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The impact of pay-for-performance on professional boundaries in UK general practice: an ethnographic study

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Abstract

The 2004 New General Medical Services (nGMS) contract exemplifies trends across the public services towards increased definition, measurement and regulation of professional work, with general practice income now largely dependent on the quality of care provided across a range of clinical and organisational indicators known collectively as the 'Quality and Outcomes Framework' (QOF). This paper reports an ethnographically based study of the impact of the new contract and the financial incentives contained within it on professional boundaries in UK general practice. The distribution of clinical and administrative work has changed significantly and there has been a new concentration of authority, with QOF decision-making and monitoring being led by an internal QOF team of clinical and managerial staff who make the major practice-level decisions about QOF, monitor progress against targets, and intervene to resolve areas or indicators at risk of missing targets. However, general practitioners and nurses appear to have accommodated these changes by re-creating long established narratives on professional boundaries and clinical hierarchies. This paper is concerned with the impact of these new arrangements on existing clinical hierarchies.

Keywords:

General practice, primary care, quality and outcomes framework, professional boundaries, managerialism

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Introduction

Recent management reforms have resulted in the growing use of centrally defined performance indicators to measure and manage public services, with financial incentives for quality an increasingly favoured mechanism for the promotion of change (Power 1997). The reshaping of UK general practice financing through the 2004 New General Medical Services (nGMS) contract (Department of Health/NHS Confederation 2003) is a radical example of such reform, with uncertain effects.

Historically, GPs had been paid by a mixture of capitation (fixed sums per patient registered), allowances (per GP), a small element of fee-for-service (specific payments for particular services), and a small number of target payments (pay-for-performance for achieving immunisation and cervical smear targets). In 2004, nGMS replaced this complex fee schedule with a single, weighted capitation formula (the 'global sum'), which was intended to better match payment and existing workload. Additional money was made available through a major pay-for-performance initiative known as the Quality and Outcomes Framework (QOF), intended to improve quality of care and reduce variation between practices. Under QOF, 20-25% of UK practices' income now depends on their performance measured against over 140 centrally-defined quality indicators. Each indicator is allocated a certain number of 'points' and each 'point' is weighted to reflect its importance as well as the work required to achieve it. In 2004-5, out of the 1,050 total points available, 550 points were allocated for the clinical care of 10 chronic diseases. For the average-sized practice during this period (~5,400 patients, ~3GPs), each point was worth £75, rising to £120 in 2005-6. A US observer declared the QOF the

‘boldest such proposal on this scale ever attempted anywhere in the world’ (Shekelle 2003:457). Prior to QOF implementation, practices were expected by the government to achieve ~75% of the available points, but in actuality achieved ~95%, generating considerable controversy about value for money (General Practitioners’ Committee Annual Report 2006; Timmins 2005).

One way of conceiving QOF is as an attempt to reconfigure general practice via a process of managerialism as part of the ‘New Public Management’ (NPM) (Clarke and Newman 1997; Ferlie *et al.* 1996; McLaughlin *et al.* 2002). Managerialism (as distinct from management more generally) involves adopting and promoting private sector or business practices as part of an attempt to refashion the welfare state. Whilst the rise of managerialism is associated with neo-liberalism as well as successive Conservative governments in the UK from 1979, New Labour policies post-1997 have continued to support this approach to public service reform, particularly in healthcare (Department of Health 1997). Underpinned by distaste for what it sees as old, outmoded, bureaucratic ways of delivering public services, NPM sees ‘‘management’ as the solution to social and economic problems’ (Newman and Clarke 1994:14). Key aspects of the NPM approach include an emphasis on contractual relationships as opposed to centralised, top-down control, and institutional accountability and transparency to funders, stakeholders and clients for quality via performance indicators (Power 1997:43). Although the 1990 GMS contract incorporated some of these elements (Lewis 1997; Harden 1993), the 2004 contract is underpinned by them. Linked to this, Nancarrow and Borthwick (2005:898) write that the UK healthcare workforce has undergone considerable change in the past

century, with neo-liberalism leading to the breakdown of traditional workforce hierarchies and the distribution of resources on the basis of achievement rather than undisputed professional status. NHS policy under New Labour has explicitly aimed to facilitate this breakdown of hierarchies (Department of Health 2000), for example through the implementation of 'Agenda for Change' (Department of Health 2004), which introduced a common pay scale for all NHS staff other than doctors.

There is considerable literature on the socially-constructed and contested nature of professionalism and professional boundaries in the primary care workforce (for example, Allen 1997; Broadbent 1998; Charles-Jones *et al.* 2003; Fournier 2000; Leese 2007; Mizrachi *et al.* 2005; Nancarrow and Borthwick 2005; Norris 2001; Witz 1992). Emphasising that the implementation of national policy depends on the reconfiguration of small, multi-professional teams, Charles-Jones *et al.* (2003) write that pre-QOF policy changes have resulted in clinical work being distributed amongst increasingly complex primary healthcare teams, that clinical work has become increasingly geared towards nurse-led chronic disease management and that general practice work is being reduced to a set of delegated medical tasks with a biomedical model of primary care gradually replacing the previous biopsychosocial one (cf. Checkland *et al.* forthcoming). Charles-Jones *et al.* (2003:87) argue that medical professionals categorise work and patients into 'hierarchies of appropriateness' where 'higher order' work is retained by the dominant profession (i.e. GPs), whilst 'lower order' work is delegated to more subordinate professionals (i.e. nurses). This is said to occur through a dual process of claims to jurisdiction over areas of practice work considered to be 'specialist' (Norris 2001) and

the delegation or 'substitution' (Nancarrow and Borthwick 2005) of 'hybrid' tasks (Charles-Jones *et al.* 2003) or 'dirty work' (Hughes 1958). Witz (1992) proposes that professionals subject to these 'demarcationary strategies' respond by employing 'dual closure' strategies involving the expansion of their areas of control and privilege through inclusionary strategies of 'upward usurpation' and that lower status, routine work is delegated to another occupational group forbidden from carrying out more complex work through strategies of 'downward exclusion'.

Few studies have considered the effects of recent changes on the boundary between clinical staff and practice managers and the boundaries constructed between them, but given the managerialist nature of QOF, this is of considerable interest. An exception is a study of the impact of the 1990 contract which found that a business discourse was 'beginning to colonise the medical discourse' with 'the boundary between the two competing discourses becoming blurred and ambiguous' (Cohen & Musson 2000: 37f). Clinical autonomy, described by Harrison and Dowswell (2002:209) as 'the ability of individual physicians to determine their own clinical practices and to evaluate their own performance', has long been considered central to the construction of professional identity (Freidson 1970; Elston 1991). Various commentators have identified the growth of managerialism as allowing the 'privileging of managers' interests' (McCourt 2001:222), with a consequent diminution of the autonomy of clinical professionals such as doctors and nurses (Degeling *et al.* 2006; Flynn 1992; Pollitt 1990). Recent writers (Exworthy and Halford 1999; Ferlie 1996; Kitchener 2000; Sheaff *et al.* 2003) have distinguished changes in clinical autonomy from changes in the managerial autonomy of

professionals. Whilst recent changes have created the potential for a redefinition of roles and responsibilities for both managers and professionals, the spread of managerialism does not necessarily mean that the autonomy of managers increases relative to that of clinicians. A more nuanced approach may therefore be to allow for the possibility that there will be winners and losers *within*, rather than *between*, these groups and that the relationships will be of a more contingent nature.

Crucially, despite QOF being a UK-wide policy, practices have remained free to deliver QOF-incentivised care in any way they wished, and have therefore ‘performed’ the QOF in locally mediated ways, and with a range of effects. Michel de Certeau (1984) distinguishes between what he terms the ‘strategies’ and the ‘tactics’ of practice. ‘Strategies’ are technologies of disciplinary power imposed by the dominant economic order that are abstracted from the everyday environment but which penetrate all environments. The ways in which these products are consumed in everyday practice are what he terms the ‘tactics’ of production. The QOF can be conceived of as one such operational ‘strategy’ which was intended to change both practice administrative systems and the delivery of clinical care, although the everyday ‘tactics’ involved in achieving these aims will differ. This paper explores the ‘tactics’ employed in the everyday practice of the QOF through the micro-level ‘culture’ of UK general practice (see Checkland *et al.* forthcoming; McDonald *et al.* 2007), focusing on the relationship between the main professionals found in UK general practice – general practitioners and nurses – and the impact of the QOF on wider practice team dynamics. First, we briefly describe broad changes in staffing and administrative systems that have taken place

within four UK practices in response to the QOF. Second, we explore potentially new professional boundaries that we observed being created in these practices through the establishment of various kinds of internal QOF teams in response to the managerial demands of nGMS. Third, we consider the ‘dual closure’ strategies (Witz 1992) employed by GPs and practice nurses in the maintenance of professional boundaries during formal interviews. Fourth, we bring together the previous two sections through fieldnotes in order to examine how the new managerial roles of practice team members interact with the more established clinical hierarchy. In the discussion, we draw together these findings and discuss their longer-term implications.

Methods and setting

This paper is based on two interlinked ethnographic studies that took place simultaneously in Scotland and England. Both studies had two case study general practices and each focussed on the effects of nGMS at practice level. Whilst the two studies were funded by separate sources, the research teams worked in close collaboration. The teams met regularly during the initial planning of the projects, during the data collection stage, as well as during the analysis of emergent findings. The agendas, emergent findings and results of the projects were therefore discussed at every stage.

Following ethical approval in both Scotland and England, the four practices were selected on a pragmatic basis, with the main criterion being their willingness to participate in the

study. An additional criterion was points achievement in the QOF, as participants in earlier focus groups in the Scottish study attributed specific moral attributes to QOF points achievement, and there appeared to be a link between points achievement and practice organization and ethos. It was therefore decided that whilst both English practices and one of the Scottish practices would have high QOF scores, the second Scottish practice would be closer to the mean. In order to avoid including a range of contextual variables, both the Scottish and the English practices were situated in the same cities and were of medium to large size.

The two Scottish practices were 'Family Practice' and 'Modern Practice'. 'Family Practice' had three full-time GP partners and three part-time practice nurses and served a socio-economically mixed population of ~4,500 patients, with a significant proportion of students and the elderly. Its dominant narrative was of a small, friendly practice committed to providing traditional holistic general practice to its patients. It achieved just over 950/1,050 points in the 2004-5 QOF. Avoiding a low score that risked being 'named and shamed' in the local press was a major concern, but the GPs were proud of their average score, which was perceived as demonstrating that the pursuit of points took second place to appropriate care for individuals. In 'Modern Practice', the dominant narrative was one of a practice long committed to delivering high quality, easily accessible care to a highly challenging, socio-economically deprived population. Comprising six part-time partners, two salaried GPs, one nurse practitioner, two G-grade nurses and a nurse trainee, the practice served a population of ~9,000 and achieved

~1,040 points in the 2004-5 QOF. This was a source of pride, because it publicly demonstrated the quality of care they provided despite the difficulties they faced.

The two English practices were 'Big Practice' and 'Medium Practice'. 'Big Practice' had a long history of innovative service delivery, and was proud of its reputation for providing high quality holistic care to patients. There were three full-time partners, four part-time partners, two salaried GPs, one GP registrar, one full-time advanced nurse practitioner, one part-time senior nurse and three chronic disease nurses. It served a moderately deprived population of ~12,000 patients and achieved ~1,040 QOF points. Although near maximum, they were not the highest scoring practice in their area, and perceived this to be a relative failure which spurred them to greater efforts in 2005-6. 'Medium Practice' served a deprived population of ~8,000 patients and saw their role as improving the overall public health of the area through effective anticipatory care for the whole population. There were three full-time and one three-quarter-time GP partners, two nurse practitioners and one practice nurse. They achieved ~1,040 points in 2004-5, which they interpreted as demonstrating their organisational effectiveness.

Ethnographic fieldwork in the practices took place between November 2005 and May 2006. Fieldwork was iterative and drew upon a range of quantitative and qualitative data in order to develop a detailed understanding of the organizational dynamics within each practice and how these, in turn, shaped practice-level responses to the QOF. A total of 48 formal audio-recorded interviews were conducted with GPs, practice nurses, practice managers, senior receptionists, IT staff and healthcare assistants. Interview topic guides

covered the following key themes: respondent’s views on the impact of the contract on their role and on the role of other primary care professionals; their views on changes in their relationships with other primary care professionals; and changes in the quality of care for patients. Table 1 below summarises the number of individuals who were formally interviewed in each of the four practices by profession:

Table 1:

	Family Practice	Modern Practice	Big Practice	Medium Practice
GPs	3	6	8	4
Practice Nurses	1	3	5	4
Healthcare Assistants			2	2
Practice Managers	1	1	1	1
IT Staff	1	1	1	
Receptionists		1	1	1

Observational work was carried out in the reception areas of the practices, in the staff coffee rooms, during practice team meetings and (in England) during patient consultations. Detailed fieldnotes were taken during all observation periods and analysed along with the interview transcripts. NVivo was used as an indexing tool and indexing codes were developed during the course of the study at the regular meetings that took place between the researchers. The observational work was informed by the interviews, which, in turn, informed subsequent interview questions. The focus of the analysis in

both studies was the same: what new clinical and administrative practices had been introduced at practice level in response to QOF incentives and requirements? How did practice team members respond to these changes in interview and informal conversation and how did these responses relate to our observations? During the course of the study it became apparent that the managerial changes that were taking place in the four practices in relation to staffing, systems and practice team organisation were not often talked about by clinical staff, with old 'clinical hierarchies' being emphasised in both discourse and practice. The nature of this apparent incongruence formed the basis of our research for this section of the study. The results reported below combine interview and observational work, with quotes used to illustrate particular points. Feedback visits took place in June 2006. During these visits the ideas that had been developed during the fieldwork were discussed with the participants, with their responses offering a degree of respondent validation as well as further data to be analysed. The fieldwork was supplemented by an interrogation of national documents relating to the GMS contract and its history, and an examination of national QOF data.

Changes to staffing and systems

Since the start of the QOF, a number of substantive changes had taken place in all four practices regarding the role of staff and the organisation of practice administrative systems. The practices had all created 'new' nursing time for QOF by employing additional nurses and/or re-organising nursing work, for example, by delegating 'routine' nursing work (like taking blood) to newly employed healthcare assistants. Clinical care

for QOF-incentivised diseases had also been changed where necessary to match QOF requirements. This had taken place either through the creation of new nurse-led clinics or through modifying the work done in existing clinics and routine surgery, for example, through the use of data entry templates which embed a QOF-compliant protocol for care. In some cases new managerial roles were created for clinical staff and the role of the practice manager was enhanced in order to ensure the efficient delivery of QOF clinical care.

To ensure the delivery of patients to these new clinics, IT systems were reconfigured to support the new disease registers which incorporated call and recall systems to identify and contact patients needing care, reminders for clinical staff of missing QOF data for patients attending for other problems, and systems for monitoring progress against QOF targets. All four practices employed new staff to carry out this new work and trained existing staff to use IT more effectively. The implementation of the QOF has therefore occurred within the context of a much wider reconfiguration of clinical work, with QOF forming part of a general shift in clinical work from hospitals to general practice. In the following section we focus on the impact of the QOF at the clinical-managerial boundary.

Changes at the clinical-managerial boundary

In all four practices we observed a concentration of authority for QOF decision-making and monitoring with an internal QOF team of clinical and managerial staff that was responsible for the successful delivery of the QOF. In the following four sub sections we

draw on both fieldwork and formal interviews to describe the ways in which these internal QOF teams have manifested themselves in each of the four practices.

Family Practice: Overall leadership for the QOF rested with the senior GP partner who had longstanding responsibility for the ‘business’ side of the practice. Acting as a self-described ‘benevolent dictator’, the other GP partners as well as the practice manager - who were happy for him to take on most of the administrative responsibilities - shared this view. This concentration of authority was also made possible through there being no formal meetings. Decisions were instead made informally during the daily mid-morning coffee break attended by the GPs, practice nurses, healthcare assistants and practice manager, as well as in the corridors, reception area and consultation rooms. Although this informality was described by all as reflecting the ‘egalitarian structure’ of the practice, decision making was generally dominated by the GPs, and QOF decision-making by the senior partner.

The senior partner took overall responsibility for monitoring and ensuring progress against QOF targets, although much of the actual work of QOF was delegated to others. Crosscutting both clinical and administrative staff, the internal QOF team he led comprised the senior practice nurse and the recently appointed computer operator who was responsible for data entry. Nurse-led disease-specific clinics for the QOF ran alongside opportunistic care, which was carried out during routine GP consultations. The senior practice nurse was responsible for ensuring that the two part-time nurses entered the QOF data into the IT system and she would liaise with the senior GP partner on

clinical and IT issues relating to the QOF. The computer operator worked closely with the senior partner on QOF data entry and in the production of reports for both him and the senior practice nurse. Whilst the other two GPs and all three nurses entered clinical data for the QOF, they did not consider themselves to have administrative responsibility for the QOF. Similarly, whilst the practice manager and reception staff would also carry out a wide range of administrative tasks relating to the QOF, it was the senior partner and the computer operator who were responsible for ensuring that the work was carried out. QOF work was therefore delegated, but the monitoring of that work and interventions to remedy perceived problems was carried out by the internal QOF team and by the senior partner in particular.

Modern Practice: The practice had a GP ‘QOF lead’ who had previously led clinical audit activities in the practice prior to the QOF. His role was met with no resistance from either the GPs or nurses, who accepted his position as a natural progression in response to changing circumstances. Each of the other GP partners had ‘nominated responsibility’ for one or more of the QOF clinical areas and was responsible for supervising the work of the practice nurses in the running of the nurse-led clinics, with the more experienced nurses having responsibility for a greater number of disease areas.

The practice had long-established fortnightly team meetings that all staff groups were invited to attend. These meetings had a written agenda that was circulated via email prior to the meeting and individuals were encouraged to add to the agenda any issues that they wished to raise. Meetings were organised and chaired by the ‘general manager’ who was

appointed in the first year of the QOF after the existing practice manager had retired. The practice had made an explicit decision to appoint someone with business experience outside the NHS, rather than someone from a senior receptionist background. This was partially in response to the administrative demands that QOF placed on the practice and its importance to practice income, and was accompanied by the appointment of a new IT manager. Although practice meetings were attended by all, control over decision making for contentious issues was retained by the GPs, and the 'QOF lead' in particular.

QOF clinical data was monitored by both the GP and nurse leads for each disease, and centrally by the general manager, who would present the practice's running points total at practice meetings. The general manager took sole responsibility for QOF organisational indicators, and perceived his role as relatively autonomous in terms of his authority over the administrative aspects of the practice and in the management of the non-clinical staff. Whilst he was careful not to claim to directly manage clinical work, he described himself as 'sitting at the centre of things and running the business'. The clinical staff, in turn, described him as an asset to the practice. Both he and the IT manager ran the recall system, meaning that they had control over which patients were seen in the nurse-led clinics, rather than the nurses themselves. Although the practice manager took on much of the QOF monitoring and intervention, this was delegated responsibility that affected nurses more than GPs.

Big Practice: At the start of the QOF, the nurses were all designated as 'clinical leads' and had delegated responsibility for particular disease areas. Those areas not covered by

the nurses were assigned to a 'lead GP' and those GPs without responsibility for a particular clinical area had very little involvement with the QOF. However, tensions eventually arose concerning information on individual clinicians' performance being openly available within the practice. This culminated in a practice 'Away Day', where a perceived lack of commitment from some individuals was addressed. It was subsequently agreed that a new internal QOF 'Management Team' was needed. This team consisted of three GPs, a nurse and the practice manager. The clinical team members were selected by ballot, with GPs voting for the three GPs and nurses voting for the nurse. The role of the team was to write rules and guidelines for the QOF and mechanisms such as ad hoc meetings were also used to highlight areas requiring attention. The leads system was retained, but the new QOF team had a place above the leads in the hierarchy, with the aim of strengthening control over GPs whose commitment had previously been found wanting by some team members. This new team was empowered to work towards more formal statements on issues such as time commitment and roles and responsibilities within the practice. In a practice that had always prided itself in being egalitarian, responsibility for QOF monitoring and intervention was shared between this new, hierarchical management team and the individual clinical leads for whom responsibility for particular QOF work had been delegated.

Although the timing of our study did not allow us to observe the impact of the new system, the construction of 'impersonal' formal rules, which cut across the old professional hierarchies, was implicitly intended to allow non-doctors to regulate the conduct of GPs within the practice.

Medium Practice: The GP ‘executive partner’ took the lead in organising for QOF alongside the practice manager and senior receptionist. The executive partner maintained overall responsibility for monitoring progress against the targets, checking the software that provided a running tally of targets hit and missed every day and ‘chasing’ colleagues whom he perceived to be missing targets. The practice promoted two receptionists to work with the existing practice secretary on the development and maintenance of IT systems. They were collectively known as the ‘IT team’, and were regarded as having a higher status than their reception colleagues. The executive partner worked closely with the IT team, and liaised separately with the practice manager and the lead nurse. The nurses in the practice each specialised in particular disease areas and whilst they were not delegated authority over these QOF areas, they were expected to strive to meet the necessary QOF targets. Where targets were being missed, the executive partner would send a message to the relevant nurse, who would then be expected to take action. In this way, hierarchical relationships between the nurses and the executive partner were maintained. However, these nurses were also authorised, in turn, to chase the other GPs in the practice if they were responsible for a particular patient missing the target. The nurses and the executive partner also met regularly without the other GPs to discuss the ongoing development of services in the practice. The IT team were closely involved in this process, joining the nurses and executive partner in meetings to discuss the best ways of meeting the new targets introduced as part of the 2006 QOF revision.

In summary, each of the four practices has developed an internal QOF team in response to the nGMS contract. A common feature of these internal QOF teams is the existence of a powerful GP who acted as the 'QOF lead' for the practice. The precise nature of this role varied, however, with the leads being more dominant in Family and Medium Practices and less so in Modern and Big Practices where internal teams had been elected. The role of the 'QOF lead' relates to a parallel aspect of practice organisation, which is the degree to which QOF clinical work was delegated to other GPs within the practice. In Family and Medium Practices, supervisory responsibility for all QOF work was mainly centralized in one GP, whereas in Modern and Big practices, responsibility was more diffuse. Thus, whilst the 'QOF leads' in Modern and Big Practices were GPs, there were also individual GP and nurse leads for particular clinical areas of the QOF who intervened and monitored in a way that did not occur in either Medium or Family Practices. In Modern Practice in particular, these clinical leads constituted 'mini-teams' for particular areas of chronic disease management that were devised along additional hierarchical lines with there being a GP supervisor as well as a nurse lead. In Big Practice, the 'clinical leads' were less GP-focussed, as there were also nurse leads for certain disease areas.

All four internal QOF teams included administrative staff, although their roles varied considerably between practices. The recently-appointed IT managers or computer operators were a feature common in all four practices, reflecting a growing need in practices to incorporate QOF-compliant information technology into their appointment, recall and consulting room systems. In Medium Practice, this had been extended to an

‘IT team’ and included two receptionists who had been promoted, as well as the senior receptionist who was part of the internal QOF team. Paralleling this, the role of the practice manager was very variable, from ‘traditional’ and uninvolved in Family Practice to powerful and expansionist in Modern Practice. The four case studies clearly identify that practices have responded to the QOF and that the micro-level ‘tactics’ (de Certeau 1984) of their responses have also varied in relation to the increased managerial demands of the QOF: whilst some professionals have adopted strong managerial roles, others have chosen not to take part or have been purposefully excluded.

Constructing professional boundaries: GPs and practice nurses

The following sub sections explore how GPs and practice nurses have constructed their professional boundaries in the face of QOF-driven change via a ‘hierarchy of appropriateness’ (Charles-Jones *et al.* 2003) that extends from hospital specialists to healthcare assistants.

GP perspectives on the boundary with hospital specialists:

The QOF has generally led to increased specialisation in particular disease areas for GPs. Whilst this was welcomed by many GPs - particularly those with special interests - most stated that they would still defer to hospital specialists for more complex decisions even within their areas of specialisation. However, they claimed to be able to provide ‘holistic’, patient-centred care that hospital specialists could not, and that it was this

‘holistic’ or ‘generalist’ aspect of their care which was distinctive to general practice work distinct:

Yes, you can have a GP who is an expert in diabetes and who could slot into the hospital clinic very easily...but taking one of them [hospital specialists] and slotting them in as a GP...they would probably be lost as to what to do.

(GP 2/Family)

However, the QOF was also seen as being a threat to GP holism because it only rewarded practices ‘for achieving certain levels and for providing clinics’ (GP4/ Modern) and that many of these clinics were now run by practice nurses. Thus, whilst achieving maximum QOF points was an indication that they were ‘heading in the right direction’ (GP1/Family), they were ultimately ‘devaluing themselves as clinicians’ (GP3/Family) in the process as they increasingly dealt with only the most complex cases.

GP perspectives on the boundary with practice nurses:

GPs clearly distinguished between QOF work which they considered to be ‘GP work’ and that which was ‘nursing work’. Whilst GPs claimed to retain the more complex work that required decision-making capabilities, nurses were delegated the more appropriate routine, task-based work:

I think that nurses do a magnificent job, don't get me wrong, but they are trained in a specific role, particularly for the chronic diseases, and I feel that you can't possibly equate the training that a GP has had with what a nurse has had and I don't think you can expect a nurse to pick up on the same sorts of things that a GP would.

(GP 3/Family)

Although delegated QOF work was important, it was also described as a mere 'paper exercise' that was based on routine, protocol-driven, task-based work that GPs no longer have time to carry out.

I think definitely for the nurses, it has been a good thing in terms of job satisfaction. They are good at it. They can see themselves achieving things as well. So I think it has been good for them. And we can see the benefits of not having to do the routine chores and the benefits of people who are better at data collection, and have time to do it.

(GP 6/Modern)

Some GPs claimed to have overall responsibility for the patient by 'rubberstamping' nursing work, with this responsibility expressed in terms of greater clinical or medical expertise.

Nurses are very good at doing things and at following criteria and they will run the clinics, but the overall medical control will always come back to us.

(GP 1/Family)

Protocol-driven work was therefore delegated to nurses, whilst GPs retained the more complex work that required decision-making capabilities. One GP stated, 'It's not the 90% of care that matters most in general practice, but rather the exceptional cases that occur 10% of the time that count' (GP4/Modern) and that it was GPs who were best placed to provide this type of care. We regularly observed nurses asking GPs for advice on difficult patients, but not the reverse, thus supporting the GPs' contentions to some extent.

Practice nurse perspectives on the boundary with GPs:

Many of the clinics for QOF-incentivised conditions are now being run by practice nurses, with GPs providing an increasingly supportive role. Many of the nurses enjoyed the opportunity that this afforded them to carve out their own personal niches and to specialise in particular disease areas:

I enjoy being given the autonomy to manage the different diseases and manage my caseload...Cos most patients with respiratory symptoms, at some stage, will get transferred to me or referred to me, and it's nice to

think that the doctors have got confidence in me for me to sort the patients out.

(Respiratory Nurse/Big)

Many nurses considered increased specialisation to be a positive effect of recent organisational changes, but that they still '[saw] the patient as a whole, not just one problem' (Nursing Team Leader/Modern). The protocol was described as only one aspect of their care and they retained a holistic overview of the whole person that GPs, in turn, were losing as their focus increasingly shifted towards delegating task-based chronic disease management work to nurses in order to achieve QOF points:

If someone comes in I will do a full check, I don't just look at the points, but I do feel that maybe the GPs are more 'It doesn't matter as long as you get their cholesterol' or whatever, whereas I don't feel that is the full check up.

(Nurse1/Family)

Nurses also claimed to achieve greater continuity of care for patients with incentivised conditions because they met with them regularly in their clinics and could offer longer appointments than GPs:

We're far better at [managing chronic disease] than the GPs because, well, in fairness we've got the time – twenty-minute, thirty-minute

appointments - so we can go over patient education and that sort of thing
and we can check whether they've had their blood test done.

(Respiratory Nurse/Big)

Whilst nursing work was perceived by many GPs as routine, protocol-driven 'dirty work' (Hughes 1958), for some nurses the 'dirty work' was the issue of 'QOF points' and 'money' and not doing 'the full check up' as a result. However, in other contexts, the achievement of QOF points was a reflection of nurses' holistic capabilities. One nurse in Modern Practice, for example, would often compare QOF points' achievement with the other nurses at break times and translated the achievement of points into the achievement of holistic care: by aiming for maximum points she was simultaneously doing what was best for her patients.

Practice nurse perspectives on the boundary with healthcare assistants:

The QOF has led to an increase in routine tasks such as taking blood samples and blood pressure readings. This work had previously been carried out mainly by nurses, but in many practices it had been handed down from nurses to the newly-appointed healthcare assistants because it was considered routine, task-based and straightforward enough for them to carry out with minimal supervision:

GP1 does the COPD with me and GP2 does the asthma with me, so
we're like a little mini-team within a big team, and then the healthcare
assistants will help with perhaps some of the menial tasks.

(Respiratory Nurse/Big)

Many nurses described themselves as specialists in chronic disease management who, like GPs, could deal with more complex problems that might arise with the healthcare assistants:

The healthcare assistants have their own hypertension clinics, which is great, because I'm here, if they've got a problem with anyone that's abnormal and I'll see them or advise them.

(CHD Nurse/Big)

Whilst the work of healthcare assistants was considered important within the changing landscape of general practice work, they were only considered capable of carrying out work that had been determined by the practice nurses under the overall direction of the GPs.

In summary, both GPs and practice nurses appear to have accommodated QOF-driven changes to clinical work by recreating well-worn professional boundaries and clinical hierarchies and exercising rhetorical strategies to create 'dual closure' (Witz 1992) between themselves and other professions. Strategies of 'upward usurpation' were employed by GPs talking about hospital specialists and nurses talking about GPs, with both claiming specialisation in particular areas of chronic disease care that was complemented by a 'holistic' approach to their work. However, GPs employed strategies

of ‘downward exclusion’ to nurses in order to counter these claims by describing nurses’ specialist knowledge as task-focused and mechanical. Such claims were made on the basis of ‘overall responsibility’ and greater technical knowledge, with protocol-driven work in chronic disease management being considered task-focussed and appropriate for delegation to nurses, and particular limited tasks for delegation from nurses to healthcare assistants.

Managing clinical hierarchies

The following is an extract from fieldnotes taken after a team meeting in Modern Practice which illustrates how the new managerial roles of practice team members interact with the professional boundaries described above:

The meeting this afternoon was chaired by the practice manager, who had prepared a PowerPoint presentation of the results of the QOF patient survey and customer complaints. Whilst the 3 GPs and 4 reception staff sat on chairs around the table in the centre of the room, the nurses sat on chairs around the periphery of the room...During the discussion on the patient survey, the practice manager stated that he had ‘precise information’ on which GPs had received good and bad comments from the ‘customers’ [the patients], but that he would discuss these comments with the GPs privately ‘so as not to embarrass anyone’. He then went on to discuss the patient comments for each of the nurses in

detail...Towards the end of the meeting he congratulated the practice on the recent increase in 'customers' from 8,000 to almost 9,000 in the past year. He explained that this was a reflection of the 'excellent customer service' that they provided, with the GPs and receptionists nodding in agreement. In the background, the nurses began laughing amongst themselves, with Nurse 1 breaking her silence by telling him that that was 'only because we have ended up getting dumped with all the patients that none of the other practices want'.

(Fieldnotes, Modern Practice, February 2006)

Despite the meeting being chaired by the practice manager, it was the lead GP who had the last word on what 'the practice line' was on many of the issues discussed. During the meeting, both the practice manager and the nurses deferred to the GPs, but in different ways. Part of the scope of the practice manager's role was to monitor the whole team's performance in the QOF. Whilst he was careful to ensure not to 'embarrass' any of the GPs, he did not appear to consider the 'naming and shaming' of the nurses as inappropriate, thus reinforcing the old clinical hierarchy. Similarly, despite their key roles within the internal QOF team, the nurses positioned themselves around the periphery of the room and remained relatively silent during the meeting compared with the GPs, which could be interpreted as both reflecting and reinforcing the old clinical hierarchy. After the meeting, the researcher had asked Nurse 1 how she felt the meeting had gone. The nurse replied that these meetings were 'all about points and targets' and that 'patients [were] more than just customers' as the practice manager had stated. This

lack of engagement in the managerial focus of the meeting offers an additional explanation for the nurses' general lack of verbal communication, with many of the practice manager's comments being met with rolled eyes and bemused expressions. Thus, whilst the QOF has created new managerial roles for clinical staff and new clinical responsibility for administrative staff that crosscuts old clinical hierarchies, this managerial authority appears to be more open to negotiation than clinical authority, with the former remaining sensitive to the latter.

Discussion

Prior to the 2004 GMS Contract, GPs had been relatively free from direct management and monitoring compared with other parts of the NHS (Harrison and Ahmad 2000), reflecting their status as independent contractors rather than NHS employees. During this period, Health Boards and PCTs relied on promoting quality improvement through the 'soft coercion' of appeals to shared professional values by local professional leaders (Flynn 2004; Sheaff et al. 2003, 2004). A key component of the new GMS 'strategy' was to significantly increase the contractual authority that Health Boards and PCTs exerted over general practice by extending the repertoire of financial and non-financial incentives available in order to change the way in which practices were internally organised. The protocol-driven care embodied in the QOF reflected existing policy aimed at developing the role of practice nurses (NHS Scotland 2004), whilst it has been argued that the delivery of the contract would require a level of management skill not hitherto seen in general practice, resulting in an overall enhancement of the status of managers at

practice-level (Checkland 2004; Department of Health/NHS Confederation 2003). The aim of this paper has been to investigate the impact of the QOF as a UK-wide ‘strategy’ by examining the everyday ‘tactics’ of practice (de Certeau 1984) performed within four UK practices.

Despite differences between the four practices in terms of patient demographics, practice size, dominant narrative and QOF performance, there are many commonalities to the ‘tactics’ used in response to the UK-wide QOF ‘strategy’. All four practices responded to QOF through the employment of new clinical and administrative staff to support the redistribution of work, the adoption of new IT systems, and the adjustment of clinical care where necessary to match QOF requirements. A significant recent change has been a concentration of authority that was also taking place within the practices, with QOF decision-making and monitoring being led by an internal team of clinical and administrative staff who made the major practice-level decisions about QOF, monitored progress against targets, and intervened to resolve areas or indicators at risk of missing targets. This constitutes a new form of internal regulation, with key clinical staff developing increased managerial responsibility over their clinical colleagues and key administrative staff developing increased responsibility for the clinical domains of the QOF (cf. Nancarrow and Borthwick 2005).

Ferlie et al. (1996:166) write that New Public Management cannot be understood as a ‘unidimensional shift of power from professionals and managers’ since it is more context-specific than this. Kitchener (2000) paints a similarly nuanced picture of the

changes taking place in general practice, with ‘winners’ and ‘losers’ being located *within* rather than *between* professions. Thus, whilst clinicians may have been ‘powerless to resist’ (Cohen and Musson 2000) the QOF, some appear to have embraced managerialism more than others. In Medium Practice, for example, the lead GP was working with nurses and IT staff and cutting GPs and the practice manager out of the loop, whilst in Modern Practice the GPs were subject to control from a new management team within which a new business-focused practice manager played a key role. New networks and relations of managerial power were therefore being established over their clinical and administrative colleagues. However, the adoption of leadership roles by clinical and administrative staff within these internal QOF teams was not a source of contention for staff who were not involved in these teams, who described this work as yet another expression of the ever-increasing ‘bureaucratization’ (Murphy 1990:73) that was taking place in general practice, with QOF accelerating existing trends. Despite these recent changes to the internal organisation of practice teams, clinical staff continued to describe the impact of the QOF in relation to the more established clinical hierarchies and it to these that we now turn.

A significant change that has taken place since the start of the QOF has been a shift in the decision-making dynamics for particular aspects of chronic disease management, with clinical work increasingly defined on the basis of complexity and ‘expert knowledge’. This reflects the findings of Charles-Jones *et al.* (2003), who write that increased ‘active management’ in UK general practice has resulted in GPs creating ‘hierarchies of appropriateness’ in relation to work and patients based on clinical discretion. Through

the adoption of Witz's 'dual closure' approach to professional boundaries, our study has shown that the 'specialist' role has increasingly formed part of practice nurses' discourse on recent changes, with specialisation in chronic disease management forming an integral aspect of their 'upward usurpation' (Witz 1992) strategies in relation to GPs.

The second point made by Charles-Jones *et al.* (2003) is that recent managerial reforms have resulted in the creation of new 'hybrid' tasks that do not require specialised knowledge and so can be carried out by anyone. Our study has revealed a concomitant increase in routine, protocol-driven work since the start of the QOF, with a parallel increase in the number of boundaries between nursing staff. Most of this 'hybrid' work had been devolved to nurses and healthcare assistants through strategies of 'downward exclusion' (Witz 1992) based on 'appropriateness' to carry out the task. However, rather than a new segmented hierarchy being created through the reduction of nursing work to a series of tasks justified by a discourse of 'holistic care' (Charles-Jones *et al.* 2003:71), we found that 'holistic care' formed an integral aspect of professionals' 'upward usurpation' strategies as they justified a continuing generalist approach that sat alongside the increased specialisation and complexity of their roles.

A focus on 'normative meta-concepts' (de Certeau 1984) could have led us to conclude that practices have responded to the QOF in ways that the policy-makers and had intended as all four practices have incorporated the managerial imperatives of the QOF into their existing systems and are more open to external audit than ever before. Such a focus could also have led us to conclude that whilst the QOF has shifted certain areas of

general practice work from GPs to practice nurses, existing clinical hierarchies within practice teams have remained largely intact. However, focusing on the everyday ‘tactics’ of practice has led to a more nuanced understanding of recent changes, with the maintenance of traditional boundaries being an integral aspect of the ‘tactics’ of change for certain practice team members, with the key to successfully implementing significant change being appearing not to upset the old order too much. For example, in Big Practice, the nurses did not challenge the GPs directly, but instead would ‘nag’ the more amiable GPs and complain to them about the GPs who they did not consider to be ‘pulling their weight’. Thus, although the old order appeared to be maintained on the surface, in everyday practice GPs who were less involved in the QOF were being subject to greater monitoring and control from other GPs, were frequently bypassed in decision-making processes related to QOF (as in Medium and Family Practices) and had delegated a great deal of responsibility to the new management team (as in Big and Modern Practices).

The four practices in this study illustrate the complexity of recent changes taking place in UK general practice through the financial incentives embedded in the QOF. The most significant change is the way in which practices have created internal QOF teams that cut across traditional clinical and administrative hierarchies and boundaries. These were not as clearly contested by participants as the changes that were taking place at the more established clinical boundaries, which were readily accounted for by participants using existing rhetorical strategies. However, the creation of new managerial roles through the QOF has reinforced and significantly extended an existing trend towards

'bureaucratization' and professional restratification (Freidson 1985) within general practice, with QOF teams drawn from many disciplines assuming responsibility for decision making and monitoring of externally defined 'quality', and therefore of a significant part of clinical work. Whether this change is permanent or will eventually become absorbed into existing clinical hierarchies dominated by doctors will only become clear with time, although the increasing complexity and scope of QOF makes it more likely that this new internal stratification within practices becomes established.

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