> and my findings suggest that overall, they and their practices were now doing more clinical work in terms of monitoring which in some cases resulted in the recruitment of additional clinical staff.

#### **7.2.2.2 Post-QOF: the impact on discretion within the consultation**

The evidence presented earlier indicated that many GPs felt that the impact on the consultation was minimal (limited to simply recording QOF data). However, both prior

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<sup>x</sup> A few of the most experienced GPs noted a particularly difference under QOF, however some also felt freer from the pursuit of QOF targets as they were nearing retirement and were financially secure. All in all there was no apparent relationship between experience and discretion for those who had pre-2004 experience.

evidence and my findings suggest that this was not necessarily the case. The introduction of QOF appears to have influenced the GP agenda within the consultation.<sup>158</sup> As I show this has impacted on both task and value discretion.

In order to provide some context for the impact of QOF on their consultations, I asked GPs about their pre-QOF and/or non-QOF consultations. Participants suggested that by comparison, these consultations were less pressured and more holistic than their current 'typical' QOF related consultations. The major reason for this perception was the fact that the vast majority of participants reported that they still had their pre-2004 appointment lengths of ten-minutes and as GP57 put it, the majority had 'no option' but to somehow 'fit' QOF in. A small number (n=3, practice ID13) did report lengthening their consultations (by 2-3 minutes), partly to accommodate the new work. Although much of this new work may have been restricted to recording existing activities, GPs are now also regularly conducting 'new work' within their consultations e.g. routine use of depression tools. Therefore, ultimately GP task discretion has been somewhat reduced within consultations. The underlying and common factor of limited time appears to be central to the ability of GPs to exercise task discretion and as I now illustrate, can also impact on a GP's ability to exert value discretion.

GPs in my sample felt that QOF represented 'another agenda' in the consultation and one which seeks to prioritise the agenda of the practice.<sup>y</sup> Some felt that the presence of this other 'agenda' in the consultation created tensions or as one GP put it, 'discomfort' for them. This appeared to arise from the differing priorities that professional training and QOF represented. Participants described how their professional training required them to elicit and concentrate on the patient's agenda i.e. to primarily establish and address the presenting patient and their needs holistically. However, as noted above and reported in previous research, concerns surround QOF's ability to undermine holistic care.<sup>158,298</sup> Not only does the mere presence of QOF make providing holistic care more difficult in principle, but the ICT systems are designed to attract,<sup>150</sup> (or as GPs perceive, distract)<sup>157,158</sup> their attention to strictly biomedical tasks. Regardless of the fact that QOF was now perceived to be a routine feature of daily work, many GPs still described the

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<sup>y</sup> The notion of 'agendas' was spontaneously used by GPs in my sample and elsewhere.<sup>158</sup>



occurrence of these tensions due to the unpredictable nature of consultations, i.e. what will the patient present with and will it be ‘appropriate’ to introduce QOF. In particular, when patient and QOF agendas were not aligned and/or conflicting,<sup>158</sup> it caused a new source of dilemma i.e. when or if to address QOF. Participants appeared to adopt various strategies (some reserved for specific times) in order to deal with these tensions. Whereas some strategies (e.g. responding flexibly or asking the patient to re-attend if they could not fulfil all QOF requirements in one visit) allow GPs to continue to exert their value discretion, other responses acted to reduce it. An example of this was that some GPs reported being or becoming ‘QOF-focused’ over time, whilst others spoke of their own experiences as a post-QOF patient i.e. they had received this type of care. Although this was not the way that they wished to practice, it appeared to be a practical solution i.e. it was seemingly the only way they could process all the required work on a daily basis. Others reported that this form of practice was limited to certain pressurised time-points (e.g. QOF year-end).

The combination of the factors discussed thus far i.e. limited time, competing agendas and a distracting ICT system meant that participants felt that, post-2004, time for other aspects of care was reduced, specifically *non-clinical* aspects of care such as interpersonal care. In other words it seems that something has had to give, and as my findings and both prior- and post-contractual research suggests,<sup>157,300</sup> it appears to be the ‘softer,’ non-clinical aspects. However, these form a central aspect of the espoused GP role and were valued as enjoyable by my participants and a major reason for choosing their career in general practice. Furthermore, these softer and largely non-incentivised<sup>z</sup> aspects of care are important for several reasons. First, interpersonal care is consistently reported by patients as a key skill for physicians to hold and they place a high priority (alongside technical competence) on it.<sup>301-305</sup> Secondly, most patient complaints centre around issues with doctors’ manner, attitude and/or communication skills.<sup>306-308</sup> Thirdly, communication skills are central to elements of effective clinical practice such as diagnosis,<sup>309</sup> and have been shown to impact on certain health outcomes.<sup>310</sup> Finally, interpersonal care forms a key part of an accepted definition of quality of care in primary care<sup>224</sup> but as many of my

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<sup>z</sup> The patient survey which is now incentivised, does include assessments relating to interpersonal care, however participants did not appear to place much importance on the results of these surveys.

participants and the literature highlight, QOF is unable to measure the quality of this important aspect of their work.

### **7.2.2.3 Why are GPs doing work not in line with their values?**

Even though many GPs in my sample broadly supported the overall goals and content of QOF, there were certain areas that were disliked or not considered legitimate for their role. Nonetheless, participants reported that these areas were being pursued and targets were seemingly being met. This resonates with earlier research which also identified that GPs questioned the relevance of the indicators introduced in 2006, stating that they were ‘not a family [general practice] practice way of doing things.’<sup>158(p232)</sup> Regardless of this view, the GPs in this study were apparently intent on meeting the targets anyway.<sup>158</sup> I now outline various reasons for this behaviour, some of which are specifically related to GP status.

First, some research suggests that QOF is becoming ‘synonymous with quality.’<sup>164</sup> Such a statement is supported by those GPs in my sample who felt that QOF and the availability of QOF scores allowed their practice (and more widely their profession) to demonstrate that they were providing a good service. Therefore despite any personal reservations individual GPs may hold, they may feel a pressure to maintain high QOF scores in order to be seen as providing ‘quality’ care. Secondly, and on a related theme, my findings in line with other research,<sup>158</sup> highlight the competitive nature of GPs. Practice-level QOF scores are publicly available, and allow GPs to compare and contrast their practice performance with neighbouring practices. Many had become accustomed to achieving full QOF points and it is possible that they wanted to maintain these high standards. Furthermore, it is possible that this competitive edge also led some GPs to criticise other GP(s) practices who they suspected had achieved high scores by at best, tick box medicine and at worst fraud.

Thirdly, for some GPs their personal experience of working with QOF appears to have influenced their attitudes and behaviours towards aspects of QOF. For instance, although many GPs in my sample disliked the requirement to routinely use depression severity measurement tools, a small number found that their patients actually liked the tools.

Consequently, the attitudes of these GPs towards the use of these tools appeared to change, seeing them in a more favourable light. Therefore they accepted a reduction in their personal discretion, as it appeared to benefit their patients. Prior research also indicated that professional and patient views on the use of such tools were divergent.<sup>311</sup> As in my sample, the GPs in this study felt that a focus on depression was required, however they did not agree with the method they were being asked to use or even that it was necessary. Many felt that they possessed the necessary knowledge to manage and diagnose depression and therefore did not require any external aids. In contrast to GPs, patient views on the tools were mostly positive with many reporting that the tool offered opportunity for self-reflection and/or a way to monitor their progress.<sup>311</sup>

Finally, participants cited various ‘pressures’ which influenced their behaviour and discretion with regards to complying with QOF targets, particularly those they considered controversial or disliked. The source of pressure to comply was however *not* the same for all GPs and many appear to be related to their status. One common source of pressure for all GPs however arose from the widespread presence of QOF teams/surveillance. I now provide a more extended discussion of the form and functions of these teams and thereby support and extend the evidence beyond that currently available.

#### **7.2.2.4 QOF teams and surveillance: reduced discretion is the new norm**

As highlighted previously, early research identified the formation and presence of QOF teams and/or leads.<sup>153</sup> All participants in my sample also reported the post-2004 formation and continued presence of QOF teams and/or QOF leads in their practices. Participants described how, prior to or early on in the implementation period of the contract, discussions had taken place in order to ascertain how best to organise their efforts towards meeting QOF targets. In each case, the outcome of these discussions appeared to result in a division of responsibility amongst practice staff, with participants now occupying one of three informal ‘positions’ within a new form of hierarchy 1) overall QOF lead, 2) partial QOF lead and 3) ‘non-lead’. As reported elsewhere,<sup>52</sup> there was little competition between GPs for lead roles, especially overall lead roles, despite (in some cases) the provision of some additional protected time. This echoes research which also suggests that GPs were content to let other colleagues take responsibility for the delivery of the targets.<sup>296</sup> GP

reluctance to take up these roles appears to relate to the perceived time and administrative intensive nature of the role<sup>aa</sup> and supports findings which suggest that voluntarism (by those possessing certain suitable managerial skills or traits) is a key factor in their ‘appointment.’<sup>52</sup>

Reflecting the findings of prior research,<sup>52,165</sup> GP principals in my study were the most likely to hold a lead role<sup>bb</sup> and/or form part of a QOF team with salaried GPs primarily designated as non-leads. The empirical evidence also indicated that some salaried GPs held partial lead responsibilities,<sup>164</sup> and this was also the case in my sample (n=3). However, one salaried GP in the APMS practice (where everyone is salaried) held overall lead responsibilities.<sup>cc</sup> In addition, some participants also reported that practice nurses held partial lead roles in their practice and supports prior findings that QOF leads may be drawn from and ‘cut across traditional clinical and administrative hierarchies.’<sup>52(p243)</sup> Regardless of the form that QOF ‘team’ may take, their common purpose and focus is to ensure that the practice meets its QOF targets. Members of these teams possessed the most knowledge and control regarding QOF content and ICT systems, confirming the suggestion that decision-making and managerial power within practices has become more concentrated.<sup>52,165</sup> In particular, overall leads appeared to hold the greatest decision making capacity by managing the activity of other practitioners within their practice. Due to their role as information/data leads they are directly able to control the ICT systems, changes they instigate are filtered down to all other practitioners whom are expected to adapt their practices accordingly. The relative power of those who control the ICT systems was also reported in a small ethnographic study (n=2 practices) conducted early in the lifetime of the contract.<sup>166</sup> My findings highlight that this phenomenon is widespread and illustrates that those who control the content of the ICT systems are in control of the ‘information process’ surrounding QOF.

In addition to varying ‘levels’ of leads (e.g. overall and partial), there were also differences amongst apparently ‘equivalent’ leads, in particular those holding partial lead

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<sup>aa</sup> The burden of the role was becoming more apparent over time, hence the designation of QOF deputies identified in R2 interviews.

<sup>bb</sup> In a small number of cases, practice managers acted as overall QOF leads on behalf of their GPs.

<sup>cc</sup> Thus far I have seen no evidence regarding the internal organisation of APMS practices in relation to QOF and there I am unaware of whether this is usual or not.

roles. Whereas, some partial leads simply oversaw the work of their salaried staff working in their area of QOF (directing nurses activity towards targets), others conducted the bulk of the target work within their area(s) themselves. This was particularly the case for the three salaried partial leads. Whereas one had volunteered for the role (in the initial hope of monetary gains), the other two had been delegated their areas of responsibility by their overall QOF lead. For example in the case of GP10 her overall lead (GP2) designated her partial lead responsibilities to ‘encourage’ her to focus on QOF targets. Regardless of how these salaried GPs came to hold their area of QOF responsibility, they all appear to have been co-opted, by their GP principals, into the pursuit of the organisational targets without receiving any immediate or direct benefits (e.g. a financial bonus).

Regardless of a GP’s position in the hierarchy (principal, salaried, lead, non-lead etc), all participants were aware of the possibility of scrutiny<sup>dd</sup> and reported how their lead(s) adopted various tactics or ‘control strategies’ in order to enhance the likelihood of the practice meeting QOF targets. For the vast majority, these largely consisted of comparisons of individual practitioner performance at practice meetings, with some leads adopting more punitive strategies (e.g. ‘name and shame’) than others. Many participants regarded the achievement of QOF as requiring a team activity and recognised that their individual actions (or rather lack of), increasingly impacted directly upon their practice’s income and for GP principals their personal income. In other words, post-QOF they are now experiencing a greater level of ‘horizontal accountability’ with their practice colleagues and peers.<sup>238</sup> This development appears to contribute to a willingness by individual GPs to accept scrutiny by other practice members and even the shame of being ‘publicly’ chastised for being the one seen as letting the side down by ‘not pulling their weight.’ In other words, many wished to avoid being seen as the deviant case or ‘outsider’ within their organisations.<sup>312</sup> In addition to these ‘soft’ or social sanctions, a small number of GP principals (n=8) within one practice (ID22) were liable to ‘harder’ financial sanctions as a result of their new partnership agreement. Whilst the presence of soft sanctions has already been reported in the empirical literature,<sup>146,153</sup> the development of such ‘hard’ sanctions has not. In this case, the GPs reported that the suggestion of

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<sup>dd</sup> Which as my findings indicate may be overt or covert.

clearly defining responsibilities and liability for under-performing originated from their lawyers. The decision to turn this suggestion into an actual feature of their partnership agreement indicates a move away from trust to the formalisation of accountability, specifically horizontal accountability, at least for this practice.

For the majority of GPs, the post-QOF formation of internal surveillance mechanisms appeared to enhance the likelihood of the majority of practitioners complying with QOF targets, including ‘controversial’ targets such as the depression indicators. In line with previous evidence derived from a small number of case studies, the level of surveillance appears to vary more widely and impact upon the level of GP discretion.<sup>296</sup> Most participants spoke of weekly performance assessments, held in practice meetings. For a small number of GPs in my sample, the level of surveillance was particularly high and left little room to avoid the targets. For instance, the two salaried GPs who had also been trainees within their current practice had particularly high levels of (daily) scrutiny. However, rather than perceiving this as controlling, they both felt that it was legitimate and beneficial both to patient care and to their continued learning. In contrast, the GP in the APMS practice regarded the level of surveillance she was under as extremely close and that it invaded her ‘privacy.’ In addition, this scrutiny differed as it was external to the practice and outside the profession (the scrutinizers were non-clinicians from head-office interested in managing her tasks). This type of surveillance may be perceived as less valid than the primarily peer led type seen in traditional partner-run practices. Indeed when I asked salaried GPs about the notion of working for a private provider, many highlighted the issue of scrutiny by non-professional managers as being problematic. They perceived that non-clinicians priorities would differ as well as questioning their ability to judge ‘professional’ decisions and therefore scrutiny by non-professionals was not considered desirable or legitimate.

The preceding evidence illustrates that internal surveillance and critical appraisal in relation to QOF performance by QOF leads/teams appears is a widespread phenomenon. In addition, GPs appear to consider these developments as legitimate and necessary to ensure that practices meet their QOF targets. My findings therefore lend weight to the suggestion that *new* professional norms may be emerging in general practice.<sup>164</sup> Such

claims have been supported by contrasting how traditional professional norms act not only to promote the notion/image of collegiality and equality amongst the medical profession but also to restrict the propensity for peer criticism. Furthermore, the new informal hierarchies, and the creation of QOF teams has been suggested to represent a new stratum within the profession, leading to a type of professional ‘re-stratification.’<sup>164</sup> The emergence of new professional norms was not anticipated by Freidson<sup>313</sup>, who predicted that re-stratification within the medical profession would lead to ‘cleavage and friction.’ The collective evidence suggests that has not occurred in general practice due to the development of ‘new norms’ which have ameliorated the occurrence of a consequential split within the profession.<sup>164</sup> My findings suggest however that the nGMS has created a situation whereby cleavage and friction are more likely to occur in the future between those GPs who are employers and those who are employees. Furthermore, this section also highlights some of the status specific sources of pressure that act to constrain an individual GP’s discretion.

#### **7.2.2.5 Status specific pressures: leading to the control of, and increasing divisions within the profession**

Prior to the introduction of nGMS, non-principal, ‘early-career’ GPs were reported as having high job satisfaction and discretion in terms of the type of work they did. Specifically these GPs felt they were doing what they considered to be ‘nice-work’ in contrast to their GP principals who conducted the ‘unrewarding’ or ‘burdensome’ work.<sup>232</sup> In contrast, recent post-nGMS research indicates a very different situation.<sup>230,231</sup> The findings of these later studies reports *salaried* GPs as doing the unrewarding work and being treated as second-class citizens within what they now regarded as a two-tier profession.<sup>230,231</sup> It appears therefore that there may also a second form of stratification occurring within the profession, with the nGMS creating a reversal of the situation between the two groups of GPs, i.e. new ‘winners and losers.’ However, as I show, even the winners have new difficulties to deal with.

Participants in my sample agreed that the 2004 version of nGMS was overall a good package deal, offering the profession increased monies and flexibility to have a better work/life balance. However, it seems that GP principals have primarily been the direct

beneficiaries. First, they had on average been in practice much longer than the salaried GPs and had worked under a variety of older out-of-hours schemes, which some described as ‘unsustainable.’ Secondly, the area that caused most consternation was the issue of pay. Equity theory suggests that individuals will compare their inputs or efforts and associated rewards with others around them, perceiving themselves as being treated fairly if the ratio of inputs to rewards is equivalent to those around them.<sup>314</sup> GP principals had, as a result of QOF monies, received large pay rises, creating an acknowledged large pay differential between the two groups of GPs. In accordance with equity theory, this led to a perception of inequality. This subsequently led some to perceive that general practice was now a hierarchical profession, with salaried GPs forming the ‘under-tier.’ Some salaried GPs were resentful of the situation, reasoning that the substantive portion of their daily work (i.e. conducting patient consultations) was largely comparable to GP principals. Others however, felt that they were fairly rewarded, reasoning that GP principals were under greater pressures and/or had greater responsibilities. Finally, of those that had actively chosen a salaried role, some were pragmatic, stating that they knew the implications of their choice and for others these implications were worth less than the ability to have a ‘portfolio career.’<sup>232</sup>

Despite the differences in pay, salaried GPs felt that they were fairly treated by their employers and were not merely left doing their GP principals ‘dirty work.’<sup>cf.230</sup> They also reported an environment of equality within their practice, citing inclusive practice meetings.<sup>ee</sup> However, it was clear that some saw their current salaried post as temporary or as an apprenticeship, and that eventually the desire to gain increased control would mean that they would seek a partnership. However, the future outlook appeared to suggest that this was becoming increasingly unlikely as the market demands have changed.

Whereas prior to 2004, the employment market meant that salaried GPs could pick and choose the kind of work they wished to undertake,<sup>232</sup> post-2004 it seems that this is less likely. Salaried GPs hoped the current situation of limited opportunities for partnership

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<sup>ee</sup> In a small number of cases salaried GPs did not work on the days when practice meetings were held and felt more excluded. This is akin to reported feelings of exclusion/isolation reported elsewhere.<sup>231</sup>



was temporary. However, it was clear that many were working in the prospect of gaining an opportunity in their current practice and includes the pursuit of areas they personally disliked. In other words, by complying with *all* of QOF (even disliked areas) these GPs were subordinating their personal preferences for their career aspirations. Such factors illustrate Lipsky's view of how the behaviour of SLBs and conforming to goals, reflects the available sanctions and incentives, as for some salaried GPs the prospect of gaining a partnership was the ultimate incentive. This is not to say that only those salaried GPs who wished to become a partner complied with all of the targets. Some appeared to do so as they perceived that as employees of their organisations, they were obliged to comply with all of the organisation's QOF targets. Others appeared to do so out of a sense of organisational loyalty arising from the fact that they had been trained and socialised in their current practices, which led some to say they did things 'just like a partner.' Only a small number of salaried GPs suggested that they did not routinely attend to QOF and reasoned that this was acceptable as their GP principals were primarily responsible for delivering QOF. Only one GP (GP30) stated that she overtly did not comply with some of QOF, specifically the depression indicators. However, this case was unusual, as she had a long established personal friendship with the practice owner as well as previously being a partner in the practice.

The relative dearth of available partnerships appears unlikely to change. The accounts of GP principals were peppered with discussions of financial pressures and combined with a perception of uncertainty regarding the future outlook of funding, seemingly means that GP principals are closing ranks. The available data shows that they are increasingly choosing to *employ* fellow GPs as opposed to making them an equitable partner.<sup>315</sup> GPs principals cited various sources of financial pressures which led to such decisions. In order to meet QOF targets, participants here as in the practices included in the early ethnographic studies,<sup>147</sup> reported additional investments in their practices in terms of staffing numbers, training or increased hours. Even for those who had not made such investments, there is the issue of rising expenses (e.g. cost of living increases for staff wages) year on year or simply the desire to maintain their personal income levels. Recent evidence in fact highlights that income levels are falling as the proportion of practice income GPs had to re-invest in their practices reached a recent record of over 62%.<sup>316</sup> In

addition, they were in effect being asked to achieve more over time (targets tightening, extended access DES etc) but with fewer financial resources being made available due to a lack of increase in the global sum.

All in all, the preceding discussion highlights that GP principals are foregoing a degree of discretion in order to make financial gains or at least to maintain their financial status quo. They appear to be on a ‘contractual treadmill’ or as has been described elsewhere, they had limited opportunities to resist or disengage from the contract<sup>ff</sup> due to their responsibility to maintain practice income (and their profit shares).<sup>213</sup> The post-QOF perceived pressures and responses of GP principals reflect the limitations outlined at the end of chapter 3 in applying the SLB framework to GP principals. To re-cap it was suggested that they should be seen as an SLB/manager ‘hybrid’ due to their dual status as workers in, and owners of the business. The presence of QOF appears to have magnified the managerial and the entrepreneurial aspect of their roles. In addition, their personal (income) objectives and organisational objectives are strongly aligned and they are therefore increasingly ‘results oriented.’ However, as I now highlight, even this picture is too simplistic as it appears that even amongst GP principals, there are some that are more results oriented and concerned with performance than others, specifically QOF leads.

As described earlier, these arrangements varied within practices, in terms of the structure and types of practitioners holding the lead roles, with overall leads holding the most influence over other practitioners and most closely resembling managers in Lipskian terms. This complexity lends weight to the suggestion for a more nuanced approach to the issue of management in modern public services versus the simple distinction Lipsky makes between managers and SLBs.<sup>234</sup> However, the difficulty in general practice remains the fact that GP principals are owners of their organisations. This is exemplified by the fact that as I identified in some cases, GP principals are ‘allowed’ to be somewhat disengaged from the pursuit of QOF targets and that salaried leads are not necessarily able to affect the activity of their GP principals. Both occurrences are related to the position of

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<sup>ff</sup> Only 2 GPs from one practice (ID12) reported that they were not pursuing all of QOF targets as they did not consider some of them to be evidence-based. They were prepared to sacrifice income to work in a manner aligned with their professional views. In addition, they were financially secure as they both also held other income-providing roles.

authority inherent to a GP principal. In other words, the informal and formal hierarchies can conflict, and in some cases the formal hierarchy wins out. Furthermore, it seems that although tensions between practitioners can exist,<sup>146</sup> (due to QOF non-compliance/'free-riding') it appears to be limited in its extent.<sup>296</sup> Where tensions do exist, there appear to be various factors that can prevent them from surfacing and spoiling otherwise established and successful working relationships/partnerships. For example, as one GP principal (GP14) put it when discussing the relative under-performance of some colleagues, 'people pull their weight in different ways.'

#### **7.2.2.6 Multiple accountability: in name only?**

I have already described how QOF has increased the horizontal accountability of GPs within their practices and impacted upon the discretion of individual GPs. In addition to this, recent theoretical work also highlighted that 'bottom-up' pressures are more prominent due to a governmental drive to promote the client's role in the evaluation of service delivery.<sup>317</sup> In general practice, the primary source of such pressures within QOF arises from the incentivisation of the patient-survey. It has however seemingly not been powerful enough to affect any significant bottom-up pressures. Prior research reported that the incentivisation of the patient survey was not a 'driving force' on practice services.<sup>157</sup> My findings echo this, as GPs from only one practice (ID11) reported making a change in their service in relation to feedback from their patient survey, which resulted in longer appointments. Most GPs were fairly apathetic to the patient survey as their survey results had always indicated high patient satisfaction. This ceiling effect (i.e. a lack of variation in responses) is a commonly known issue with regard to patient satisfaction measures and therefore any further attempts to increase bottom-up pressures may require new levers.

Finally, there is the issue of top-down accountability. As highlighted in chapter 2, although QOF is voluntary, PCTs are mandated to inspect practices and assess their QOF data. Despite this external scrutiny, QOF inspection visits were not considered overly intrusive by my participants. This may reflect that fact GPs are routinely achieving their QOF targets, that the visits were not perceived as punitive in nature and/or that the systems were not perceived as very effective, particularly in regards to detecting

fraudulent activities. In addition, other pressures stemming from the PCT in terms of reducing prescribing costs for example, were often not considered as a priority in comparison to meeting the immediate needs of their patients.

Finally, Lipsky posits that enacted policy frequently does not reflect official policy. The evidence presented suggests that on the surface, enacted policy does reflect official policy. QOF provides clear rules, GPs have developed systems in order to police themselves and their efforts towards the official policy rules and QOF achievement levels remain high across general practice.<sup>318</sup> However, it is not GPs, but PNs who are delivering the bulk of the policy goals. Furthermore there have been unintended losses in other dimensions of quality and presumably the government did not intend for targets to be achieved via a 'tick-box' approach. Aside from this, it is clear that within the remit of QOF, the policy making aspect of the GP role has been largely reduced but it is important to note that significant space does remain outside of QOF, not only for policy making but also the exercise of discretion. This reflects the views of many GPs within my sample who saw QOF as representative of only a small aspect of their role.

### **7.3 Conditions of work**

#### **7.3.1 Scarce resources?**

The scarcity of resources perpetuated by high demand is argued as being a key factor in SLBs being unable to realise their high ideals within their daily work. Lipsky argued, the availability of additional monies to organisations does not necessarily lead to alleviation or improvement in service levels as funds may be directed to the salaries of SLBs.

Similarly, QOF was a financial boost for general practice, but according to national data, many GP principals awarded themselves large pay rises,<sup>169</sup> rather than investing in their practices and improving/expanding services etc. However, at a local level the degree of investment can vary. Empirical studies indicated that although GP principals may have had pay rises, some also invested in their services and staffing levels.<sup>52</sup> My findings also illustrate that many GPs principals described enlarging (headcount and/or hours) or enhancing (via training) their staffing capacity. Expansions to the staff complement were primarily at the level of administrative staff and/or the lower end of their clinical hierarchy and seemingly led to some alleviation of the overall burden of QOF work on

GPs. Such factors may explain why surveys illustrate that the proportion of practice income GPs have to re-invest in their practices is increasing over time.<sup>316</sup>

In terms of actual GP numbers, few reported recruiting additional GPs, only replacing outgoing members. Given that the newly developed bureaucratic systems within practices had resulted in increased patient contacts,<sup>gg</sup> the demand for the static base number of GPs is in fact growing. In addition, modelling projections in 2007 indicate a growing gap between demand growth and GP supply in England,<sup>319</sup> perpetuating the issue of high patient demand and low GP supply. In summary, the evidence suggests that the issue of the relative ratio of high client numbers to GPs will be maintained for the foreseeable future.

Another key resource is the time allowed for client-interactions. The vast majority of participants (n=59)<sup>hh</sup>, still had the common pre-2004 consultation lengths of 10 minutes. The scarcity of time appeared to become more apparent for GPs post-QOF. They described increased pressures (relative to pre-QOF or non-QOF consultations) as a result of attempting to accommodate the two often conflicting agendas (patient vs. QOF), which at times resulted in one or the other of the agendas not being attended to. In addition, even where GPs felt they were already doing the clinical work in QOF targets, they still related that time was scarcer for the other aspects of their role (e.g. interpersonal care) simply as a result of recording QOF data or in Lipskian terms, the ‘form-filling’ aspect of a SLBs role. In other words, the bureaucratic role of GPs had increased post-QOF. However, as many patients now visit the practice nurse who conducts much of the form-filling for GPs, some GPs felt this was a better system as they actually have more time to reflect upon the PN collated information. This may therefore allow GPs to make ‘better’ or less pressured decisions.

The final resource relates to an SLB’s personal experience for the role, particularly that inexperience was disadvantageous. The issue of personal experience in relation to QOF

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<sup>gg</sup> Either as patients had multiple conditions, because appointment length are insufficient to deal with all requirements (patient and QOF) in one go and/or because patient attended at the ‘wrong time’ for the system and so they had to call them in again.

<sup>hh</sup> The 3 missing are those in practice 13 who lengthened their consultations.

has not been addressed within the literature and therefore the evidence here is limited to my findings. They appear to suggest that in contrast to inexperience making QOF work more difficult, some of the less experienced GPs suspected that ‘older’ GPs found the 2004 transition difficult, as they would have had prior ways of working, conducting their consultations etc. whereas many of those in practice since 2004 had simply not known their work any other way. QOF templates appeared to provide a level playing field because experience did not come into one’s ability to follow the templates. Furthermore, it may have been expected *a priori*, for clinical experience to be a factor in whether or not GPs would have a greater propensity to become QOF-focused or not. For instance, one could hypothesise that GPs with the greatest pre-QOF experience would be the best placed to resist becoming QOF-focused or that new entrants may be socialised by their practice colleagues into becoming QOF-focused. My findings suggest that experience does not appear to be a major factor, as GPs with varying levels spoke of resorting to being QOF focused either in response to busy or pressurised periods (e.g. QOF year-end) or that they were becoming more QOF-focused overall.

### **7.3.2 Goal conflict?**

As highlighted in chapter 3, the introduction of QOF has the potential to create many of the types of goal conflict raised by Lipsky. The first source of goal conflict stems from social engineering goals vs. client-centred goals. In GP terms, this can be translated into the population or public health approach to care embodied in QOF vs. their espoused focus on the individual and holistic care. Although many GPs suggested that QOF represented as one GP put it ‘herd medicine’ they also related that for the most part this did not conflict with their focus the individual patient. They reasoned that all guidelines and targets had to be adapted to the individual and (for the most part) were also to an individual patient’s benefit. In other words, the two goals were not necessarily in conflict if one applied discretion. The only area that GPs appeared to highlight as representing primarily a public health or epidemiological interest, was the collection of what they deemed as ‘unnecessary’ population-level data (e.g. on smoking). Of course the current plans to place GPs at the heart of commissioning,<sup>320</sup> will necessitate a change to a more population-focused approach to care, at least for the sub-set of GPs who will be making the decisions on the local commissioning boards. It will be interesting to see if any

conflicts arise within this sub-set or whether they filter down and feature more prominently in the everyday decision-making of the rank and file GP.

A second and new source of goal conflict specifically associated with the introduction of QOF concerns the dilemmas now posed by the obvious presence of dual-agenda consultations, particularly when the agendas are in conflict.<sup>158</sup> In Lipskian terms, this is an example of client-centred goals vs. organisational goal conflict or in this case patient-centred goals vs. organisational goals. For some GPs this type of conflict only arose sporadically as they had either relatively little exposure to QOF or their QOF exposure was primarily limited to doing medication reviews where patients were attending specifically for a medication review and therefore the two agendas were aligned. Other GPs however appeared to relate that this type of conflict occurred in a significant proportion of their consultations which were increasingly complex.<sup>ii</sup> As I highlighted earlier, GPs are seemingly adopting various strategies to deal with this source of conflict, one of which resulted in them being/becoming QOF-focused due to the perceived pressures of time and workload. In such cases, GPs are choosing the most efficient way for them to attend to the organisation's goals of meeting QOF targets and process their patients quickly, over being patient-centred.<sup>jj</sup> A small number appeared to resolve this source of conflict by reasoning that it was of clinical importance that individual patients had their particular QOF elements up to date i.e. that they were in fact being patient-centred. Such views appeared to alleviate any tensions they may have had in being/becoming QOF-focused. Other GPs however, reported maintaining an approach reflective of their professional training by attending to QOF opportunistically i.e. when and/if appropriate etc, thereby also lessening this source of goal conflict. In summary therefore, whereas this may be a source of tension in theory or at specific times, GPs for the most part are finding ways of resolving this source of conflict or do not see it as a conflict in the first place.

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<sup>ii</sup> This was a major reason why the GPs in practice 13 had lengthened their appointments i.e. to be able to deal with both agendas more effectively.

<sup>jj</sup> This is an example of 'goal displacement' i.e. the norm of individual patient orientation has become subordinate to the needs of the organisation. This may also explain why the over-medicalisation of patients is reportedly occurring.

The final issue relates to role expectations, specifically the contradictory expectations that shape the SLB role from various reference groups. GPs reported that they were in effect, attempting to meet the demands of three very different reference groups: the government, their patients and their local PCTs. Evidence collected earlier in the lifetime of the nGMS contract (Nov 2005 – May 2006) also highlighted this by suggesting that GPs may be experiencing tensions between the dual requirements of implicit rationing (e.g. prescribing budgets) and the adherence to explicit rules within QOF.<sup>146</sup> Since this period, one would assume that tensions may have increased as the government has chosen to tighten QOF targets. My data suggests that GP principals are still feeling this tension but not to an extent that it affects their service. GPs related that they were striving to meet these new stricter targets for the benefit of their patients, whilst at the same time receiving pressure from their PCTs to reduce their prescribing costs. Despite this, GPs spoke of a need to do their best for their patients, and effectively disregarded the PCT priorities. It will however be interesting to see how this type of conflict plays out once the other reference group is a sub-section of their own peers under the new commissioning arrangements effective from 2013.<sup>320</sup>

Lastly, in terms of the supposition that clients are not a significant determinant of the nature of the SLB role and practice, QOF appears to have done little to raise the profile of patients. In some ways QOF can be seen to have downgraded the espoused focus of GP work, the individual; as a consequence of practices increasingly becoming structured and systematised around the most efficient ways of dealing with their patient population and collecting points. This was exemplified by the combination of two new QOF induced factors: the fragmentation of care (patients being required to see a PN *then* a GP etc), and the strict call/re-call systems. This has led to patients with multiple QOF conditions being required to attend their practice on several separate visits.<sup>150</sup> This downgrades the value of a patient's time in relation to the needs of organisational efficiency. Furthermore, patients were seemingly regarded less as unique individuals and more as an 'object to get points.' GPs also placed little importance on or made few changes in response to the direct mechanism of patient feedback, the incentivised patient survey.<sup>157</sup> This may reflect one or more of several issues: 1) any income-loss related to the survey is small,<sup>321</sup> 2) patient



satisfaction is usually high 3) patients are not in a position to assess technical competence and/or that their patients are essentially ‘non-voluntary’ as alternatives to traditional partner-run arrangements remain small.<sup>227</sup> If the trend for the marketisation of general practice continues to a stage where real competition/choice occurs, the role of patients in influencing GP services may increase in the future. Recent work however highlights various factors (e.g. patients loyalty to GPs/practices) which suggests that patient choice will not necessarily be a powerful lever for service changes and/or quality improvement.<sup>322</sup>

### **7.3.3 Performance measures and predicted consequences**

Lipsky described how during the period of his writing, measuring the performance of SLBs was crude and problematic. However, as I also discussed the ‘technology’ of performance measurement has moved on somewhat since the 1970s. Medicine represents a good example of the improved technology with the EBP movement demonstrating that it is possible to define and measure complex work. In general practice, QOF and its associated ICT systems represent the latest attempt to measure performance. In addition, to the acceptance that complex work can be reduced to a series of performance markers, the traditional professional norms which prevent the scrutiny and criticism of other GPs/professionals seem to be changing. Rather than resist these measures, GPs have for the various outlined reasons not only accepted the performance measures but embraced them.

In chapter 3 section 3.6 I outlined the three predictions Lipsky made that would result from the introduction of performance measures to SLB work. I now discuss each one in turn. First, does the introduction of QOF provide goal clarity and allow GPs to direct their energies with less ambivalence than prior to QOF? The answer appears to be yes and no. The combined evidence suggests that some GPs view QOF templates as aide-memoires, i.e. they provide clarity in terms of what they are required to do and facilitate the processing of their work. As GP57 put it, as a result of QOF ‘You know what to do, and it's easily done.’ In particular, this is the case when the patient and QOF agendas are aligned. However, as outlined earlier, the introduction of QOF also served to increase the

ambivalence in judging when and if to complete QOF in certain consultations where it seemed inappropriate.

Lipsky's second prediction is that SLBs will concentrate on the measured activities. This reflects concerns raised by research conducted just prior to the introduction of QOF.<sup>300</sup> This study reported that GPs felt linking money to clinical activity may mean that 'tunnel-vision' could occur i.e. a focus on incentivised activities at the expense of non-incentivised work.<sup>300</sup> Again the post-QOF evidence for this actually occurring is mixed and limited. At the individual level, some GPs reported to be more QOF-focused than others. Some appear to resort to this more biomedical approach at particularly busy time points but otherwise claim to maintain a holistic approach to care. What is clear is that practice resources are increasingly organised around the needs of meeting QOF targets. As I highlighted in chapters 5 and 6, GP principals appear to have made similar internal changes to their practice organisation in an effort to maximise their ability to meet QOF targets. These converging lines of change resulted in: altered roles and responsibilities for practitioners; increasing sub-specialisation; new informal QOF related hierarchies and increasing bureaucratisation. Such findings support the existing empirical literature suggests that post-2004, individual practices responded to the needs of QOF in a similar manner, resulting in the emergence of converging organisational forms.<sup>165</sup> This new 'singular,' organisational form has it seems arisen in a quest for efficiency as many of the changes were accompanied by a rhetoric of efficiency, with respect to organisational and financial efficiency. Overall such changes reflect Lipsky's point regarding how behaviour in organisations becomes compatible with how the organisations are evaluated and may provide an explanation for the differing fortunes of incentivised and un-incentivised areas. My findings and the qualitative literature provide no consensus as to whether or not non-incentivised care has suffered since 2004. Quantitative evidence on this is limited, but supports the view that non-incentivised areas of clinical work *are* suffering in comparison to those incentivised.<sup>222</sup> Furthermore a study conducted in the US investigated the effects of removing incentives for certain screening activities over a period of four years (vs. the five years where the activities were incentivised) and found declines in performance levels for those newly non-incentivised activities.<sup>323</sup>

Thirdly, has fraud and deception intruded into performance measurement? My findings reflect those in the exiting literature,<sup>157;151,223</sup> and indicate that whilst some GPs admit to data manipulation (e.g. changing readings on the cusp of target levels), it is not widespread.

Finally, although the technology of performance measurement has improved to measure aspects of clinical care, it is not capable of measuring the quality of care provision overall. As highlighted in the literature, QOF only measures the measurable<sup>297</sup> and thereby neglects complex areas of a GP's role that patients consider to be important.<sup>298</sup> This was reflected in my findings as GPs felt QOF could not capture important aspects of their work (e.g. IP care) and that QOF scores do not indicate the quality of patient interactions. Furthermore, many were critical as there was no way to tell how the scores were achieved i.e. high QOF scores did not necessarily translate into high quality care provision as they can be achieved by 'unprofessional' (tick-box) means.

#### **7.3.4 Client relations**

As highlighted in chapter 3, the APMS contract option offers the potential to dramatically change the non-voluntary nature of patient relationships with traditional partner-run practice arrangements. Actual alternatives to traditional general practice provision have however remained low throughout the study period<sup>227</sup> and may explain why GPs only viewed APMS as a potential and not an actual threat. As a result, the non-voluntary nature of patients who seek GP services currently remains intact. Existing empirical evidence highlights that patient choice has reduced post-QOF.<sup>150</sup> This reflects my findings which highlight patients reduced choice terms of choosing when to attend and who they see on attending. The structured call/re-call systems treat chronic disease patients in Lipskian terms as 'bundles of bureaucratically relevant attributes' and act to summon patients to regularly attend their GP practices. An example of the inflexibility and bureaucracy of the system was highlighted by one GP who described the awkward situation of patients being recalled to the practice just after they have attended, as it was 'the wrong time' for the practice and its QOF targets. Furthermore, patients can be required to attend specific QOF clinics, where they may not see the provider of their choice and as reported elsewhere are limited in their access to skilled medical care.<sup>150</sup>

Lastly, where patients do not attend (perhaps as they feel capable of effectively self-managing their conditions) they may still be pursued simply as part of QOF-point gathering exercise. In my sample, this was limited to telephoning patients at home, but other evidence suggests that some practitioners actually visit patient homes to chase QOF points.<sup>150</sup> Such actions highlight the tension between patient autonomy and professional responsibility for the delivery of EBP.

In my sample, some GPs acknowledged the post-QOF reduction in patient choice, stating for example that they would not previously have 'chased' patients who regularly did not attend their practice. Others however, felt QOF provided them with a mandate to 'chase' patients, that they had essentially been given greater responsibility for ensuring their patients received the necessary care. Finally, it appears that where GPs are being/becoming QOF focused, they are using QOF templates (e.g. by blaming the computer prompts) to control the structure of the consultation process by prioritising their agenda over the patient's. In turn, this reduces the opportunity for patients to introduce 'non-relevant,' potentially distracting and/or time-consuming elements to the consultation. Furthermore, adopting a QOF-focused approach maximises the likelihood of individual GPs meeting their organisational targets and reduces the potential of experiencing sanctions from under-performance. These findings may provide a supplementary explanation for recent evidence which also suggests that GPs utilised QOF templates in order to limit the opportunities for patients to introduce their own topics.<sup>228</sup>

## **7.4 Advocacy and alienation**

### **7.4.1 Advocacy**

If as Lipsky described, the ability of SLBs to advocate for patients (in terms of securing the best outcome and devoting dedicated time/effort to the individual) is undermined by the organisational need for mass processing, it could be argued that the implementation of QOF has reduced the capacity for GP advocacy. Post-QOF, practices have undergone a process of QOF-induced internal re-organisation, driven by a need to meet QOF targets (not the needs of individual patients) in the most efficient manner. However, the evidence shows GPs perceive that QOF has produced improved or standardised levels of care. GPs appear to extend this logic and perceive that *all* registered patients now have the same

chance of receiving high ‘quality’ care and that the system reduces the likelihood of inequalities of service/bias. This is because non-attending patients are no longer ignored once they fail to attend, but are actively reminded about the care available to them. In addition, some patients appear to like the use of depression tools which they see as providing an important ‘objective adjunct’ to their GPs personal judgement.<sup>311</sup> However, as I discuss in section 7.5, my data illustrates that these tools are not being used in a uniform manner and that GPs are developing new shortcuts.

Finally, GPs also placed importance on the ability to exception report certain patients, which effectively allows them to continue to advocate for individual patients whose interests would not be served by the pursuit of targets.

#### **7.4.2 Alienation**

The combined evidence suggests that clinicians perceive much of QOF template-work as routine, mechanistic and largely undesirable work to conduct. Template work therefore can be characterised, and was also perceived by GPs as alienating, hence many were happy to ‘offload’ as GP14 put it, such work to their nurses. Such sentiments resonate with research conducted on the 1990 ‘GP’ contract which indicated that GPs used their practice nurses as ‘absorbing mechanisms’,<sup>324</sup> for their ‘dirty work.’<sup>325</sup> This may provide an explanation as to why many GPs seemed as Lipsky states are ‘willing to accept organisational re-structuring’ and ‘less concerned with protecting their own connection with clients.’ QOF-induced organisational changes within practices and the reported reduction in GPs’ personal continuity<sup>168</sup> with their chronic disease patients would reflect this statement because many GPs are increasingly only working on part of the ‘product’ and process. Rather than perceiving this as alienating, many GPs in my sample were satisfied with the new arrangements. They perceived their work post-QOF to be more satisfying as they were now seeing more diverse and complex cases which required the creative use of their knowledge and decision-making. Others cited various factors which meant their work was less favourable i.e. they had less job satisfaction post-QOF. For example, internal re-organisations (in the quest for organisational efficiency) meant that some were increasingly ‘pushed’ into being sub-specialised, resulting in a loss of variety in their work. Others concerns reflected those reported in the existing literature and

include the loss of continuity with patients<sup>157</sup> (as GPs are increasingly the second point of contact for chronic-disease patients)<sup>kk</sup> and feeling ‘de-skilled.’<sup>161</sup> Such findings illustrate that GPs (or at least a sub-set) are increasingly becoming ‘partial’ practitioners.<sup>133</sup>

As the preceding paragraph highlights, GP principals are able to make decisions which can subsequently lead to an increase or decrease in feelings of alienation towards their work. As my findings illustrate this includes the ability to decide to: give staff a ‘QOF holiday;’ to re-structure their surgeries in order to limit the amount of routine/repetitive QOF-related appointments e.g. medication reviews and/or award (and also remove) financial bonuses for QOF achievement to salaried staff. This resonates with Lipsky’s suggestion for ways that managers may exert their discretion to reduce worker alienation and again points to the limitations of viewing GP principals as SLBs. By comparison, it is clear that salaried GPs are not able to exert the same level of control over the type of work they do. The available empirical evidence suggests that salaried GPs are experiencing feelings of alienation as they have little control over the type of work they do and perceive that they have been delegated undesirable work, specifically, the ‘left-over or discarded jobs...the less complex and perhaps less professionally satisfying or challenging work.’<sup>230(ibid p914)</sup> As highlighted previously however, although salaried GPs in my sample acknowledged that they did work designated to them by their employers, they mostly felt that they were not simply left doing a principals ‘dirty work,’<sup>325</sup> but were engaged in varied work and felt fairly treated by their employers. However, my findings and a recent report do suggest that the views and experiences of salaried GPs are somewhat context dependent.<sup>231</sup> Many salaried GPs in my sample compared and contrasted their experiences within their current practice with where they trained or the experiences of other salaried GPs they knew of elsewhere. What is clear from my findings is that whilst many salaried GPs are content to remain salaried (as this allows them to pursue other areas of work etc) some eventually wish to become GP principals in the future and this is driven by a need to have more control.

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<sup>kk</sup> Variety of work and personal continuity were the main reasons that many cited for choosing a career in general practice, therefore over time should the trend continue, both job satisfaction and recruitment may suffer.

There is also the issue of whether QOF has impacted upon the ability of GPs to control the input (i.e. patients) and outcomes of their work. It would be appropriate to remind the reader at this point that QOF contains features which would appear to reduce the potential for GP alienation in relation to this point. Specifically, the decision to pay for progress towards targets (as opposed to an all or nothing approach) and the ability to exception report. I was curious as to what GPs felt about a version of QOF without exception reporting. When asked, many GPs felt that this would lead to negative results for patients (who may be inappropriately treated) and for themselves, as they would be penalized for patient actions (e.g. non-attendance, non-compliance) that were beyond their control. Furthermore, many perceived it would create an unequal playing field with those practices in affluent areas having an advantage.<sup>11</sup> Under the current system (and despite my sample containing GPs working in slightly more deprived areas than the national average) few GPs reported any difficulties in meeting the targets. This supports evidence which indicates that although deprived practices may have initially been at a disadvantage to more affluent practices, the gap in QOF achievement had closed between 2004-7.<sup>221</sup> In other words, the views of my GPs working in more deprived areas may reflect the later time point that I collected my data. The preceding highlights the importance of exception reporting to feelings of alienation. Whereas my questions regarding the removal of exception reporting were hypothetical in nature, there are now reports that proposals are afoot to remove the exception reporting facility.<sup>326</sup> In addition to my findings, lessons on the effect this have can be drawn from the US, where some health plans utilize P4P systems, but do not have the exception reporting facility.<sup>327</sup> The lack of an exception reporting facility led to physicians feeling unfairly penalized and accountable for their patients' actions as well as a 'subtle pressure to get rid of non-compliant patients.' (ibid p756).

Finally, it appear that GPs are feeling increasingly alienated from QOF over time as they doubt their ability to affect the outcome of their QOF-related work, specifically the overall QOF score. For example, many felt that the incentivisation of the patient survey

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<sup>11</sup> GPs in the most deprived areas related that their patient's had 'bigger issues' to deal with (e.g. housing issues) than their often symptomless chronic diseases and often did not attend or comply with advice, medications etc.

undermined their ability to achieve full QOF points.<sup>mm</sup> However, many still perceive that the majority of targets are largely within practitioner control and that points awarded reflect the effort invested.<sup>77</sup> Furthermore, it seems that GPs feel that QOF has enabled them to increase control over the outcomes of their work, as they feel that the current focus on process measures has produced better quality of care. This appears to convey to GPs that they can control or at least influence (proxy) outcomes and sometimes even ‘significant outcomes’ such as a reduction in the incidence of heart attack.<sup>nn</sup> However, when asked about proposals to an outcome-focused QOF,<sup>329</sup> payment by outcome-results was not favoured. The negative views reflected the issues that arose for the removal of exception reporting i.e. that they would be unfairly penalised for factors beyond their control. In other words, should the proposals come to fruition we may see GPs increasingly alienated from their work and this may have negative implications for the future of recruitment and retention within the profession.

### **7.5 Consequences and coping mechanisms**

My findings illustrate that prior to the introduction of QOF, GPs felt more able to work in an atomistic manner. As GP50 put ‘it we were operating much more individually before.’ Post-QOF however, I have shown that GPs are experiencing greater horizontal accountability. Furthermore, the use of uniform standardised templates would appear to restrict the scope for them to deviate and/or continue in their prior ways of working. In some cases this was welcomed i.e. where patient needs were aligned with QOF, they were actually perceived as helpful to them completing the necessary QOF work. In addition, many perceived that QOF had improved care as GPs were no longer left to their own devices and that they were now all singing from the same hymn sheet i.e. standardised working practices and having less discretion to ‘do your own thing’ was somewhat welcomed. However, some GPs did appear to form new routines and short-cuts, primarily for areas that they did not like. For example, many disliked the depression tools and found ways around it or as one GP put it he ‘intelligently bypassed it (GP37).’

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<sup>mm</sup> Recent negotiations mean that the 2011/12 QOF will no longer pay according to patient survey results.

<sup>nn</sup> Recent evidence however suggests that QOF had no discernible effects on processes of care or on hypertension related clinical outcomes.<sup>328</sup>



In terms of GPs showing example of modifying the concept of their job, most appeared not to have done so. Prior to QOF it appeared that GPs were modifying the concept of their job in response to a re-distribution of work, specifically GPs appeared to be reconfiguring their identities as ‘biomedical specialists.’<sup>156</sup> My evidence suggests that post-QOF, GPs are maintaining (or returning to) their claims to a holistic approach and describe the changes as marginal to their personal practice. This echoes research which identified a post-QOF trend towards increasing biomedicalisation, despite GPs claims to continue to practice ‘holistically.’<sup>43</sup> As the authors put it however, even if GPs have never been truly holistic, QOF has produced changes that ‘go further in the direction of a biomedical, disease-oriented model of care than has been seen before.’<sup>43</sup> As I illustrated in section 7.2.1.2 there has been an impact on value discretion and there is increasingly evidence to suggest that the focus of general practice has ‘shifted from patients and the diseases that make them suffer, to the diseases themselves and their measurement within the patient.’<sup>298(p436)</sup> Some salaried GPs in my study certainly felt that their practices and principals were so focused on achieving QOF that patients are now seen as an ‘object to get points.’ Finally, it is also clear that some GPs were becoming more specialised as a result of QOF, by for example being the diabetes lead in their practice. This caused tensions for some who identified themselves primarily as generalists and were unwilling to modify the concept of their job to one resembling a consultant or ‘biomedical specialist.’

## **7.6 Future outlook**

Lipsky made various suggestions to improve the future of street-level practice and the service received by its clients. The first of Lipsky’s suggestions surrounds the need to enhance client involvement and empower them so that they become powerful figures in the determination of the services they need to access. There has been a significant build-up of government rhetoric regarding increased patient involvement in service design but until recently few actual mechanisms within the focus of this work general practice. Within QOF, the recent move to incentivise the results of the patient survey within QOF reflects this rhetoric. However, in reality it appears to be an ineffective means for enhancing the likelihood of patient power. Furthermore, despite the fact that general practice has move towards Lipsky’ suggested model of street-level units/practice rather

than individuals being responsible for patients, I would say that QOF has done little to improve patient empowerment or involvement and if anything, it appears to have downgraded it. However, the recent coalition White Paper *Equity and Excellence: Liberating the NHS*<sup>320</sup> states that patients will be at the ‘heart of the NHS’ system, one that offers ‘personalised care that reflects individuals’ health and care needs.’ (ibid p3) This government aims to achieve this by placing GPs at the centre of commissioning; and ensuring that the voice of patients is ‘strengthened’ through various means including a patient commission operating at a national and local level known as Healthwatch. Furthermore the recent health select committee report extend the initial proposals in the White Paper<sup>320</sup> by recommending that local commissioning bodies have a duty to consult Healthwatch when making decisions about service provision.<sup>330</sup> As well as any national mandates to engage with patients, further motivations to satisfy client demands arises from the fact as of April 2013 GPs will be directly accountable to their patients for their commissioning decisions. Whereas currently GPs are able to deflect any patient anger arising from commissioning decisions (e.g. lack of services) onto their PCTs, from 2013 many will have to sit face to face with their patients and presumably have to explain the decisions of their own profession.

The second major area surrounds the concept of the ‘professional fix.’ Lipsky discussed how the espoused service orientation of the professional has often been shown to fail. For example rather than placing primacy on the needs of the client, professionals have been shown to favour their own preferences, leading for instance to the neglect of more challenging cases in favour of those easier to process. In addition, he argues that such failures are allowed to perpetuate by the fact the professions, are by definition, only accountable to their peers who are traditionally reluctant to criticise each other and scrutiny is difficult as they work in isolation.

These improvements as well as the fact that high QOF scores have been achieved across the profession, appear to strengthen the position of the profession who can now demonstrate their service levels. However, in terms of the issue of the professionals placing their clients’ needs over the needs or preferences of the professional, the

introduction of QOF has somewhat reduced the available time and ability to focus on the individual patient.

Regarding the second issue of scrutiny and accountability, QOF *has* introduced new levels of scrutiny and accountability (primarily at the horizontal level and only within the remit of QOF) but these remain under the control of the profession i.e. GPs remain accountable to each other. However, new norms appear to be emerging which means that it is now more commonplace for GPs to criticise the performance of each other. The emergence of new norms is also supported by: 1) evidence that other reforms such as Practice-Based Commissioning (PBC) exposed GPs within their practices to peer review (e.g. in terms of referral rates) from GPs outside their practices (i.e. the PBC consortia leads),<sup>164,331</sup> 2) recent calls by the RCGP chair for a ‘clampdown’ on poorly performing GPs and 2) a recent survey found that one in five GPs had reported a GP colleague for incompetence or impaired practice during their time in practice.<sup>332</sup> Whereas this is commendable, the real test will come with the new commissioning arrangements as GPs will be responsible for rooting out ‘unfit’ GPs.

## **7.7 Summary**

It appears that the introduction of the nGMS contract and QOF in 2004 has instituted changes within general practice that fundamentally change the way that GPs work and relate to one another. QOF has been implemented within practices by a series of common changes which have increased the level of bureaucracy within practices as well as the bureaucratic aspect of the GP role. GPs appear to have removed much of the impact on their own work by delegating much of the determinate template related work lower down the clinical hierarchy to their PNs. It is also clear however that the actual degree of impact of the contractual changes on individual GPs is context specific. For example, local decisions regarding the degree of delegation of template work to nurses and/or the level of investment into practices can vary. Such variations have implications for feelings of alienation or the level of discretion individuals feel. In order however to answer the call for ‘in-depth’ studies of the SLB framework within specific *professions*,<sup>237</sup> and to answer my research question of whether the conceptualisation of GPs as SLBs is still

appropriate post-QOF, I focus my analytical summary on the key common changes that have occurred within general practice.

The introduction of the nGMS and QOF has done little to change the fact that GPs are public service workers who directly interact with citizens in the course of their jobs. However it has impacted to varying degrees on many of the aspects of the framework and as Lipsky highlighted, the analysis is less likely to be appropriate if the key characteristics of 'relatively high' discretion were reduced and the conditions of work changed. Post-QOF it appears that overall levels of discretion, (although reduced vs. pre-QOF) still remain high *within* the remit of QOF and by the fact that much of QOF work has been delegated to staff lower down the clinical hierarchy. In addition, conditions of work remain inadequate relative to the tasks required of GPs, and some e.g. time have become even more scarce; demand continues to be high and has increased in due to the increased patient attendance required by QOF and is projected to continue to increase; goal conflict still exists for many GPs and patients remain (and as a result of QOF are in some respects even more) non-voluntary. In these respects, GPs can still be seen to fit the SLB framework. However, QOF has changed a central condition in relation to performance measurement, namely that performance measurement oriented towards goal achievement is now possible, at least for a sub-section of GP work. The fact that performance is not only visible, measurable but also incentivised leads me to the conclusion that post-QOF the conceptualisation of GPs, and in particular GP principals, as SLBs appears less useful in understanding the responses of GPs in relation to QOF. I argue that the post-QOF responses of this sub-group of GPs (and overall leads in particular) are more akin to Lipsky's description of managers, rather than the SLBs they oversee. The comparison of responses of practising GPs to prescriptive policies pre- and post-QOF exemplifies this and to finish the summary I now compare the findings from the last study to use the SLB framework pre-QOF (data collection March 2002-March 2003)<sup>132</sup> to my post-QOF findings.

Both studies set out to investigate the attitudes and experiences of GPs to non-compulsory prescriptive policies and in both cases GP attitudes were positive as they perceived that both could lead to improved patient care (e.g. via standardisation). Despite this the GPs in

the pre-QOF study did not have a strategy to ensure implementation.<sup>132</sup> No individual GP took responsibility for the implementation of the NSFs within their practice and consequently there was no systematic way of implementing the policy i.e. no ‘information process.’ As a result individual GPs interpreted the complex policy as they wished and only used aspects that made the practicalities of doing their job easier. In other words GPs (regardless of status) reacted as SLBs and their actions meant that enacted policy did not reflect official policy. However, there were also instances of behaviour that did *not* conform to expected SLB behaviour but instead resembled behaviour that would be expected of managers who are ‘results oriented.’<sup>132</sup>

We now move forward a year to 2004 and the introduction of by far the most prescriptive policy in the history of general practice, QOF. We now see that there are clear figures and lines of responsibility for implementing policy, resulting in a strong information process. In other words, GPs are policing themselves and their colleagues to ensure that for the most part enacted policy reflects official policy. In addition, individual practices have been internally re-configured along similar lines to maximise the likelihood of meeting targets. Such ‘managerial’ responses were also noted the last time that the direct link between finances and clinical work was made under the 1990 contract.<sup>333</sup> However, GP principals have gone a step further to anything seen before and have also implemented internal surveillance mechanisms within their organisations. Although such responses can be seen in part as a result of the development of new professional norms, these not offer the full explanation. Presumably the formation of these new norms has occurred over a longer period than the few intervening years between the two studies. The key difference appears to lie in the fact that QOF is a P4P scheme and that the monies earned through QOF represent a significant portion of practice income which has made GP principals increasingly results oriented. In other words the overall responses of GP principals reflect their priorities as owners of, rather than workers in their organisations. It also provides an explanation as to why 1) the majority of GP principals continue to ensure their practices pursue the *whole* of QOF irrespective of whether or not aspects of it are aligned with their professional views and 2) some of QOF-related changes meant that GPs felt their work was now ‘harder’ and/or more alienating. Future changes to QOF will test the priorities of GP principals as there are plans to remove two indicators (worth

approximately £1800 per practice) which incentivise practices to measure blood pressure in patients with hypertension and chronic kidney disease.<sup>334</sup> These plans reflect the fact that NICE view these indicators as being sufficiently embedded in practice<sup>00</sup> and that their removal will allow room for new indicators. The combined evidence would suggest that QOF has become ‘normalized’ within general practice,<sup>336</sup> however the removal of direct incentivisation may mean that this process is reversed or at least somewhat reduced in limited areas. Such changes will rely solely on GP principals’ professionalism and commitment to providing the necessary levels of clinical care for their practice population. However, the limited evidence on the removal of incentives in the United States indicates that activity will drop.<sup>323</sup>

Finally, in regard to salaried GPs, Lipsky argues that SLBs have different priorities to their managers and that the relationship is ‘intrinsically conflictual.’ Although some professed to be less QOF-focused than their GP principals, for the most part salaried GPs did not appear to have differing priorities as they were aligned behind the concept of EBP (to the point where one could say it had become naturalized) and as a result, most of QOF. Only areas not perceived as evidence-based were questioned and from the accounts of overall QOF leads these were less well attended to by all practitioners but these are seemingly nonetheless ‘mopped-up’ by some means in time for the practice to meet its targets. Furthermore, it appears that for those salaried GPs who aspire to become GP principals, it would appear counter-productive to the realisation of these aspirations to display ‘conflictual’ behaviour. In this case, Lipsky’s framework fails to acknowledge that SLBs may themselves have aspirations to one day become the managers of their organisations.

The conclusion that Lipsky’s framework is less appropriate to understanding the impact of QOF, begs the question as to what other theoretical positions may be of continued use to studying the profession. I suggest that my findings in combination with those from the literature suggest that notion of re-stratification may be of continuing value. Support for this suggestion arises from the identified changes at the micro-level of the profession

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<sup>00</sup> NICE cite evidence for this as being stable high achievement and low exception reporting. The combination of these factors make it possible to draw up lists of suitable candidate indicators for removal and is in line with the advice from their professional advisors.<sup>335</sup>

where multiple vertical strata are developing. Firstly, *within* practices, there exists a division between those GPs holding QOF lead role responsibilities and those that do not, the latter individuals experiencing and accepting scrutiny by their colleagues.

Additionally, *between* practices via PBC, there are those GPs occupying positions on the boards of consortia that not only set the goals and priorities for other practices within the consortia but also scrutinise the performance of practices within their consortia. The forthcoming changes as proposed in the recent White Paper<sup>320</sup> however appears to provide the greatest possibilities thus far for a clear demarcation within the profession, with those occupying the lead commissioning roles having the greatest influence over their rank-and-file colleagues. Further research is required to explore the impact and consequences of these changes for the profession.

### **7.8 Strengths and limitations**

This study benefited by using qualitative methods in order to explore in-depth the effects of a central policy within localised contexts. Much of the empirical literature derives from a small convenience sample of four practices conducted early in the life of the contract<sup>153,165</sup> and although important, the generalisability of these findings was not well-established. My findings add weight to the relevance and consensus of the concepts arising from early research as many of them continue to be identifiable some years on. Furthermore, in contrast to the small ethnographic studies which form the evidence-base for much of the post-QOF qualitative literature, my findings are derived from a large and diverse sample of GPs. In addition, although the sample was not ‘representative,’ the final sample did closely approximate national statistics for many of the key characteristics. Furthermore, QOF is an evolving policy and most studies provided a ‘snapshot’ of the policy and views in time. I was however able to assess views over time as I collected data over a period of almost 2 years. My study was also able to explore the stability of GP views and experiences by conducting follow-up interviews with over a third of the first round interviewees. However, in practice, little difference was found between the first and second round interviews, except for views on further changes to QOF.

Finally, although the interviews provided much rich data and insight into the perceived impact of the new contractual arrangements, one limitation is that no direct observation

was undertaken. This was due to a change in the original design of the overall project that I was employed by. Many of the topics raised by my analysis could benefit from supplementary observational work, particularly regarding the impact of QOF on the consultation. In addition, the perceived impacts on the consultation could be enhanced by including a patient perspective.

## **7.9 Conclusion**

This study was devised to investigate the perceived impact of a significant policy change in UK general practice. The findings from this thesis support much of the existing empirical literature and taken together indicate that the profession is undergoing a period of significant change. Furthermore, these changes have been driven primarily by GP themselves, starting with in Freidsonian terms the ‘knowledge elites’ (involved in contract/QOF negotiations) down to the GP principals who have chosen to implement and police their practice responses. The results of such changes include a highly bureaucratised ‘GP service’ not only for practitioners to work within but also for patients to be processed through. In addition, QOF has created a situation where the profession is undergoing a process of re-stratification which has contributed to a ‘collapse’ in traditional professional norms and the development of new norms including the ‘normalisation’ of EBP. As a result, GPs are now simultaneously able to strengthen their claims to the provision of a high quality service as well as to reduce the ground for some of the criticisms usually levelled at them. However, under the new commissioning arrangements announced in the White Paper<sup>320</sup> and due to come into full effect from 2013, the profession will undoubtedly be exposed to new criticisms due to the unprecedented level of responsibilities they will have for the health system. Given such changes, one can foresee a further layer strata, with those holding the lead commissioning roles and ‘managing’ the resources that rank-and-file colleagues require access to. In addition, it seems that the future of a significant portion of the GP workforce appears to rest in the hands of their GP principal colleagues. This may create cleavage and mean that any underlying frictions may surface. In other words, further re-stratification may occur with a split between those who are employers and those who are employees. This suggestion has some credence as recent reports illustrate momentum for the creation of a rival union



to the BMA, one which would specifically cater to and protect the needs of salaried GPs.<sup>337</sup>

Finally, although as I discussed earlier, the presence of QOF makes the GP/SLB analogy less useful to studying GP responses to QOF, and in particular GP principals, this is not to say that the framework is not helpful beyond the remit of QOF and/or GP responses to future policies. For example, should the proliferation of private sector APMS practices occur and/or the enforced 'proletarianisation' of new recruits into the profession continue, a significant number of GPs may find themselves working in the type of tall hierarchies described by Lipsky in the 1970s.

## Reference List

- 1 Stevens R. The evolution of healthcare systems in the United States and the United Kingdom. Similarities and differences. In: B Davey, A Gray, C Seale, eds. *Health and Disease: A Reader*. Buckingham: Open University Press, 2001;319-325.
- 2 Loudon I. The origin of the general practitioner. *Journal of the Royal College of General Practitioners* 1983;**33**:13-23.
- 3 Royal College of General Practitioners. *The Founding Story*. London: Atalink Ltd, 1992.
- 4 Jewson ND. The Disappearance of the Sick-Man from Medical Cosmology, 1770-1870. *Sociology* 1976;**10**:225-244.
- 5 Armstrong D. The emancipation of biographical medicine. *Social Science & Medicine* 1979;**13a**:1-8.
- 6 Loudon I. The concept of the family doctor. *Bulletin of the History of Medicine* 1984;**58**:347-362.
- 7 Digby A. *The evolution of British General Practice 1850-1948*. Oxford: Oxford University Press, 1999.
- 8 Lawrence C. *Medicine in the making of modern Britain 1700-1920*. London: Routledge, 1994.
- 9 Stacey M. *The Sociology of health and healing. A textbook*. New York: Routledge, 1988.
- 10 Green DG. Medical care in Britain before the welfare state. *Critical Review* 1993;**7**:479-495.
- 11 Peckham S, Exworthy M. *Primary Care in the UK*. Basingstoke: Palgrave Macmillan, 2003.
- 12 Honigsbaum F. *The Division in British Medicine: a History of the Separation of General Practice from Hospital Care, 1911-1968*. London: Kogan Page, 1979.
- 13 Digby A, Bosanquet N. Doctors and Patients in an Era of National Health Insurance and Private Practice, 1913-1938. *The Economic History Review* 1988;**41**:74-94.
- 14 Bosanquet N. Quality of care in general practice - lessons from the past. *Journal of the Royal College of General Practitioners* 1989;**39**:88-90.

- 15 Day P. The State, the NHS, and General Practice. *Journal of Public Health Policy* 1992;**13**:165-179.
- 16 Wolper LF. *Health Care Administration. Planning, Implementing and Managing Organised Delivery Systems*. London: Jones and Bartlett, 2004.
- 17 Starfield B, Shi L, Macinko J. Contributions of Primary Care to Health Systems and Health. *The Millbank Quarterly* 2005;**83**:457-502.
- 18 Starfield B. *Primary Care: Concept, Evaluation, and Policy*. New York: Oxford University Press, 1992.
- 19 Lord Dawson of Penn. *Interim Report on the Future Provisions of Medical and Allied Services United Kingdom Ministry of Health Consultative Council on Medical Allied Services*. London, HMSO. Available at: <http://www.sohealth.co.uk/history/Dawson.htm> [Accessed: 12/09/09].1920.
- 20 Baggott R. *Health and Health care Britain*. London: MacMillan Press Ltd, 1994.
- 21 Innes Williams D. The past: 'The good old days'. *Journal of the Royal Society of Medicine* 1998;**91**:5-7.
- 22 Morris S, Goudie R, Sutton M, et al. Determinants of General Practitioners' wages in England. *Health Economics* 2011;**20**:147-160.
- 23 Lewis J. The Medical Profession and the State: GPs and the GP Contract in the 1960s and the 1990s. *Social Policy & Administration* 1998;**32**:132-150.
- 24 Kendall I. The Founding of the NHS. In: G Moon, R Gillespie, eds. *Society and Health: an introduction to social science for health professionals*. London: Routledge, 1998;143-159.
- 25 Anthony E. The GP at the crossroads. *BMJ* 1950;**1**:1077-1079.
- 26 Stevens R. *The Impact of Specialisation and State Medicine. Medical Practice in Modern England*. New Brunswick: Yale University Press, 2003.
- 27 Collings JS. General practice in England today: a reconnaissance. *Lancet* 1950;**1**:555-585.
- 28 Hadfield SJ. A field survey of general practice, 1951-2. *BMJ* 1953;**2**:683-706.
- 29 Anon. Good General Practice. *The British Medical Journal* 1954;**1**:746-748.
- 30 Petchey R. Collings report on general practice in England in 1950: unrecognised, pioneering piece of British social research? *BMJ* 1995;**311**:40-42.
- 31 Hunt JH. The renaissance of general practice. Lloyds Roberts Lecture 1957. *Journal of the Royal College of General Practitioners* 1972;**22**:Suppl-20

- 32 Royal College of General Practitioners. *Foundation of the College*. Available at: [http://www.rcgp.org.uk/services/history\\_heritage\\_archives/history\\_chronology/chronology/foundation\\_of\\_the\\_college.aspx](http://www.rcgp.org.uk/services/history_heritage_archives/history_chronology/chronology/foundation_of_the_college.aspx) [Accessed 13/04/2010].2010.
- 33 Lewis J. Primary care opportunities and threats: the changing meaning of the GP contract. *BMJ* 1997;**314**:895
- 34 Laing A, Marnoch G, McKee L, Joshi R. Administration to innovation: the evolving management challenge in primary care. *Journal of Management in Medicine* 1997;**11**:71-87.
- 35 Royal College of General Practitioners. *Profile of UK practices June 2004*. Information sheet no.2. Available at: <http://judas.sgul.ac.uk/nelhpc/pcel/cache.php?id=1145> [Accessed: 25/07/08]. London.2004.
- 36 British Medical Association. *Third Joint Report of Discussions*. London: BMA, 1966.
- 37 Torgesen I. *How primary care grew up*. Available at: <http://www.hsj.co.uk/resource-centre/how-primary-care-grew-up/952457.article> [Accessed 25/06/2008].2008.
- 38 Hunt JH. The Founding of a college. *Journal of the Royal College of General Practitioners* 1973;**23**:5-20.
- 39 Hunt JH. The Renaissance of General Practice. *British Medical Journal* 1957;**1**:1082
- 40 Balint M. *The doctor, his patient and the illness*. London: Pitman Publishing Co., 1957.
- 41 Nettleton S. *The Sociology of Health and Illness*. Cambridge: Polity Press, 1995.
- 42 Bosanquet N, Salisbury CJ. The practice. In: I Loudon, J Horder, C Webster, eds. *General Practice under the National Health Service*. London: Clarendon Press, 1998;
- 43 Checkland K, Harrison S, McDonald R, Grant S, Campbell S, Guthrie B. Biomedicine, holism and general medical practice: responses to the 2004 General Practitioner contract. *Sociology of Health & Illness* 2008;**30**:788-803.
- 44 Royal College of General Practitioners. *The Future General Practitioner*. London: British Medical Journal, 1972.
- 45 Howie J, Heaney D, Maxwell M. Quality, core values and the general practice consultation: issues of definition, measurement and delivery. *Family Practice* 2004;**21**:458-468.

- 46 Alonso Y. The biopsychosocial model in medical research: the evolution of the health concept over the last two decades. *Patient Education and Counseling* 2004;**53**:239-244.
- 47 Borrell-Carrio F, Suchman AL, Epstein RM. The Biopsychosocial Model 25 Years Later: Principles, Practice, and Scientific Inquiry. *Annals of Family Medicine* 2004;**2**:576-582.
- 48 Royal College of General Practitioners. *Curriculum for speciality training for general practice: The core statement: being a general practitioner* Available at: [http://www.rcgp-curriculum.org.uk/PDF/curr\\_1\\_Curriculum\\_Statement\\_Being\\_a\\_GP.pdf](http://www.rcgp-curriculum.org.uk/PDF/curr_1_Curriculum_Statement_Being_a_GP.pdf) (Accessed 22/05/2008), 2008.
- 49 Kemper KJ. Holistic pediatrics = good medicine. *Pediatrics* 2000;**105**:214-218.
- 50 Hasegawa H, Reilly D, Mercer SW, Bikker AP. Holism in primary care: the views of Scotland's general practitioners. *Primary Health Care Research & Development* 2005;**6**:320-328.
- 51 Sanders T, Harrison S. Professional legitimacy claims in the multidisciplinary workplace: the case of heart failure care. *Sociology of Health & Illness* 2008;**30**:289-308.
- 52 Grant S, Huby G, Watkins F, et al. The impact of pay-for-performance on professional boundaries in UK general practice: an ethnographic study. *Sociology of Health & Illness* 2009;**31**:229-245.
- 53 Dowrick C, May C, Richardson M, Bundred P. The biopsychosocial model of general practice: rhetoric or reality? *British Journal of General Practice* 1996;**46**:105-107.
- 54 Wilkes E. Rethinking established dogma. Is good general practice possible? *British Medical Journal (Clinical Research Ed)* 1984;**289**:85-86.
- 55 May C, Dowrick C, Richardson M. The confidential patient: the social construction of therapeutic relationships in general medical practice. *Sociological Review* 1996;**44**:187-203.
- 56 Baker R. Will the future GP remain a personal doctor? *British Journal of General Practice* 1997;**47**:831-833.
- 57 Tarrant C, Windridge K, Boulton M, Baker R, Freeman G. Qualitative study of the meaning of personal care in general practice. *BMJ* 2003;**326**:1310
- 58 Gray DJ. The Key to personal care. *Journal of the Royal College of General Practitioners* 1979;**29**:666-678.
- 59 McCormick J. Death of the personal doctor. *The Lancet* 1996;**348**:667-668.

- 60 Olesen F, Dickinson J, Hjortdahl P. General practice---time for a new definition. *BMJ* 2000;**320**:354-357.
- 61 Royal College of General Practitioners. *What is General Practice?* Available at: [http://www.rcgp.org.uk/patient\\_information/what\\_is\\_general\\_practice.aspx](http://www.rcgp.org.uk/patient_information/what_is_general_practice.aspx) [Accessed: 14/04/10].2010.
- 62 Smith L, Morris J. Ethical dilemmas for general practitioners under the UK new contract. *Journal of Medical Ethics* 1994;**20**:175-180.
- 63 Gulliford M, Naithani S, Morgan M. What is 'continuity of care'? *Journal of Health Services Research Policy* 2006;**11**:248-250.
- 64 Guthrie B, Wyke S, Brampton S. Controversy in primary care: Does continuity in general practice really matter? Commentary: A patient's perspective of continuity. *BMJ* 2000;**321**:734-736.
- 65 Stokes T, Tarrant C, Mainous AG, Schers H, Freeman G, Baker R. Continuity of Care: Is the Personal Doctor Still Important? A Survey of General Practitioners and Family Physicians in England and Wales, the United States, and the Netherlands. *Annals of Family Medicine* 2005;**3**:353-359.
- 66 Kearley KE, Freeman G, Heath A. An exploration of the value of the personal doctor-patient relationship in general practice. *British Journal of General Practice* 2001;**51**:712-718.
- 67 Pereira AG, Pearson SD. Patient attitudes toward continuity of care. *Archives of Internal Medicine* 2003;**163**:909-912.
- 68 Cheraghi-Sohi S, Hole AR, Mead N, et al. What Patients Want From Primary Care Consultations: A Discrete Choice Experiment to Identify Patients' Priorities. *Annals of Family Medicine* 2008;**6**:107-115.
- 69 Pereira Gray D, Evans P, Sweeney K, et al. Towards a theory of continuity of care. *Journal of the Royal Society of Medicine* 2003;**96**:160-166.
- 70 Hannien J, Takala J, Keinanen-kiukaanniemi S. Good continuity of care may improve quality of life in Type 2 diabetes. *Diabetes Research and Clinical Practice* 2001;**51**:21-27.
- 71 Freeman G, Hjortdahl P. What future for continuity of care in general practice? *BMJ* 1997;**314**:1870
- 72 Royal College of General Practitioners. *The Primary Health Care Team*. Available at: [http://www.ucl.ac.uk/pcph/education/undergrad/cbt/year4/documents/cgp1/rcgp\\_phct.pdf](http://www.ucl.ac.uk/pcph/education/undergrad/cbt/year4/documents/cgp1/rcgp_phct.pdf) [Accessed 16/04/10].2003.
- 73 Department of Health. *Primary health care: an agenda for discussion*. London. HMSO, 1986.

- 74 Yerrell P, Reed A. The anachronism of policy for nursing in general practice: Conceptualising a way forward. *Nursing Times Research* 1997;**2**:245-257.
- 75 McGuigan S. *Compendium of Health Statistics*. London: Office of Health Economics, 1997.
- 76 Iliffe S. The modernisation of general practice in the UK: 1980 to 1995 and beyond (Part II). *Postgraduate Medical Journal* 1996;**72**:539-546.
- 77 Roland M. Linking physician pay to the quality of care: a major experiment. *New England Journal of Medicine* 2004;**351**:1488-1454.
- 78 Broadbent J. Practice nurses and the effects of the new general practitioner contract in the British NHS: the advent of a professional project? *Social Science and Medicine* 1998;**47**:497-506.
- 79 Silcock J, Ratcliffe J. The 1990 GP contract -- meeting needs? *Health Policy* 1996;**36**:199-207.
- 80 Richards A, Carley J, Jenkins-Clarke S, Richards DA. Skill mix between nurses and doctors working in primary care-delegation or allocation: a review of the literature. *International Journal of Nursing Studies* 2000;**37**:185-197.
- 81 Stilwell B, Greenfield S, Drury M, Hull FM. A nurse practitioner in general practice: working style and pattern of consultations. *Journal of the Royal College of General Practitioners* 1987;**297**:154-157.
- 82 Horrocks S, Anderson E, Salisbury C. Systematic review of whether nurse practitioners working in primary care can provide equivalent care to doctors. *BMJ* 2002;**324**:819-823.
- 83 Department of Health. *Neighbourhood Nursing - a focus for care*. London. HMSO, 1986.
- 84 Howden CL. Neighbourhood Nursing. *Family Practice* 1987;**4**:1-2.
- 85 Royal College of General Practitioners. *Practice Nurses*. Available at: ([http://www.rcgp.org.uk/pdf/ISS\\_INFO\\_19\\_AUG%2004.pdf](http://www.rcgp.org.uk/pdf/ISS_INFO_19_AUG%2004.pdf))[Accessed: 28/04/10].2004.
- 86 Royal College of General Practitioners. *The Primary Care Practice and its Team*. Available at: [http://www.rcgp.org.uk/PDF/ISS\\_INFO\\_21\\_FEB07.pdf](http://www.rcgp.org.uk/PDF/ISS_INFO_21_FEB07.pdf) [Accessed:30/04/10].2007.
- 87 Sibbald B, Shen J, McBride A. Changing the skill-mix of the health care workforce. *Journal of Health Services Research Policy* 2004;**9**:28-38.
- 88 Laurant M, Reeves D, Hermens R, Braspenning J, Grol R, Sibbald B. Substitution of doctors by nurses in primary care. *Cochrane Database of Systematic Reviews* 2004;

- 89 Bosley S, Dale J. Healthcare Assistants in General Practice: practical and conceptual issues of skill-mix change. *British Journal of General Practice* 2008;**58**:118-124.
- 90 NHS Working in Partnership Programme. *WiPP HCA Initiative Taking a count*. Available at: [http://www.wipp.nhs.uk/uploads/WP0055\\_HCA\\_Taking\\_Count\\_5pp.pdf](http://www.wipp.nhs.uk/uploads/WP0055_HCA_Taking_Count_5pp.pdf) [Accessed: 29/04/10].2007.
- 91 McKinlay JB, Marceau LD. The end of the golden age of doctoring. *International Journal of Health Services: planning, administration, evaluation* 2002;**32**:379-416.
- 92 Harrison S. Co-optation, commodification and the medical model: governing UK medicine since 1991. *Public Administration* 2009;**87**:184-197.
- 93 Day P, Klein R. Two views on the Griffiths Report. The mobilisation of consensus versus the management of conflict: decoding the Griffiths Report. *British Medical Journal* 1983;**287**:1813-1816.
- 94 NHS Management Inquiry. *Report*. London. Department of Health, 1983.
- 95 Harrison S, McDonald R. *The Politics of Healthcare in Britain*. London: Sage, 2008.
- 96 Glendinning C. GPs and Contracts: Bringing General Practice into Primary Care. *Social Policy & Administration* 1999;**33**:115-131.
- 97 Hood C. A public management for all seasons? *Public Administration* 1991;**69**:3-19.
- 98 Ackroyd S, Hughes JA, Soothill K. Public Sector Services and their management. *Journal of Management Studies* 1989;**26**:603-619.
- 99 Power M. *The Audit Society*. Oxford: Oxford University Press, 1997.
- 100 Klein R. *From status to contract: the transformation of the British medical profession*. London. Royal Society of London, 1990.
- 101 Department of Health. *Working for patients*. London. HMSO, 1989.
- 102 Neal J. *Practice Based Commissioning: an introduction*. Available at: <http://masharani.co.uk/PBC/BMJPBCanIntroduction.pdf> [Accessed: 10/05/10].2005.
- 103 Harrison S. Working the markets: purchaser/provider separation in English Health care. *International Journal of Health Services* 1991;**21**:625-635.
- 104 Le Grand J, Bartlett W. *Quasi-Markets and Social Policy*. London: McMillan Press Ltd, 1993.



- 105 Moon G, Mohan J, Twigg L, McGrath K, Pollock A. Catching waves: the historical geography of the general practice fundholding initiative in England and Wales. *Social Science & Medicine* 2002;**55**:2201-2213.
- 106 Mays N, Goodwin N, Bevan G, Wyke S. *Total Purchasing: a profile of pilot projects*. London. King's Fund, 1997.
- 107 Harrison S, Choudhry N. General Practice Fundholding in the UK National Health Service: Evidence to Date. *Journal of Public Health Policy* 1996;**17**:331-346.
- 108 Mannion R. *Practice based commissioning: a summary of the evidence*. Available at: <http://www.york.ac.uk/media/healthsciences/documents/research/HPM11final.pdf> [Accessed: 14/06/2008]. University of York, 2005.
- 109 Dusheiko M, Gravelle H, Yu N. *The impact of budgets for gatekeeping physicians on patient satisfaction: evidence from fundholding*. Centre for Health Economics: University of York, 2004.
- 110 Cowton CJ, Drake JE. Taking the lead in Fundholding. *Journal of Management in Medicine* 1999;**13**:218-233.
- 111 Hannay D, Usherwood T, Platts M. Workload of general practitioners before and after the new contract. *BMJ: British Medical Journal* 1992;**304**:615-618.
- 112 Iliffe S. The modernisation of general practice in the UK: 1980 to 1995 and beyond. Part I. *Postgraduate Medical Journal* 1996;**72**:201-206.
- 113 Sibbald B, Enzer I, Cooper C, Rout U, Sutherland V. GP job satisfaction in 1987, 1990 and 1998: lessons for the future? *Family Practice* 2000;**17**:364-371.
- 114 Sutherland VJ, Cooper CL. Identifying distress among general practitioners: Predictors of psychological ill-health and job dissatisfaction. *Social Science & Medicine* 1993;**37**:575-581.
- 115 Rout U, Rout JK. Job Satisfaction, Mental Health and Job Stress Among General Practitioners Before and After the New Contract--a Comparative Study. *Family Practice* 1994;**11**:300-306.
- 116 Leese B, Young R, Sibbald B. GP principals leaving practice in the UK. *The European Journal of General Practice* 2002;**8**:62-68.
- 117 Young R, Leese B. Recruitment and retention of general practitioners in the UK: what are the problems and solutions? *British Journal of General Practice* 1999;**49**:829-833.
- 118 Department of Health. *The New NHS: Modern, dependable*. London. The Stationery Office, 1997.

- 119 Sheaff R, Holbourne A, Khong CK. *Personal Medical Services Contracts: A Handbook*. Manchester. NPCRDC, The University of Manchester, 2001.
- 120 Williams J, Petchey R, Gosden T, Leese B, Sibbald B. A profile of PMS salaried GP contracts and their impact on recruitment. *Family Practice* 2001;**18**:283-287.
- 121 Lewis R, Gillam S, Gosden T, Sheaff R. Who contracts for Primary Care? *Journal of Public Health Medicine* 1999;**21**:367-371.
- 122 The Information Centre. *General and Personal Medical Services England 1998-2008*. Available at: <http://www.ic.nhs.uk/webfiles/publications/nhsstaff2008/gp/Bulletin%20Sept%202008.pdf> [Accessed 16/04/10].2008.
- 123 Wilkin D, Gillam S, Smith K. Tackling Organisational Change in the New NHS. *British Medical Journal* 2001;**322**:1464-1467.
- 124 Department of Health. *A first class service: Quality in the new NHS*. London. Department of Health, 1998.
- 125 Power M. The evolution of the audit society, its politics of control and the advent of CHI. In: A Miles, JR Hampton, B Hurwitz, eds. *NICE, CHI and the NHS reforms: enabling excellence or imposing control?* London: Aesculapius, 2000;127-137.
- 126 Sackett DL, Rosenberg WMC, Gray JAM, Haynes RB, Richardson WS. Evidence based medicine: what it is and what it isn't. *BMJ* 1996;**312**:71-72.
- 127 NHS Executive. *Clinical Guidelines: using clinical guidelines to improve patient care within the NHS*. Leeds.1996.
- 128 Sackett DL. A science for the art of consensus. *JNCI Journal of the National Cancer Institute* 1997;**89**:1003-1005.
- 129 Harrison S. The politics of evidence based medicine in the United Kingdom. *Policy & Politics* 1998;**26**:15-31.
- 130 Harrison S. Policy emergence and policy convergence: the case of "scientific-bureaucratic medicine" in the USA and UK. *British Journal of Politics and International Relations* 2002;**4**:1-24.
- 131 Department of Health. *National Service Frameworks*. Available: <http://www.dh.gov.uk/en/Healthcare/NationalServiceFrameworks/index.htm> [Accessed 27/07/08].2008.
- 132 Checkland K. National Service Frameworks and UK general practitioners: street-level bureaucrats at work? *Sociology of Health & Illness* 2004;**26**:951-975.

- 133 Marshall M, Roland M. The New Contract: renaissance or requiem for general practice? *British Journal of General Practice* 2002;**52**:531-532.
- 134 Royal College of General Practitioners. *The GMS contract (overview and resources guide)*. Available at: [http://www.rcgp.org.uk/pdf/ISS\\_INFO\\_GMS07.pdf](http://www.rcgp.org.uk/pdf/ISS_INFO_GMS07.pdf) [Accessed 26/04/10].2007.
- 135 Beecham L. Most GPs would consider resigning from NHS. *BMJ* 2001;**322**:1381
- 136 Department of Health. *The NHS Plan: a plan for investment, a plan for reform*. London. The Stationery Office, 2000.
- 137 McDonald R, White J, Marmor TR. Paying for Performance in Primary Medical Care: Learning about and Learning from "Success" and "Failure" in England and California. *Journal of Health Politics, Policy and Law* 2009;**34**:747-776.
- 138 Department of Health. Primary Care contracting. Available at:[www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/PrimaryCare/PrimaryCareContracting/fs/en](http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/PrimaryCare/PrimaryCareContracting/fs/en) [Accessed: 12/10/2007] *Department of Health* 2006;
- 139 Peckham S. The New General Practice Contract and Reform of Primary Care in the United Kingdom. *Health Policy* 2007;**2**:34-48.
- 140 Pollock AM, Price D, Viebrock E, Miller E, Watt G. The market in primary care. *BMJ* 2007;**335**:475-477.
- 141 Wright J, Martin D, Cockings S. Overall Quality of Outcomes Framework scores lower in practices in deprived areas. *British Journal of General Practice* 2006;**56**:277-279.
- 142 Lewis R, Gillam S. A fresh new contract for general practitioners. *BMJ* 2002;**324**:1048-1049.
- 143 Shekelle P. New Contract for general practitioners. *BMJ* 2003;**326**:457-458.
- 144 Jeffries D. Save our soul. *British Journal of General Practice* 2003;**53**:888
- 145 Heath I. The road to hell. *BMJ* 2007;**335**:1185
- 146 McDonald R, Checkland K, Harrison S. The new GP contract in English primary health care: an ethnographic study. *International Journal of Public Sector Management* 2009;**22**:21-34.
- 147 Checkland K, Harrison S. The Impact of the Quality and Outcomes Framework on practice organisation and service delivery: summary of evidence from two qualitative studies. *Quality in Primary Care* 2010;**18**:139-146.

- 148 Rosenthal MB, Dudley RA. Pay-for-Performance: Will the Latest Payment Trend Improve Care? *JAMA* 2007;**297**:740-744.
- 149 Doran T, Fullwood C, Reeves D, Gravelle H, Roland M. Exclusion of Patients from Pay-for-Performance Targets by English Physicians. *The New England Journal of Medicine* 2008;**359**:274-284.
- 150 Checkland K, McDonald R, Harrison S. Ticking boxes and changing the social world: data collection and the new UK general practice contract. *Social policy and Administration* 2007;**41**:693-710.
- 151 Gravelle H, Sutton M, Ma A. Doctor behaviour under a pay for performance contract: Treating, Cheating and case finding? *The Economic Journal* 2010;**120**:F129-F156
- 152 Marshall M, Harrison S. It's about more than the money: financial incentives and internal motivation. *Quality and Safety in Health Care* 2005;**14**:4-5.
- 153 McDonald R, Harrison S, Checkland K, Campbell SM, Roland M. Impact of financial incentives on clinical autonomy and internal motivation in primary care: ethnographic study. *BMJ* 2007;**334**:1357-1359.
- 154 Cole A. UK GP activity exceeds expectations. *BMJ* 2005;**331**:536
- 155 The Information Centre. *Domain Summary. Quality and Outcomes Framework (QOF) for April 2008 - March 2009, England. Available at: [http://www.ic.nhs.uk/webfiles/QOF/2008-09/England%20tables/QOF0809\\_National\\_DomainSummary.xls](http://www.ic.nhs.uk/webfiles/QOF/2008-09/England%20tables/QOF0809_National_DomainSummary.xls) [Accessed: 24th June 2010].*2009.
- 156 Charles-Jones H, Latimer J, May C. Transforming general practice: the re-distribution of medical work in primary care. *Sociology of Health & Illness* 2003;**25**:71-92.
- 157 Maisey S, Steel N, Marsh R, Gillam S, Fleetcroft R, Howe A. Effects of pay for performance in primary care: A qualitative study. *Journal of Health Services Research and Policy* 2008;**13**:133-139.
- 158 Campbell SM, McDonald R, Lester H. The Experience of Pay for Performance in English Family Practice: A Qualitative Study. *Annals of Family Medicine* 2008;**6**:228-234.
- 159 Gemmell I, Campbell S, Hann M, Sibbald B. Assessing workload in general practice in England before and after the introduction of the pay-for-performance contract. *Journal of Advanced Nursing* 2009;**65**:509-515.
- 160 Charles-Jones H, Latimer J, May C. Transforming general practice: the re-distribution of medical work in primary care  
41. *Sociology of Health & Illness* 2003;**25**:71-92.

- 161 Campbell S, McDonald R, Lester H. The experience of pay for performance in English family practice: a qualitative study. *Annals of Family Medicine* 2008;**6**:228-234.
- 162 McGregor W, Hussein J, O'Donnell C, Mercer SW, Watt G. Impact of the 2004 GMS contract on practice nurses. *British Journal of General Practice* 2008;**58**:711-719.
- 163 Zuboff S. *In the Age of the Smart Machine*. Oxford: Heinemann Professional Publishing Ltd, 1988.
- 164 McDonald R, Checkland K, Harrison S, Coleman A. Rethinking Collegiality: Restratisation in English general medical practice 2004-2008. *Social Science & Medicine* 2009;**68**:1199-1205.
- 165 Huby G, Guthrie B, Grant S, et al. Whither British general practice after the 2004 GMS contract?: Stories and realities of change in four UK general practices. *Journal of Health Organisation and Management* 2008;**22**:63-78.
- 166 McDonald R, Harrison S, Checkland K. Incentives and control in primary health care: findings from English pay for performance case studies. *Journal of Health Organization and Management* 2008;**22**:48-62.
- 167 Campbell S, Reeves D, Kontopantelis E, Middleton E, Sibbald B, Roland M. Quality of Primary Care in England with the Introduction of Pay for Performance. *New England Journal of Medicine* 2007;**357**:181-190.
- 168 Campbell S, Reeves D, Kontopantelis E, Sibbald B, Roland M. Effects of Pay for Performance on the quality of primary care in England. *New England Journal of Medicine* 2009;**361**:368-378.
- 169 National Audit Office. *NHS Pay Modernisation: New contracts for general practice services in England*. London. The Stationery Office, 2008.
- 170 Whalley D, Gravelle H, Sibbald B. Effect of the new contract on GPs' working lives and perceptions of quality of care: a longitudinal survey. *British Journal of General Practice* 2008;**58**:8-14.
- 171 Timmins N. Do GPs deserve their recent pay rise? *BMJ* 2005;**331**:800
- 172 NHS Employers. *Revisions to the GMS contract 2006/7. Delivering investment in general practice*. Available at: [http://www.nhsemployers.org/SiteCollectionDocuments/Revisions\\_to\\_the\\_GMS\\_contract\\_-\\_full\\_CD\\_120209.pdf](http://www.nhsemployers.org/SiteCollectionDocuments/Revisions_to_the_GMS_contract_-_full_CD_120209.pdf) [Accessed:02/01/11].2006.
- 173 The Information Centre. *Quality and Outcomes Framework Achievement Data 2008/9* Available at: <http://www.ic.nhs.uk/webfiles/QOF/2008-09/QOF%20Achievement%20and%20Prevalence%20Bulletin%202008-09.pdf> [Accessed:23/05/10].2009.

- 174 Nowotny S. *GP contract poll results in huge yes vote for government offer* (available at: <http://www.pulsetoday.co.uk/story.asp?storycode=4117744>) [Accessed on: 30/04/10].2008.
- 175 NHS Employers. *Contract changes 2008/09*. Available at: [http://www.nhsemployers.org/PayAndContracts/GeneralMedicalServicesContract/GMSContractChanges/Pages/GMS-ContractChangesFor2008\\_09.aspx](http://www.nhsemployers.org/PayAndContracts/GeneralMedicalServicesContract/GMSContractChanges/Pages/GMS-ContractChangesFor2008_09.aspx) [Accessed:11/11/10].2010.
- 176 NHS Employers. *QOF Changes and New Indicators for 2009/10*. Available at: [http://www.nhsemployers.org/SiteCollectionDocuments/QOF\\_changes\\_GMS\\_contract\\_2009-10\\_cd\\_110209.pdf](http://www.nhsemployers.org/SiteCollectionDocuments/QOF_changes_GMS_contract_2009-10_cd_110209.pdf) [Accessed: 11/11/10].2010.
- 177 NHS Primary Care Commissioning. *GMS Contract 2009/10 financial changes*. Available at: <http://www.pcc.nhs.uk/gms-contract-2009-10-financial-changes> [Accessed:08/02/2011].2011.
- 178 NHS Employers. *Changes to QOF 2009/10*. Available at: <http://www.nhsemployers.org/PayAndContracts/GeneralMedicalServicesContract/QOF/Pages/ChangesToQOF200910.aspx> [Accessed:08/28/2011].2010.
- 179 Flexner A. Is Social work a profession? *School and Society* 1915;1:901-911.
- 180 Greenwood E. The attributes of a profession. *Social Work* 1957;2:44-55.
- 181 Wilensky HL. The Professionalization of everyone? *American Journal of Sociology* 1964;70:137-158.
- 182 Freidson E. *Professional Dominance*. New York: Atherton Press, 1970.
- 183 Johnson TJ. *Professions and Power*. London: The MacMillan Press Ltd, 1972.
- 184 Weber M. *The Methodology of the Social Sciences*. New York: Free Press, 1949.
- 185 Etzioni A. *The Semi-professions and their Organisation*. New York: Free Press, 1969.
- 186 Freidson E. *Profession of Medicine. A study of the sociology of applied knowledge*. New York: Harper and Row, 1970.
- 187 Haug M. Deprofessionalisation: an alternative hypothesis for the future. *Sociological Review Monograph* 1973;2:195-211.
- 188 McKinlay JB, Arches J. Towards the proletarianization of physicians. *International Journal of Health Services* 1985;15:161-195.
- 189 McKinlay JB, Stoeckle J. Corporatisation and the social transformation of doctoring. *International Journal of Health Services* 1988;18:191-205.

- 190 Starr P. *The Social Transformation of American Medicine: the Rise of a Sovereign Profession and the Making of a Vast Industry*. New York: Basic Books, 1982.
- 191 Navarro V. Professional Dominance or Proletarianisation?: Neither. *The Milbank Quarterly* 1988;**66**:57-75.
- 192 Sheaff R, Smith K, Dickson M. Is GP Restratisation Beginning in England? *Social Policy & Administration* 2002;**36**:765-779.
- 193 Mahmood K. Clinical Governance and professional restratification in general practice. *Journal of Management in Medicine* 2001;**15**:242-252.
- 194 Evetts J. New directions in state and international professional occupations: discretionary decision-making and acquired regulation. *Work, employment and society* 2002;**16**:341-353.
- 195 Lipsky M. *Street-Level Bureaucracy. Dilemmas of the Individual in Public Services*. New York: Russell Sage Foundation, 1980.
- 196 McDonald R. Street-level bureaucrats? Heart disease, health economics and policy in a primary care group. *Health and Social Care in the Community* 2002;**10**:129-135.
- 197 Lipsky M. Street-Level Bureaucracy and the Analysis of Urban Reform. *Urban Affairs Review* 1971;**6**:391-409.
- 198 Weatherley R, Lipsky M. Street-level bureaucrats and institutional innovation: Implementing special-education reform. *Harvard Educational review* 1977;**47**:171-197.
- 199 Prottas JM. *People-processing: the street-level bureaucrat in public service bureaucracies* . Lexington,MA: Lexington Books, 1979.
- 200 Hawley W, Lipsky M. The Study of City Politics. In: W Hawley, M Lipsky, eds. *Theoretical Perspectives on Urban Politics*. Englewood Cliff, New Jersey: Prentice-Hall, 1976;
- 201 Hill M, Hupe P. *Implementing Public Policy*. London: Sage, 2002.
- 202 Blau P. *The Dynamics of Bureaucracy: A Study of Interpersonal Relations in Two Government Agencies*. Chicago: University of Chicago Press, 1955.
- 203 Hero R. Citizen contacting and bureaucratic treatment-response in urban government: Some further evidence. *The Social Science Journal* 1986;**23**:181-187.
- 204 Vincent C, Evans J, Lunt I, Young P. Professionals Under Pressure: the administration of special education in a changing context . *British Educational Research Journal* 1996;**22**:475-491.



- 205 Clark-Daniels C, Daniels R. Street-level Decision Making in Elder Mistreatment Policy: An empirical case study of service rationing. *Social Science Quarterly* 1995;**76**:460-473.
- 206 McNeal L, Dunbar C. In the eyes of the beholder: Urban student Perceptions of Zero tolerance Policy. *Urban Education* 2010;**45**:293-311.
- 207 Halliday S, Burns N, Hutton N, McNeill F, Tata C. Street-Level Bureaucracy, Interprofessional Relations, and Coping Mechanisms: A Study of Criminal Justice Social Workers in the Sentencing Process. *Law and Policy* 2009;**31**:405-428.
- 208 Thompson FJ. Street-Level Bureaucracy: Dilemmas of The Individual In Public Services. *Journal of Health Politics, Policy and Law* 1983;**7**:968-970.
- 209 Dunham AA, Schied T, Brandon W. Physicians as advocates for their patients: depression treatment in primary care. *Research in the Sociology of Health Care* 2008;**26**:141-165.
- 210 Dowswell G, Harrison S, Wright J. Clinical guidelines: attitudes, information processes and culture in English primary care. *International Journal of Health Planning and Management* 2001;**16**:107-124.
- 211 Harrison S, Dowswell G. Autonomy and bureaucratic accountability in primary care: what English general practitioners say. *Sociology of Health & Illness* 2002;**24**:208-226.
- 212 Campbell SM, Reeves D, Kontopantelis E, Sibbald B, Roland M. Effects of Pay for Performance on the Quality of Primary Care in England. *The New England Journal of Medicine* 2009;**361**:368-378.
- 213 McDonald R. Market reforms in English primary medical care: Medicine, habitus and the public sphere. *Sociology of Health and Illness* 2009;**31**:659-672.
- 214 QResearch. *Comorbidity of Diseases in the New General Medical Services Contract for General Practitioners: Analysis of QRESEARCH Data Available at: ([http://www.qresearch.org/Public\\_Documents/DataValidation/Comorbidity%20of%20diseases%20in%20the%20new%20GMS%20contract%20for%20GPs.pdf](http://www.qresearch.org/Public_Documents/DataValidation/Comorbidity%20of%20diseases%20in%20the%20new%20GMS%20contract%20for%20GPs.pdf))* [Accessed: 17/10/10.2005.
- 215 Audit Commission. *Transforming Primary Care: the Role of PCTs in Shaping and Supporting General Practice*. London.2004.
- 216 Royal College of General Practitioners. *General Practice in the UK: a basic overview*. Available at: [http://www.rcgp.org.uk/pdf/ISS\\_INFO\\_04\\_MAY05.pdf](http://www.rcgp.org.uk/pdf/ISS_INFO_04_MAY05.pdf) [Accessed: 10/05/10].2005.



- 217 Royal College of General Practitioners. *General Practitioner Workload*. Available at: [http://www.rcgp.org.uk/pdf/ISS\\_INFO\\_03\\_APRIL04.pdf](http://www.rcgp.org.uk/pdf/ISS_INFO_03_APRIL04.pdf) [Accessed: 10/05/10].2004.
- 218 The Information Centre. *2006/7 UK general practice workload survey*. Available at: <http://www.ic.nhs.uk/webfiles/publications/gp/GP%20Workload%20Report.pdf> [Accessed: 06/05/2008]2007.
- 219 Chassin MR, Loeb JM, Schmaltz SP, Wachter RM. Accountability Measures. Using Measurement to Promote Quality Improvement. *New England Journal of Medicine* 2010;**363**:683-688.
- 220 The Joint Commission. *Key Historical Milestones*. Available at: [http://www.jointcommission.org/assets/1/18/SIWG\\_Vision\\_paper\\_web\\_version.pdf](http://www.jointcommission.org/assets/1/18/SIWG_Vision_paper_web_version.pdf) [Accessed: 11/10/10].2010.
- 221 Doran T, Fullwood C, Kontopantelis E, Reeves D. Effect of financial incentives on inequalities in the delivery of primary clinical care in England: analysis of clinical activity indicators for the quality and outcomes framework. *The Lancet* 2008;**372**:728-736.
- 222 Doran T, Kontopantelis E, Valderas J, et al. The effect of financial incentives on incentivized and non-incentivized activities. Evidence from the U.K.'s Quality and Outcomes Framework. *BMJ* 2011;**In Print**:
- 223 Doran T, Fullwood C, Reeves D, Gravelle H, Roland M. Should physicians be able to exclude individual patients from pay-for-performance targets? Analysis of exception reporting in the English pay-for-performance. *New England Journal of Medicine* 2009;**359**:274-284.
- 224 Campbell S, Roland M, Buetow S. Defining Quality of Care. *Social Science and Medicine* 2000;**51**:1611-1625.
- 225 Cheraghi-Sohi S, Bower P. Can the feedback of patient assessments, brief training, or their combination, improve the interpersonal skills of primary care physicians? A systematic review. *BMC Health Services Research* 2008;**8**:179
- 226 Allsop J, Mulchay L. *Regulating Medical Work. Formal and Informal controls*. Buckingham: Open University Press, 1996.
- 227 Heins E, Pollock AM, Price D. The Commercialisation of GP services: a survey of APMS contracts and new GP ownership. *British Journal of General Practice* 2009;**59**:339-349.
- 228 Blakeman T, Bower P, Reeves D, Chew-Graham C. Bringing self-management into clinical view: a qualitative study of long-term condition management in primary care consultations. *Chronic Illness* 2010;**6**:136-150.

- 229 Charles-Jones H, Latimer J, May C. Transforming general practice: the re-distribution of medical work in primary care. *Sociology of Health & Illness* 2003;**25**:71-92.
- 230 Lester H, Campbell S, McDonald R. The present state and future direction of primary care: a qualitative study of GPs' views. *British Journal of General Practice* 2009;**59**:908-915.
- 231 Morrow G, Kergan C, Wright P. *Support for Sessional GPs. Report for the Royal Medical Benevolent Fund.*2011.
- 232 Jones L, Green J. Shifting discourses of professionalism: a case study of general practitioners in the United Kingdom. *Sociology of Health & Illness* 2006;**28**:927-950.
- 233 Howe D. Knowledge, power and the shape of social practice. In: M Davies, ed. *The Sociology of Social Work*. London: Routledge, 1991;202-220.
- 234 Evans T. Professionals, Managers and Discretion: Critiquing Street-Level Bureaucracy. *British Journal of Social Work* 2010;368-386.
- 235 Evans T, Harris J. Street-Level Bureaucracy, Social Work and the (Exaggerated) Death of Discretion. *British Journal of Social Work* 2004;**34**:871-895.
- 236 Dworkin R. *Taking Rights Seriously*. London: Duckworth, 1978.
- 237 Taylor I, Kelly J. Professionals, discretion and public sector reform in the UK: re-visiting Lipsky. *International Journal of Public Sector Management* 2006;**19**:629-642.
- 238 Hupe P, Hill M. Street-level bureaucracy and Public Accountability. *Public Administration* 2007;**85**:279-299.
- 239 Bovens M, Zourdis S. From street-level to system-level bureaucracies: how information and communication technology is transforming administration. *Public Administration Review* 2002;**62**:174-185.
- 240 Evans T, Harris J. A case of mistaken identity? Debating the dilemmas of street-level bureaucracy with Musil et al. *European Journal of Social Work* 2006;**9**:445-459.
- 241 Shekelle P. New Contract for general practitioners. *BMJ* 2003;**326**:457-458.
- 242 Green J, Thorogood N. *Qualitative Methods for Health Research*. London: Sage, 2005.
- 243 Bryman A. *Social Research Methods*. Oxford: Oxford University Press, 2001.

- 244 Beich A, Gannik D, Malterud K. Screening and brief intervention for excessive alcohol use: qualitative interview study of the experiences of general practitioners. *BMJ* 2002;**325**:
- 245 Strandberg E, Ovhed I, Hakansson A, Troein M. The meaning of quality work from the general practitioner's perspective: an interview study. *BMC Family Practice* 2006;**7**:60
- 246 Porter S, Ryan S. Breaking the boundaries between nursing and sociology: a critical realist ethnography of the theory-practice gap. *Journal of Advanced Nursing* 1996;**24**:413-420.
- 247 Hammerlsey M. *What's wrong with ethnography?* London: Routledge, 1992.
- 248 Bhaskar R. *The possibility of naturalism: a philosophical critique of the contemporary human sciences.* London: Harvester Wheatsheaf, 1989.
- 249 Houston S. Beyond Social Constructionism: Critical Realism and Social Work. *British Journal of Social Work* 2001;**31**:845-861.
- 250 McEvoy P, Richards D. Critical realism: a way forward for evaluation research in nursing? *Journal of Advanced Nursing* 2003;**43**:411-420.
- 251 Denzin N, Lincoln Y. *The Landscape of Qualitative Research: theories and issues.* Thousand Oaks,CA: Sage, 2003.
- 252 Patton M. *Qualitative Research & Evaluation Methods.* California: Sage, 2002.
- 253 Strauss AL, Corbin JM. *Basics of qualitative research: Grounded theory procedures and techniques.* Sage, 1990.
- 254 Pope C, Mays N. Reaching the parts other methods cannot reach: an introduction to qualitative methods in health and health services research. *BMJ* 1995;**311**:42-45.
- 255 Mays N, Pope C. Qualitative research in health care: Assessing quality in qualitative research. *BMJ* 2000;**320**:50-52.
- 256 Mays N, Pope C. Qualitative Research: Rigour and qualitative research. *BMJ* 1995;**311**:109-112.
- 257 Presser S, Couper MP, Lessler JT, et al. Methods for Testing and Evaluating Survey Questions. *Public Opinion Quarterly* 2004;**68**:109-130.
- 258 Ericsson K, Simon H. *Protocol Analysis: Verbal Reports as Data.* Cambridge: M.I.T. Press, 1984.
- 259 Cheraghi-Sohi S, Bower P, Mead N, McDonald R, Whalley D, Roland M. Making sense of patient priorities: applying discrete choice methods in primary care using 'think aloud' technique. *Family Practice* 2007;**24**:276-282.

- 260 Seale C. Quality in Qualitative Research. *Qualitative Inquiry* 1999;**5**:465-478.
- 261 Hoddinott P, Pill R. A review of recently published qualitative research in general practice. More methodological questions than answers? *Family Practice* 1997;**14**:313-319.
- 262 Hamberg K, Johansson E, Lindgren G, Westman G. Scientific Rigour in Qualitative Research--Examples From a Study of Women's Health in Family Practice. *Family Practice* 1994;**11**:176-181.
- 263 Chapple A, Rogers A. Explicit guidelines for qualitative research: a step in the right direction, a defence of the 'soft' option, or a form of sociological imperialism. *Family Practice* 1998;**15**:556-561.
- 264 Popay J, Rogers A, Williams G. Rationale and standards for the systematic review of qualitative literature in health services research. *Qualitative Health Research* 1998;**8**:341-351.
- 265 Miles M, Huberman A. *Qualitative Data Analysis. An expanded sourcebook*. Thousand Oaks, California: Sage, 1994.
- 266 Berg BL. *Qualitative research methods for the social sciences*. Boston: Pearson Education, 2009.
- 267 Silverman D. *Qualitative Methodology and Sociology*. Aldershot: Gower Publishing Company, 1985.
- 268 Britten N, Jones R, Murphy E, Stacy R. Qualitative Research Methods in general practice and primary care. *Family Practice* 1995;**12**:104-114.
- 269 Denzin NK. *The research act in sociology: a theoretical introduction to sociological methods*. London: Butterworths, 1970.
- 270 Patton M. *Qualitative evaluation methods*. Newbury Park,CA: Sage, 1980.
- 271 Bell AJ. "Oh yes I remember it well!" Reflections on using the life-grid in qualitative interviews with couples. *Qualitative Sociology Review* 2005;**1**:51-67.
- 272 Goffman E. *The presentation of self in everyday life*. New York: Anchor Books, Doubleday, 1959.
- 273 Seale C. Qualitative Interviewing. In: C Seale, ed. *Researching society and culture*. London: Sage, 1998;
- 274 Eisenhardt KM, Graebner ME. Theory building from cases: opportunities and challenges. *Academy of Management Journal* 2007;**50**:25-32.
- 275 Hammerlsey M, Atkinson P. *Ethnography: principles in practice*. London: Routledge, 1995.

- 276 Dingwall R. Accounts, interviews and observations. In: G Miller, R Dingwall, eds. *Context and method in qualitative research*. London: Sage, 1997;
- 277 Novik G. Is there a bias against telephone interviews in qualitative research. *Research in Nursing and Health* 2008;**31**:391-398.
- 278 Thomas R, Purdon S. *Telephone methods for social surveys*. Available from: <http://sru.soc.surrey.ac.uk/SRU8.html> [Accessed: 16/06/10].1994.
- 279 Chapple A. The use of telephone interviewing for qualitative research. *Nurse Researcher* 1999;**6**:85-93.
- 280 Mays N, Pope C. *Qualitative Research in health care*. London: BMJ, 1996.
- 281 Faugier J, Sargeant M. Sampling hard to reach populations. *Journal of Advanced Nursing* 1997;**26**:790-797.
- 282 Browne K. Snowball sampling: using social networks to research non-heterosexual women. *International Journal of Social Research Methodology* 2005;**8**:47-60.
- 283 Baxter J, Eyles J. Evaluating Qualitative Research in Social Geography: Establishing 'Rigour' in Interview Analysis. *Transactions of the Institute of British Geographers* 1997;**22**:505-525.
- 284 The Information Centre - Workforce and facilities. *General and Personal Medical Services. England*. Available at: [http://www.ic.nhs.uk/webfiles/publications/workforce/nhsstaff9909/General\\_Practice\\_Bulletin\\_1999\\_2009.pdf](http://www.ic.nhs.uk/webfiles/publications/workforce/nhsstaff9909/General_Practice_Bulletin_1999_2009.pdf) [Accessed: 10/06/10]2010.
- 285 Department for Communities and Local Government. *Indices of Deprivation*. Available at: <http://www.communities.gov.uk/corporate/researchandstatistics/statistics/subject/indicesdeprivation> [Accessed: 07/05/2011]2011.
- 286 Miles M, Huberman A. *Qualitative data analysis. A sourcebook of new methods*. Beverley Hills, California: Sage, 1984.
- 287 Glaser BG, Strauss AL. *The Discovery of Grounded Theory*. Chicago: Aldine, 1967.
- 288 Thorne S. Data analysis in qualitative research. *Evidence Based Nursing* 2000;**3**:68-70.
- 289 Denscombe M. *The good research guide for small-scale social research projects*. Buckingham: Open University Press, 1998.
- 290 Coffey A, Atkinson P. *Making sense of qualitative data. Complementary research strategies*. Thousand Oaks, California: Sage, 1996.

- 291 NIHR. *About the SDO programme. Available at:*  
<http://www.sdo.nihr.ac.uk/aboutthesdoprogramme.html>  
[Accessed:18/06/10].2010.
- 292 Guthrie B, McLean G, Sutton M. Workload and reward in the Quality and Outcomes Framework of the 2004 general practice contract. *British Journal of General Practice* 2006;**56**:836-841.
- 293 Doran T, Fullwood C, Gravelle H, et al. Pay for performance programs in family practices in the United Kingdom. *New England Journal of Medicine* 2006;**355**:375-384.
- 294 Doran T, Campbell S, Fullwood C, Kontopantelis E, Roland M. Performance of small general practices under the UK's Quality and Outcomes Framework. *British Journal of General Practice* 2010;**60**:e335-e344
- 295 Tahrani AA, McCarthy M, Godson J, Taylor S, Capps N, Macleod AF. Diabetes care and the new GMS contract. *British Journal of General Practice* 2007;**57**:483-485.
- 296 McDonald R, Harrison S, Checkland K. Incentives and control in primary health care: findings from English pay for performance case studies. *Journal of Health Organization and Management* 2008;**22**:48-62.
- 297 Heath I, Hippisley-Cox J, Smeeth L. Measuring performance and missing the point? *BMJ* 2007;**335**:1075-1076.
- 298 Mangin D, Toop L. The quality and outcomes framework: what have you done to yourselves? *British Journal of General Practice* 2007;**57**:435-437.
- 299 Roland M. The Quality and outcomes framework: too early for a final verdict. *British Journal of General Practice* 2007;**57**:525-527.
- 300 Roland M, Campbell S, Bailey N, Whalley D, Sibbald B. Financial incentives to improve the quality of primary care in the UK: predicting the consequences of change. *Primary Health Care Research & Development* 2006;**7**:18-26.
- 301 Wensing M, Jung J, Mainz J, Olesen F, Grol R. A systematic review of the literature on patient priorities for general practice care. Part 1: Description of the research domain. *Social Science and Medicine* 1998;**47**:1573-1588.
- 302 McBride CA, Shugars DA, DiMatteo MR, Lepper HS, O'Neil EH, Damush TM. The Physicians role. *Archives of Family Medicine* 2007;**3**:948-953.
- 303 Buetow S. What do patients want from their general practitioners and their patients want from general practice and are they receiving it: a framework. *Social Science and Medicine* 1995;**40**:213-221.
- 304 Coulter A. What do patients and the public want from primary care? *BMJ* 2005;**331**:1199-1201.

- 305 Cheraghi-Sohi S, Bower P, Mead N, McDonald R, Whalley D, Roland M. What are the key attributes of primary care for patients? Building a conceptual 'map' of patient preferences. *Health Expectations* 2006;**9**:275-284.
- 306 Coulter A. *Trends in patients' experience of the NHS*. Available at: [http://www.pickereurope.org/Filestore/PIE\\_reports/landmark/Trends\\_in\\_patients\\_experience\\_of\\_the\\_NHS.pdf](http://www.pickereurope.org/Filestore/PIE_reports/landmark/Trends_in_patients_experience_of_the_NHS.pdf) [Accessed: 02/02/10]. Oxford. Picker Institute Europe, 2006.
- 307 Hutchison A, Williams M, Meadows K. Perceptions of good medical practice in the NHS: a survey of senior health professionals. *Quality and Safety in Health Care* 2007;**8**:213-218.
- 308 Wofford MM, Wofford JL, Bothra J, Kendrick SB, Smith A, Lichstein PR. Patient complaints about physician behaviours: a qualitative study. *Academic Medicine* 2004;**79**:134-138.
- 309 Bower P. Measuring Patients' assessments of primary care quality: the use of self-report questionnaires. *Expert Review Pharmacoeconomics Outcomes Research* 2003;**3**:551-560.
- 310 Stewart M. Effective physician-patient communication and health outcomes: a review. *Canadian Medical Association Journal* 2007;**152**:1423-1433.
- 311 Dowrick C, Leydon GM, McBride A, et al. Patients' and doctors' views on depression severity questionnaires incentivised in UK quality and outcomes framework: qualitative study. *BMJ* 2009;**338**:b663
- 312 Becker H. *Outsiders: Studies in the Sociology of Deviance*. New York: Free Press, 1963.
- 313 Freidson E. The Reorganization of the Medical Profession. *Medical Care Research and Review* 1985;**42**:11-35.
- 314 Adams JS. Inequality in Social exchange. In: L Berkowitz, ed. *Advances in Experimental Psychology*. New York: Academic Press, 1965;267-299.
- 315 Iacobucci G. *GPs split over calls for salaried profession*. Available at: <http://www.pulsetoday.co.uk/story.asp?storyCode=4122121&sectioncode=23> [Accessed: 31/10/10].2010.
- 316 Quinn I. *Practice expenses ratio breaks 60% barrier*. Available at: <http://www.pulsetoday.co.uk/story.asp?sectioncode=23&storycode=4127131> [Accessed: 30/10/10].2010.
- 317 Taylor I. Discretion and Control in Education: The Teacher as Street-level Bureaucrat. *Educational Management Administration & Leadership* 2007;**35**:555-572.

- 318 The Information Centre. *Domain Summary: Quality and Outcomes Framework (QOF) for April 2009 - March 2010, England*. Available at: [http://www.ic.nhs.uk/webfiles/QOF/2009-10/National%20tables/QOF0910\\_National\\_DomainSummary.xls](http://www.ic.nhs.uk/webfiles/QOF/2009-10/National%20tables/QOF0910_National_DomainSummary.xls) [Accessed: 21/10/10].2010.
- 319 NHS Workforce Review Team. *Workforce Summary - General Practitioners*. Available at: <http://www.cfwi.org.uk/intelligence/previous-projects/workforce-summaries/general-practitioners> [Accessed: 31/10/10].2008.
- 320 Department of Health. *White Paper. Equity and Excellence: Liberating the NHS* Available at: [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/@ps/documents/digitalasset/dh\\_117794.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_117794.pdf) [Accessed: 10/01/2011].2010.
- 321 Lester H, Campbell S. Developing Quality and Outcomes Framework (QOF) indicators and the concept of 'QOFability'. *Quality in Primary Care* 2010;**18**:103-109.
- 322 Marshall M, McLoughlin V. How do patients use information on health providers? *BMJ* 2010;**341**:1255-1257.
- 323 Lester H, Schmittiel J, Selby J, et al. The impact of removing financial incentives from clinical quality indicators: longitudinal analysis of four Kaiser Permanente indicators. *BMJ* 2010;**340**:e340
- 324 Laughlin R, Broadbent J, Shearn D, Willing-Atherton H. Absorbing LMS: the coping mechanism of a small group. *Accounting, Auditing and Accountability* 1994;**7**:59-85.
- 325 Hughes EC. *Men and their work*. Glencoe, Illinois: Free Press, 1958.
- 326 Anekwe L. *Government considers ditching exception reporting*. Available at:<http://www.pulsetoday.co.uk/story.asp?sectioncode=23&storycode=4127345> [Accessed on: 25/10/10].2010.
- 327 McDonald R, Roland M. Pay for Performance in Primary Care in England and California: Comparison of Unintended Consequences. *Annals of Family Medicine* 2009;**7**:121-127.
- 328 Serumaga B, Ross-Degnan D, Avery AJ, et al. Effect of pay for performance on the management and outcomes of hypertension in the United Kingdom: interrupted time series study. *BMJ* 2011;**342**:322-322
- 329 Iacobucci G. *Tories to reshape QOF to focus on public health outcomes*. Available at:<http://www.pulsetoday.co.uk/story.asp?storycode=4124760> [Accessed: 31/10/10].2010.



- 330 Health Select Committee. *Health Committee - Fifth Report Commissioning: further issues*. Available at:  
<http://www.publications.parliament.uk/pa/cm201011/cmselect/cmhealth/796/79602.htm> [Accessed: 05/04/2011]. 2011.
- 331 Coleman A, Checkland K, Harrison S, Dowswell G. *Practice-based commissioning: theory, implementation and outcome*. Available at:  
<http://www.medicine.manchester.ac.uk/primarycare/npcrdc-archive/archive/PublicationDetail.cfm/ID/265.htm> [Accessed: 11/05/2011] Final Report.2009.
- 332 Iacobucci G. *One GP in five has blown whistle on a colleague*. Available at:  
<http://www.pulsetoday.co.uk/story.asp?storycode=4127430> [Accessed: 12/12/10].2010.
- 333 Cohen L, Musson G. Entrepreneurial Identities: Reflections from Two Case Studies. *Organization* 2000;**7**:31-48.
- 334 Praities, N. Two QOF indicators face axe. In: *Pulse of the Montana State Nurses Association*. 2010;Available at:  
<http://www.pulsetoday.co.uk/story.asp?sectioncode=23&storycode=4127937> [accessed: 05/12/10]
- 335 Reeves D, Doran T, Valderas J, et al. How to identify when a performance indicator has run its course. *British Medical Journal* 2010;**340**:899-901.
- 336 May C, Finch T, Mair F, et al. Understanding the implementation of complex interventions in health care: the normalization process model. *BMC Health Services Research* 2007;**7**:148
- 337 Iacobucci G. *Salaried GPs to thrash out details of own union in split from BMA*. Available at: <http://www.pulsetoday.co.uk/story.asp?storycode=4125857> [Accessed: 22/10/10].2010.
- 338 McDonald R, Cheraghi-Sohi S, Tickle M et al. *The impact of incentives on the behaviour and performance of primary care professionals*. Available at:  
<http://www.sdo.nihr.ac.uk/files/project/158-final-report.pdf> [Accessed: 10/10/10].2010.

# Appendix 1

## Background to Study

The research process began when I took up a post as research associate in October 2007 on a three-year, longitudinal NHS Service and Delivery Organisation (SDO) funded project. The project aimed to investigate the impact of incentives (financial and otherwise) contained within the recent contractual reforms on the motivations, behaviours and performance of primary care professionals (PCPs) across three areas of primary care namely; general practice, pharmacy and dentistry. As contracts can change and in the case of GPs, one key aspect i.e. QOF is specifically designed to do just that, it also aimed to analyse how these changes would affect the motivations, behaviours and performance of those affected. In order to achieve its aims the project utilised a multi-method, multi-stage design, linking analyses of national routinely collected quantitative data supplemented with further empirical data collection in the form of qualitative interviews. My role within the project was to manage the data to day requirements of the qualitative arm of the project as well as to undertake the data collection and take part in the analysis of the collected data across all sectors of interest (see<sup>338</sup> for the project report). In summary therefore, my task was to identify and formulate an area suitable for doctoral research within the scope of the data I was to collect.

Given the breadth of the project aims, there was a lot of scope to choose a topic within any of the individual professions/areas or indeed to look at the impact of the new contracts across the various professions. After discussions with my supervisory team, I made the decision to focus on general medical practice for reasons which were largely pragmatic i.e. it was an area I was somewhat familiar with as 1) I had previously worked as a research associate on a two-year project that aimed to elicit patient preferences for various aspects of general practice. 2) my MRes dissertation focused on assessing the effectiveness of interventions designed to improve the interpersonal care of primary care physicians. Given that undertaking doctoral research is widely known to be a long and at times difficult journey, it seemed to make sense to minimise any other difficulties that I may have incurred during the process by attempting to undertake research outside an area I at least had some familiarity with. In addition, and in relation to the first point, I was

also influenced by the fact that I work in a research group that produces research in relation to general practice and indeed produced research that directly fed into the focus of this research (i.e. QOF) such as the General Practice Assessment Questionnaire (GPAQ). Finally, the QOF has been described by some as ‘the boldest such proposal on this scale ever attempted anywhere in the world.’<sup>241(p457)</sup> The opportunity to conduct research on an area regarded in this way and attracting international interest also proved too much of a temptation to resist.

## Appendix 2

NPCRDC  
5th Floor  
Williamson Building  
The University of Manchester  
Oxford Road  
Manchester  
M13 9PL

TELEPHONE

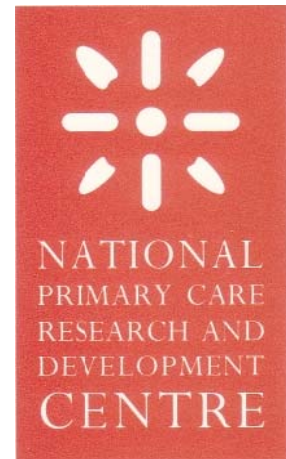
0161-275 7601

FACSIMILE

0161-275 7600

DIRECT LINE

0161-275-7654



### **Study of New Contracts (Incentives) in Primary Care Participant Information Sheet**

#### **Introduction**

In recent years new contracts have been introduced for some groups of Primary Care Professionals (PCPs). Our study is concerned with GPs, primary care dentists and community pharmacists. The new contracts mean that there have been changes to the rules under which these groups of staff provide services to the NHS. In particular, the new contracts emphasise targets and payments to be made for meeting those targets. This means that new financial incentives have been introduced to encourage PCPs to meet specific targets. In addition some PCPs are becoming more involved in local commissioning processes.

We are interested in findings out about the effect of incentives on PCPs. The research is aimed at providing some understanding of the ways in which incentives impact on patterns of working within PCP organisations, rather than looking at whether they meet targets. In order to do this we want to interview staff who work in PCP organisations as well as staff working in the PCT whose duties are connected with the new PCP contracts and other relevant stakeholders. We will, for example, also interview patient group representatives and private sector provider representatives.

This research will help us learn from what works well and may suggest some areas where the contracts' effects are not in line with those intended by policy makers and we will feed these findings into policy makers with the aim of promoting the delivery of high quality care in PCP organisations.

We would like to invite you to help us assess what happens in PCP organisations as part of this process.

#### **What will I have to do if I take part?**

If you agree to take part a researcher will interview you. The interview will be audiotaped.

**What are the possible risks of taking part?**

There are no risks in taking part in the study.

**Are there any possible benefits?**

It is hoped that we can use what we learn to inform policy making in this area in the future.

**Do I have to take part?**

No, taking part is voluntary. If you would prefer not to take part you do not have to give a reason. If you take part but later change your mind you can withdraw at any time from the study.

**Will my taking part in the study be kept confidential?**

Any information you provide will be kept confidential. The information we collect will be stored in a locked cabinet and will be destroyed five years after the end of the study.

**What will happen to the results of the research study?**

We will produce a final report of the results for the people who funded the study. All data will be anonymised i.e. no personal details of any kind will be made public. We will also publish articles and papers about the study and produce a report for the PCP organisations and the various stakeholders who participated in the research.

**Who is organising and funding the research?**

The research is organised by a team from the Universities of Manchester and York. It is funded by the NHS Service Delivery and Organisation Research & Development Programme.

**Who has reviewed the study?**

The study has been reviewed by funder's reviewer process and an NHS Research Ethics Committee.

**What do I do now?**

If you consent to the request to be interviewed then we would like you to sign a consent form. If you do not consent, then please tell the researcher.

Thank you very much for taking the time to read this.

If you wish to obtain any more information or ask any questions about this research you may contact:

**Dr Ruth McDonald, Research Fellow, University of Manchester  
National Primary Care Research and Development Centre  
Williamson Building**

**University of Manchester**

**0161 275 7601**

**[ruth.mcdonald@manchester.ac.uk](mailto:ruth.mcdonald@manchester.ac.uk) (email)**

**Sudeh Cheraghi-Sohi, Research Associate, University of Manchester  
National Primary Care Research and Development Centre  
Williamson Building**

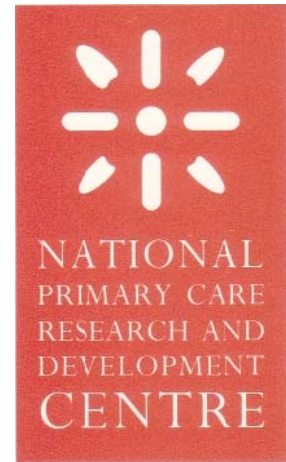
**University of Manchester**

**0161 275 7654**

**[Sudeh.cheraghi-sohi@manchester.ac.uk](mailto:Sudeh.cheraghi-sohi@manchester.ac.uk) (email)**

# Appendix 3

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## CONSENT FORM (Version 1, 01/12/06)

TELEPHONE  
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DIRECT LINE  
 0161-275-3535

Title of Project: **NEW  
 CONTRACTS (INCENTIVES) IN  
 PRIMARY CARE**

Principal investigator: Dr Ruth  
 McDonald

I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.	
I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without any detriment to myself and my organisation.	
I understand that the interview will be audio-taped	
I agree to take part in the above study.	
I understand that only the members of the research team have access to the information collected during the study.	
I am aware that the information collected during the interview will be used to write up a report on the project, as well as journal articles and books.	
I understand that information collected during the course of the research project will be treated as confidential. This means that my name, or any other information that could identify me, will not be included in anything written as a result of the research.	
I understand that when this research is completed the information obtained will be retained in locked filing cabinets in a storeroom in the National Primary Care R&D Centre, University of Manchester for 5 years and then will be destroyed.	

Name of Participant	Date	Signature
Name or Person Taking Consent		

## Appendix 4 - Topic Guide

How long have you been a fully qualified GP for?

What made you go into general practice?

What do you like about it?

What do you dislike about it?

Describe the primary health care team here and your position in it

(NEED TO ASCERTAIN STATUS – SALARIED, OWNER, LOCUM ETC\*\*\*) – IF SALARIED THEN ALSO ASK SPECIFIC UNDERLINED QUESTIONS.

How long have you been at this practice?

Did you train here?

If no, ask how their old practice was in comparison to this.

Did you actively seek a salaried role or did you want a partnership after training?

What do you like about being salaried?

Are there any negatives to being salaried?

Do you want to be a partner in the future?

Is there anything unusual about this practice?

*Staff skill mix?*

*Services offered?*

*What type of contract do you hold (GMS, PMS etc)?*

How has the new GP contract had an impact on you?

*Prompt:*

*Ability to opt out of out-of-hours care? – for those who just entered prior to and after 2004, ask if it affected their decision to choose general practice*

*Changes in volume of work? More paperwork?*

*Changes in nature of work?/ working patterns*

*Changes in relationships with patients?*

*Changes in relationships with PCT – support from PCT?*

*PCT Inspection process?*

*Prompt – targets/ incentives/ bonus*

What do you like about it?

*Prompt – impact on quality?*

What do you dislike about it?



*Seeing fewer patients?*  
*Seeing different patients?*  
*Should it take into account local population factors?*  
*Impact on non-incentivised areas?*

What were your consultations like pre-QOF in comparison to now? (if appropriate – if not ask about non-QOF consultations in comparison)

What % of your daily consultations would you say involve QOF?

Has the contract changed the nature of the consultation?  
*Prompt – routines – when do you address QOF in the consultation?*  
*Prompt – use of templates, views on templates, loss of eye contact?, box ticking*  
*Prompt – patients' agenda lost?*

Do you think that the QOF (or aspects of it) impacts on your role as a GP?  
*Prompt - advocacy*

Are there any indicators that you find problematic?  
*Prompt depression screening, CKD*  
*Are all indicators pursued by the practice?*

What (if any) changes were made in your practice in order to meet the QOF targets?  
*Prompt – some practices formed QOF teams – have you? If so:*  
*Prompt – who takes responsibility for monitoring in the practice?*  
*Prompt – how was it decided who would take responsibility?*  
*Prompt – do you chase people up / get chased up etc?*  
*Prompt – do **you** check progress on the computer?*

Has it had an impact on the other people who work here?  
*Changes in skill mix, hours etc*

How have nurses roles changed since the introduction of the new contract? *Becoming more specialised?*  
*Seeing different patients?*  
*Type of care?*  
*Prompt – some evidence to say GPs feeling de-skilled? Do you? If so, how?*

More practices are making statements about high QOF scores in their ads for staff – how would you interpret this?

How do you feel about public/peer access to your practice's performance?

What are your views about money and QOF – what other factors are there that influence GPs in responding to QOF?

*Prompt – health improvement*

*Prompt – practice reputation*

Do you think that it has had an impact on the profession of general medical practice?

*Prompt – morale*

*Prompt – public perception- media stories of money etc for GPs*

What are your views on the negotiations with government over the contract 2007/8?

*Prompt extended hours DES - clarify if and why they are or are not offering it.*

What do you think about private companies e.g. Care UK coming in to run practices & employing all the staff?

If salaried, ask about their views on what they think that would be like working for a private company in comparison to a traditional GP run practice

What do you think the impact of an increasingly salaried GP workforce will have on general practice?

How do you think GPs' and nurses' roles will change in the future?

Exception reporting facility

*Can you give me an example of when you have done this?*

*How would you feel if this was removed?*

Evolving QOF: What are your views on:

The patient survey?

*Prompt – incentivisation*

New Indicators?

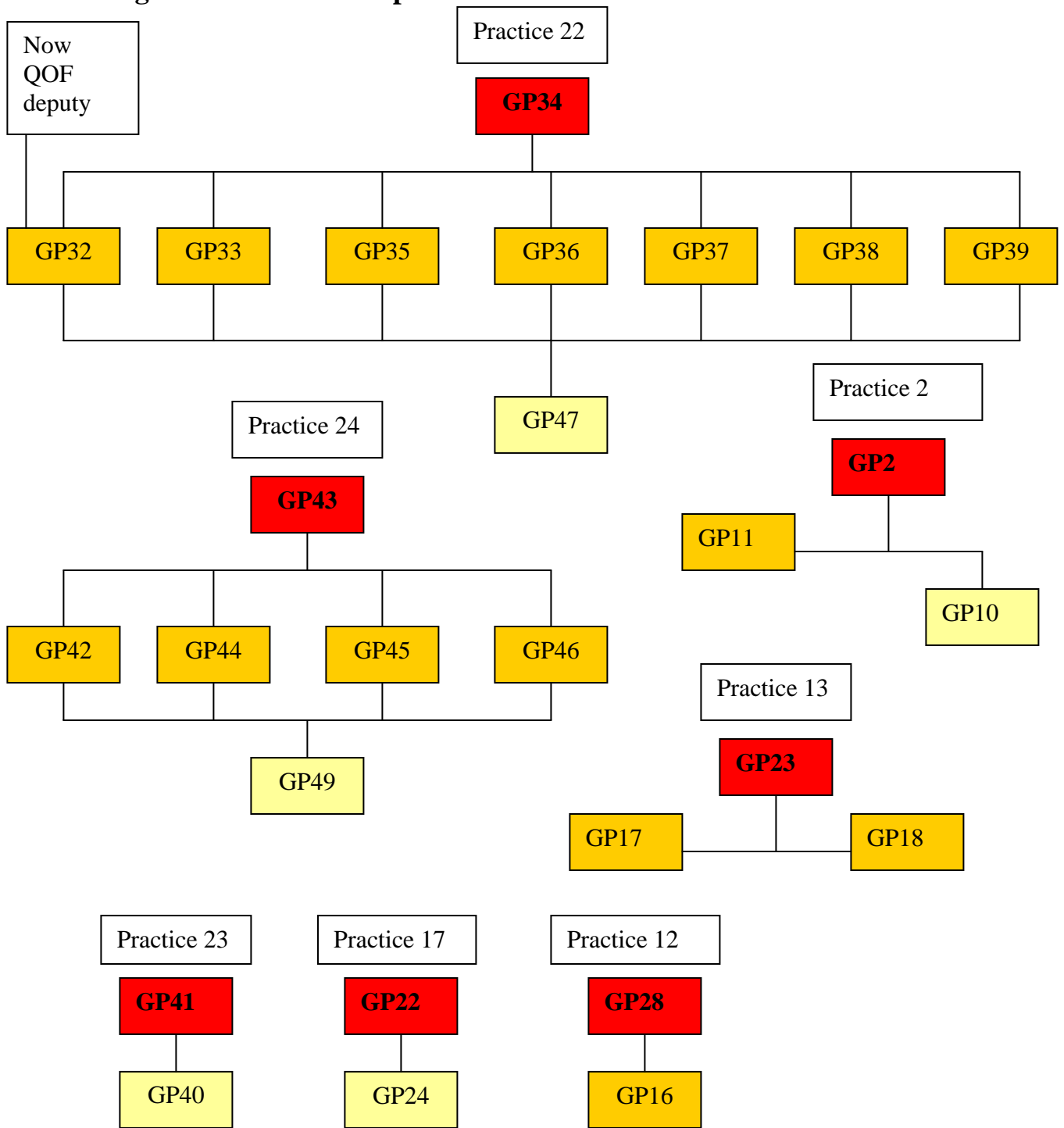
*Prompt – 2009 HbA1c targets*

An outcome-based QOF?

Final thoughts about the future of the contract/QOF

*Prompt – tension between tighter targets and PCT budget constraints?*

**Appendix 5: A diagrammatic representation of QOF team arrangements for selected practices**



**Overall GP QOF leads represented in dark shaded boxes**  
**Medium shade boxes represent partners interviewed in the practice**  
**Lightest boxes represent salaried GPs interviewed in the practice**

