Investigating the impacts of the Quality and Outcomes Framework and the General Practice Patient Survey on staff and patient experiences in English general practice

To what extent do contemporary theories about audit culture explain how QOF is manifest in practice?

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Investigating the impacts of the Quality and Outcomes Framework and the General Practice Patient Survey on staff and patient experiences in English general practice. To what extent do contemporary theories about audit culture explain how QOF is manifest in practice?

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Abstract

The aim of this thesis is to investigate the impacts of performance metric tools (the Quality and Outcomes Framework and the General Practice Patient Survey) on staff and patients in English general practice.

The literature would benefit from more studies adopting a whole-practice approach to understanding how staff and patients have delivered, understood, and received the two tools. The thesis asks what might we understand better from taking an anthropological inspired approach to data collection – one that seeks to include all voices within the practice team? What do voices that are not frequently heard on this topic, add to our understanding of the impacts of the QOF and the GPPS? Using a case study approach, designed to give a snapshot of English general practice, the thesis shows that staff experiences of the two tools differ for several reasons and these differences influence how they are implemented in practice. The thesis also shows that patients remain largely unaware of these tools despite their being heralded as facilitating patient choice when introduced.

Dedication

For my children Max and Lucia; my husband, Matthew and our beautiful Laika. To my mum, Nicole, and my brother, Sefton. What a wonderful bunch of people you all are x

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Chapter 1: Introduction – Chapter Aims

This chapter seeks to introduce the aims of the thesis to the reader and give an overview of each chapter and what each one will address. It will introduce the research question and how it was developed and researched. The contributions the research makes to the field and the main findings to emerge from the research are addressed.

The thesis aims to understand how external regulations in the form of the Quality and Outcomes Framework (QOF) and the General Practice Patient Survey (GPPS) which were introduced to general practice in the UK in 2004 and 2006 respectively, impacted on staff and patient experiences in English general practice. A secondary question seeks to understand if and how the QOF and the GPPS have embedded themselves into the everyday practice of staff in English general practice.

The QOF is the largest performance incentive payment scheme in general practice in the world. The GPPS is the biggest patient satisfaction survey in operation. They employ different methodologies and reporting mechanisms. This thesis seeks to understand how they have impacted on patient and staff experiences in English general practice and if and how they have embedded themselves into English general practice.

The QOF is an example of GP practices having the means to exercise direct control over their results. Throughout the financial year, practices will be aware of their performance in relation to the QOF and if they are on target to achieve their QOF points. If their performance slips during the year, they will be aware of it (if they have chosen to monitor it) and will be able to adapt their practice, if they so wish. The GPPS is an example of a performance tool over which practice staff feel they do not have any control. Practice staff will not be aware of their performance on it during the year and are informed of their results by NHS England. These differences are important in understanding how practices and their staff respond to and deliver the two tools. It also helps our understanding of staff attitudes towards them.

1.1 General practice

While much media attention is awarded to secondary care in the form of long-running hospital dramas set in A&E departments, it is general practice where most people access and experience the NHS. Pollock writes that,

> "It can be argued that the provision of 24-hour general medical services for the entire population was the NHS's single greatest achievement. Whereas before 1948 you could get basic medical attention only if you were an insured working man, or had enough income to pay a doctor's fee, under the NHS every family became entitled to basic medical attention as of right" (2005).

Occupying a privileged position of being the only place in the medical profession where patients and doctors meet alone, general practice offers a rich ground for research. It is in this arena, that I have chosen to site my study.

1.1.1 The Quality and Outcomes Framework (QOF)

The Quality and Outcomes Framework (QOF) was introduced in 2004 into English general practice. It is a performance incentive tool, which offers practices a quantity of points in return for meeting set targets across certain long-term conditions. For example, if practices created a disease register comprising those patients registered with the practice who were deemed to be at risk of developing Type 2 diabetes, the practice would receive a pre-agreed number of QOF points. Each point has a monetary value and at fiscal year-end, practices are awarded a payment reflecting the number of QOF points achieved. The policy aims, intentions and unintended consequences of the QOF are discussed later in the thesis.

1.1.2 The General Practice Patient Survey (GPPS)

The General Practice Patient Survey (GPPS) was introduced in 2006 in England. It is a postal questionnaire sent to 2% of registered general practice patients in England. Since 2011, the survey has been sent to patients twice per year. Prior to this, it was sent out on a quarterly basis (April 2009 – March 2011) and on an annual basis Jan 2007- March 2009. Ipsos-MORI conducts the survey on behalf of the Department of Health and Social Care and since 2013, to reflect reformed NHS organisational structures the publication of the survey results has been coordinated by NHS England.

The questionnaire asks about when patients last saw a GP or nurse at their practice, how easy or difficult it is to make an appointment at their surgery, waiting times, satisfaction with opening hours, the quality of care received from their GP and practice nurses, out-of-hours care, and NHS dentistry; as well as their current health circumstances (Ipsos-MORI, 2013).

At the time that fieldwork was conducted Question 28 of the GPPS was worded as below and was included in the Overall Experience section:

Overall, how would you describe your experience of your GP surgery?

- Very good
- Fairly good
- Neither good nor poor
- Fairly poor
- Very poor

This research project investigates how patient and staff experiences at four case study sites in England were impacted by these two performance management tools. The research interviews followed a loosely structured topic guide but remained open to staff and patients sharing their whole experience with the interviewer. Participants were encouraged to think widely and deeply about their working lives at the practice and as patients receiving care. Staff offered insights that drew upon their dual status as staff at the case-study site as well as being a patient at their own practice, as parents and/or as carers for others. These reflections illustrate the many roles' participants fulfil in their daily lives.

The thesis makes its contributions to the field of understanding organisational change and how it impacts on staff and patient experiences in general practice through the application of anthropological principles in the sampling methods it employs. One finding from the literature review was that frequently the main voice heard in discussions about the impacts of QOF on general practice, was that of the senior management team in the practice. Sometimes, this included the nurse practitioner and practice manager's voices, but voices from other staff roles in the practice were not heard in the literature to the same extent. With a few exceptions, non-clinician members of the team did not regularly have their opinions sought out in relation to how QOF had impacted their practice or delivery of quality in patient care. Papers which sampled the views and experiences of a wider range of clinician and administrative staff included work on investigating the impacts of QOF on nurses (Grant et al, 2008) and on practice organization (Checkland et al 2010).

In recognition of the emphasis on inclusivity and holistic research principles of anthropological enquiry, I purposively sought out their views. While QOF is often portrayed as a tool that affects GPs, non-clinician team members play a large role in its administration, ensuring targets are met and that GPs can 'perform' and deliver it.

Findings from my fieldwork were made possible by the inclusivity of sampling among practice staff at the case study sites. An inclusive sampling methodology revealed a nuanced picture and the many subtle impacts of QOF (and less so, the GPPS) on practice staff. This affected how they approached and performed their work and understood their role and placement within the practice team. The thesis makes contributions towards a better understanding of organisational responses to external regulation as well as how individuals and staff adapt and re-shape their roles in response. It offers a new way of understanding the deep structural changes that QOF and the GPPS have made in modern general practice and seeks to reflect the diversity of staff experiences. Concepts of performative accountability, diffused state control and creeping regulation that often follow implementation of new public management ideals are addressed in this thesis.

The two tools (the QOF and the GPPS) have been addressed abundantly in the literature. The QOF has been examined in terms of its construction (Doran et al., 2014; Gillam & Siriwardena, 2011; McCartney, 2016) financial incentives (Jeffries., 2009; Kramer, 2012a; Roland, 2013; Tanday, 2009) and impact on quality standards (de Wet et al., 2012; Gillam et al., n.d.) amongst other things. The literature encompasses its introduction in 2004 and continues to the present day.

The GPPS received attention in the literature upon its introduction in 2006. Once introduced the uses of its data have changed, with its most recently being incorporated into the Clinical Quality Commission's Intelligent Monitoring data criteria in 2014 (Blake et al., 2015; CQC, 2013).

The literature on QOF and the GPPS and their impacts on staff and patient experience in English general practice would benefit from an increased focus on studies using a whole practice approach to investigating the effects of the tools on general practice in the UK. Current research into QOF has mainly sought the views of clinician staff and not concentrated to the same degree on how QOF is experienced by patients, with some exceptions (Stokoe et al., 2016). Research on

the GPPS has mainly concentrated on the mechanisms of how its ratings correspond to other quality measures as well as how it relates to patient satisfaction and experience. There has been some research employing an ethnographic perspective in seeking to answer questions such as how the QOF and the GPPS impact not just on quality and performance ratings, but on how the two tools alter the culture of an organization and impact on inter-professional relations within the practice team (Checkland et al., 2008; McDonald, Checkland, & Harrison, 2009; Nelson et al., 2018). This thesis seeks to contribute to this stream of literature.

The thesis sought to place the tools in their political theory and policy context. The research located the introduction of QOF and the GPPS within the context of new public management theory (Hood, 1991, 1995; Bach, 2011). NPM has been gaining policy ground in the UK since the early 1980s, introduced under the Thatcher and Major administrations and the thesis interprets both tools as NPM-inspired. Findings from the thesis demonstrate that general practice staff respond to QOF and the GPPS in ways we had not fully understood previously. Nuances in organisational and staff behaviour and cultural shift were revealed through the application of anthropological principles of investigation to the collection of fieldwork data.

The thesis adopts a social constructionist approach to the research data and topic (Berard, 2006; Burr, 2015). Its aim was not to discover one 'truth' about how QOF and the GPPS have affected those who work in English general practice. It sought to capture a plurality of views. Such pluralism undoubtedly produced messy and untidy results. Some views contradicted others which had been expressed during fieldwork interviews. It was not the aim of this thesis to present a tidy picture of the topic – it was the aim of the thesis to capture the topic's nuances and to try to give a voice to all the views revealed by the investigation, presented through a snapshot of English general practice at the time of data collection. The aim was to gather these voices, interpret them using the theoretical lens chosen for the project and after discussion and consideration arrive at a clearer picture of how QOF and GPPS have influenced modern general practice in the UK.

The thesis took as its theoretical starting point Shore and Wright's 2015 paper which created an analytical framework identifying the five effects of audit culture: domaining; classificatory; perverse; individualising and totalizing and governance

(2015). My research aimed to explore whether these five findings were also present in the context of English general practice and the QOF and the GPPS. The thesis considered if the five effects identified by Shore & Wright were applicable only to the field that their 2015 paper investigated (the macro-economic context of the Big Five accountancy firms) or if they might also apply to the context of English general practice. When (or if) differences were found between their findings and mine, they were explored with an attempt made to understand them.

I anticipated that the five effects of audit identified by Shore and Wright (2015) would be found in the context of my fieldwork and that my research would identify further effects which might be specific to the context of English general practice. I used the Shore & Wright paper as a theoretical starting point and expected it to take my understanding of the topic some of the way in interpreting my data. I anticipated that the use of ethnographic sampling methods would produce research findings which would demand explanations requiring analysis that reached beyond that of Shore & Wright's Analytical Framework.

1.2 Concepts and Variables

There were several concepts that might have been addressed by this thesis. To retain focus on the research question, the thesis addressed concepts in the following fields of study.

In the sociology of professions, the thesis discussed how the GP profession operates within the wider medical profession and how it sought to exercise power and influence in the policy sphere.

The thesis is informed by Freidson's body of work which focused on the professional role of medical doctors(1970). My thesis considered the role of doctors in relation to the QOF and the GPPS but also considered how the two tools have impacted on the nursing and administrative workforce in English general practice. Using Friedson's work on doctors in the medical profession, the thesis considered how the QOF and the GPPS might have impacted on attempts by nursing and administrative bodies to professionalise.

A snapshot of English general practice between the years of 2015/16 was sought because the thesis aimed to understand the impacts of the QOF and the GPPS on practice staff and patients in a given time period. This approach was inspired by

Bloch's approach to his ethnography on circumcision rituals among the Merina of Madagascar. Bloch wrote that taking this approach afforded the ethnographer or researcher certain benefits,

> "It does not pretend…to account for the phenomenon totally. It is therefore, both a theoretical book, in that it proposes general conclusions, and also a book about specific events in specific places at specific times. This hybrid nature has been characteristic of anthropology since the time of Malinowski and Radcliffe-Brown and has, I believe, been one of its strengths, enabling it to avoid the empty platitudes 'pure' theory often means and the pointless particularity of some recent studies.' (Bloch, 1986, p. 2)

In relation to this thesis, Bloch's words are relevant in that my research simply aims to present a picture of how QOF and the GPPS operated at the time of fieldwork (2015-17). Implementation and performance of policy and regulations is an ongoing process, and this thesis does not seek to present a 'final' picture of how the two tools operate in English general practice. Instead, it seeks to invite further investigation in the full recognition that this is an ever-changing field, one with which academic research needs to keep up.

Within the field of political theory, the thesis focused on the new public management literature. Concepts such as the role of the state in new public management theory as well as the political 'reach' of the state through the employment of concepts such as 'accountability' and 'transparency' are examined in relation to the research question.

Within the field of policy implementation, the thesis examined concepts such as Lipsky's street-level bureaucracy (1969) and Bourdieu's low-level bureaucrats through an investigation of power within the implementation cycle. The thesis drew on anthropological literature and examined concepts of audit culture and performative accountability (Strathern 1997, 2000a, 2000b) in relation to the QOF and GPPS in English general practice.

The thesis seeks to understand how patients have experienced the QOF and the GPPS. Central to this topic is the concept of how patients understand the concept of *choice* and if they feel the two tools have increased their patient choice. The thesis draws on the literature on patient choice, particularly in relation to general practice.

The thesis also investigates the concept of patient satisfaction and its relationship to patient choice. The thesis argues that the concept of patient satisfaction is ill defined and thus poses challenges to implementation and delivery.

Finally, the thesis drew on the field of economics to examine the historical development of the concept of 'audit' from its emergence in the Middle Ages to its near total dominance as a form of accountability and exertion of power in the modern state.

The thesis is guided through these concepts by using the theoretical lens provided by Shore & Wrights Analytical Framework outlined in their 2015 paper. Using the Analytical Framework of Shore & Wright, enables the thesis to address the concepts from the varied fields in ways that allows analysis to pick out the aspects relevant to the thesis and analysis of the fieldwork data.

1.3 Methodology

The study design identified four case study general practice sites. The sites were selected using polar type sampling (Eisenhardt, 1989).

The practices were chosen to represent a mix of those which had achieved high performance on quality ratings (measured by the overall QOF score) and high performance on patient satisfaction (measured by Q28 on GPPS, outlined above), as well as a balance of rural and city locations.

One-to-one in-depth qualitative interviews were conducted with practice staff to which all staff were invited. Patient interviews were conducted on a one-to-one basis and patients were recruited through the practice-based Patient Participation Group which operated at each case study site. I was introduced to the Patient Participation Group through the practice manager. I was mindful that such an introduction might encourage patients to view me as 'working' for the practice. I was careful to reiterate to all patients and staff interviewees that anything we spoke about in the interviews was completely confidential and would not be passed back to the practice manager or other staff members.

1.4 Main Findings

The main findings from the thesis encompass theoretical, empirical, and methodological contributions. Theoretical findings involved a reappraisal of the

current literature on professions arguing that if it is to be of use in understanding modern general practice, the literature must adapt to reflect the modern world of life in English general practice and be able to reflect the impacts of regulatory demands on all practice staff. The thesis makes a theoretical contribution by arguing that if we extend the concept of Shore and Wright's *perverse* consequences of audit culture to one of *unintended* consequences, their theory becomes more useful to an analysis of how the introduction of QOF and the GPPS has affected English general practice.

The thesis makes some empirical contributions, notably the finding that the impacts of external regulation on UK general practice are not experienced homogenously amongst staff members in a practice. This finding resonates with and confirms, previous literature (Heath et al, 2008; McDonald et al, 2007) which revealed stratification within practice teams after QOF was introduced. Factors such as role and employment contract impacted on how QOF and GPPS were interpreted and performed by staff who in turn, delivered them to patients. The thesis makes a methodological contribution which argues for a holistic approach to research that seeks to understand how a policy or topic impacts those tasked with its implementation; those tasked with its delivery and those who receive it. The thesis argues that employing an inclusive approach to sampling, results in a fuller understanding of how the tools/policy under investigation work in practice.

1.5 Layout of the thesis

This first chapter introduces the main concepts used in the investigation and the research question. It is followed by chapter 2, which examines the policy context that led to the development of the Quality and Outcomes Framework and the General Practice Patient Survey. This chapter locates their development within the lineage of new public management theory and its roots in UK public policy since the late 1980s.

Chapter 3 explores the literature in this field and its analysis. This chapter will introduce the literature reviewed and discuss the methods used for searching, including the identification of key terms and databases to search. Gaps in the literature will be identified and considered in relation to the research question.

The thesis moves on to chapter 4, Theory. This chapter discusses the theories used in the thesis. The discussion will explain the selection of theories that have been drawn upon in the thesis as well as the advantages and disadvantages that each

one brings. The chapter includes analysis of those theories that were not used in the thesis, along with the reasons why they were not selected.

Chapter 5 is the chapter that discusses the Methods used in the research. This chapter will outline the methodology chosen to conduct the research. The chapter will discuss methods that might have been used during the investigation and will explain why some were selected and others not.

Chapter 6 presents empirical findings from the fieldwork, drawing upon interviews with staff and patients. This chapter groups together findings that talk about negative experiences of the two tools and how they impacted on people's experiences, both as staff and patients.

Chapter 7 is the second empirical chapter and presents a contrasting view of the impact that the QOF and the GPPS have had on staff and patients. This chapter focuses on findings from the fieldwork, identified by participants, as enhancing their experience of work, and contributing positively towards the team morale. These findings draw mainly on interviews with staff. Patient interviewees rarely spoke about positive experiences at their practice.

Chapter 8 is the Discussion chapter. In this chapter findings from the research will be discussed in relation to the literature. The Discussion chapter will consider the contributions made by this research project to the field.

Chapter 9 is the Concluding chapter. This chapter will ensure that the thesis has attempted to answer all the identified gaps that emerged from the literature review. It will consider any limitations the project faced and how they were overcome. It also considers how these impacted on the research findings. The chapter will consider further research opportunities.

The next section of this chapter outlines what each chapter seeks to address in further detail.

Chapter 2 examines the policy context that led to the development of the QOF and the GPPS. This locates the QOF and the GPPS in the policy context that produced them. The findings cover the emergence of new public management theory in the UK dating back to the mid 1980s and how it ushered in cultural changes to public services. The chapter highlights how these changes impacted specifically on general

practice in the UK and prepared the ground for initiatives such as QOF and the GPPS in the early 2000s. The chapter draws a policy line linking performance related programmes such as QOF back to the mid 1980s and the Thatcher and Major administrations. The chapter demonstrates how subsequent administrations have continued this link regardless of their political affiliations.

Chapter 3 conducts a review of the literature. The chapter will give a broad introduction to key papers explaining their significance to the research question. The selection criteria used to include and exclude papers and research will be justified. The thesis utilised several types of literature which is explained in the chapter. The chapter will seek to identify gaps in the literature and will explain how such gaps contributed to the development and formation of the research question.

Chapter 4 is the Theory chapter. It works with the identified gaps in the literature and the research question to begin thinking about which theoretical perspectives will be most useful when approaching the data and literature. There are several theoretical perspectives that might be employed to address the research question and each of these will be addressed in this chapter. Each potential theoretical lens will produce different interpretations of the data in relation to the research question. This chapter aims to identify and select the theoretical approach that will be most appropriate to the research question.

Chapter 5 is the Methods chapter. It explains the methods selected to conduct this study. It begins with the research question and the theoretical lens and explains how the most appropriate methods to answer the question were chosen. The chapter will explore the many methods that might have been used to address the question and will explain why some were selected and others were not. It will address sampling decisions and the identification and selection of case study practices. Each decision will be examined in terms of its contribution towards answering the research question.

Chapter 6 is the first of two chapters presenting empirical findings from the fieldwork research. These findings came from observations and one to one interviews with practice staff and patients. The chapter loosely groups findings together that focus on the negative impacts that the QOF and the GPPS have had on staff and patient

experiences. The findings are complex and nuanced and the chapter presents them in full.

Chapter 7 is the second empirical chapter of the thesis and concentrates on a group of findings that demonstrate how QOF has impacted positively on staff experiences. This chapter draws upon interviews with staff more than patients. Within the fieldwork interviews patients rarely spoke about positive patient experiences at their practice.

Chapter 8 discusses the findings described in the previous two chapters and considers how they speak to the research question, the literature, and the theory. The chapter will draw together the findings, theory, methods, and literature to consider the contributions the thesis makes to the field.

Chapter 9 concludes the thesis. The chapter will reflect on the original aims of the research and will consider the contributions each chapter made towards answering the research question. It will discuss any limitations the research project encountered and how these were negotiated. The chapter will consider the impact on the study these negotiations and shifts might have had and how these may have influenced the study's findings. The chapter concludes with looking ahead to further research and how findings from this study might support further research in this cross-disciplinary field of investigation.

Chapter 2: Policy Analysis Review

2.1 Introduction and aim of chapter

This chapter outlines the results of a scoping policy analysis review of the grey and policy literature conducted to delve deeper into the policy context that led to the development of the QOF and the GPPS. The identification of the need for this chapter arose when it became clear that analysis of the policy landscape preceding the introduction of the two tools might be helpful. The chapter suggests that both tools (the QOF and the GPPS) should be viewed as the culminations of policy trends that date back to the Thatcher government in the mid-1980s which were continued by subsequent government administrations (Mohan, 2009).

2.2 Structure of the chapter

This chapter focuses on the new public management theory that became established in England under the Thatcher and later the Major administrations. The chapter examines how the concept of the 'engaged patient' is central to the success of the new public management model. The 'engagement' of the patient with concepts such as 'choice' and the 'market' as well as with their own health are discussed. The chapter locates the policy origins of both the QOF and the GPPS firmly within the new public management tradition. The GPPS is identified as core to the new public management project and the chapter argues that its role has been central to the shift in the concept of patient to one of healthcare consumer. The GPPS is examined at length from this perspective. QOF is discussed in its role in the new public management project and how it relates to the GPPS seen from this angle.

This chapter focuses on the origins of introducing (or forcing) accountability onto organisations and professions and will argue that these roots can be traced back to the mid-1980s government administrations, in England. Chapters 6 and 7 will investigate the impacts on staff of institutionalising the principle of accountability as integral to the concept of good governance. The chapter deals with concepts in turn, and as such does not follow a chronological order.

2.3 Shore & Wright's Effects of Audit culture

Shore & Wright's (2015) paper identified five effects of what they termed audit culture. The five effects are domaining, classificatory, totalizing and individualizing, governance and perverse. These are explained in detail in chapter 4, the Theory

chapter. This chapter will argue that two of the five effects in particular – classificatory and governance – are relevant to a better understanding of the policy context that produced QOF and the GPPS.

The classificatory effects of audit culture recognises that statistics and classificatory systems are never neutral or value-free. Shore & Wright argue that to impose accountability and performance measures on professions and public services, categories of data must be available to make measurements and/or ranking, possible. If it does not exist, it must be created. The process of knowledge creation is a political act and the resulting targets and measurements, represent the values of the government of the day, or to borrow Alford's terminology, the values of the dominant structural interests (1975) and should never be considered as value free.

Shore & Wright's concept of governance effects invite us to consider how audit culture forces organisations/professions to open themselves up to public scrutiny and accountability. Once the principle of 'giving account' of oneself has been established, it must then be adopted as a principle of good governance. In this chapter I will employ the category of governance (as identified by Shore & Wright) to better understand the effects that QOF and GPPS have had on the profession of general practice. Shore & Wright suggest that while the project of making organisations and professionals more accountable to the state and the public is portrayed as a positive development, there is a coercive dynamic in such a move.

2.4 The policy context that delivered performance measures and targets to English general practice, 1980s-2000s

New public management (hereafter NPM) methods of managing public services began to be adopted by some governments from the late 1980s onwards. Britain, under a Thatcher government was particularly enthusiastic and was seen as an early adopter of the novel approach to managing public services (Hyndman & Lapsley, 2016). While some have noted the difficulty in pinning down a definition of NPM techniques, there is broad agreement that the key principles of NPM methods can be understood as follows:

> "devolved management, the application of commercial management techniques, emphasis on outcomes, targets, performance measurement, shorter hierarchies with strong line management control, increased service-

> user involvement and perhaps most significantly for professionals, a proliferation and strengthening of quality auditing, through organisations relevant to their profession", (Taylor & Kelly, 2006, p. 600)

Strathern notes that the adoption of NPM techniques in countries which spanned different continents was not a coincidence:

> "New forms of managerial government have not sprung unaided from the local cultures of any of these countries. They are the outcome of policy measures on the part of specific governments reinforced by a corporate community which gives them international credibility. For these outcomes have involved the deliberate promotion of key concepts and thus, as a matter of policy, deliberate attempts to modify people's cultural outlooks", (Strathern, 2000d, p. 288)

2.41 The end of consensus management - The Griffiths Report (1983)

The Griffiths Report ushered in the end of consensus management, whereby multiple actors had to reach agreement before a decision could be passed (Read, 2014). The report saw the end of NHS administrators who were replaced by a full time NHS Management Board.

There had been previous attempts to introduce financial incentives for improvements in quality into general practice, one of which was called the Good Practice Allowance. It was rejected by the medical profession in the mid-1980s and was never implemented. The BMA published a report of the meeting in 1986. It states that:

> 'the conference said 'No' to a Good Practice Allowance… Dr (Michael) Wilson told the conference that the (Good Practice Allowance) was political and provocative, prepared by a policy unit whose main contact seemed to have been with philosophers, privateers, and trendy professors' ("Report on the 1986 Conference of Local Medical Committees," 1986).

Roland argued that at the time, there was reluctance to accept that widespread variation existed within general practice (2004, p. 1448).

Following the rejection of the Good Practice Allowance in the 1980s, there followed attempts to introduce limited versions of performance related pay in the 1990 Act.

These included payments for GPs who reached high coverage of patients receiving immunization or being offered screening with regular cervical smears. While they were not popular within the profession, these two incentives resulted in higher levels of immunisation and smear tests. They also resulted in higher equity in the provision of these services at a national level (Middleton & Baker, 2003).

One of the reasons the profession rejected the Good Practice Allowance was because it did not agree that quality could be measured. Roland wrote that there was a high level of 'professional protectionism which took the form of denying the existence of poor practice' (Roland, 2004). Roland credits the professions' turnaround in attitude towards accepting the existence of poor practice and variations in quality of care, with the growing body of evidence-based policy that occurred in the 1990s in the UK and the US (Seddon et al., 2001). Consequently, during the 1990s, there emerged evidence of variations in quality within primary care at the same time that it became possible to define and therefore measure some aspects of quality (Howie, 1997).

2.4.2 The emergence of the engaged patient and the concept of patient choice

The engaged patient is crucial to the narrative of any service following NPM principles. It revolves around the concept of the engaged patient who can fully exercise informed choice, a mechanism which allows the state to perform a purely regulatory role. Its roots can be traced back to The Citizens Charter (HMSO, 1991) and the Patients Charter (The Patient's Charter: Raising the Standard, 1991) introduced by the Major government.

> "The Patients Charter was published by the British Conservative government in 1991 as a way of putting the Citizen's Charter initiative into practice in the National Health Service (Department of Health 1991). It outlined seven existing rights and three new rights to be introduced from 1 April 1992. Details were also given of nine national charter standards. These national rights and standards referred to general rights, such as access to care and explanations of proposed treatment, and to specific rights such as the right to be registered with a general practitioner (GP) and maximum waiting times for ambulances", (Britten & Shaw, 1994).

The authors point out that despite being a document focussing on what the patient wants – not one patient was consulted in its development.

> "Although the document concluded with a statement of 'what a patient wants of an A and E department', patients' views were totally absent", the authors went on to warn that, "For the rights and standards to be meaningful to patients, they should correspond to patients' priorities", (Britten & Shaw, 1994)

Writing in his autobiography, John Major reflected on his thinking on what became the Citizens Charter (HMSO, 1991).

> "We had to end the excessive focus on financial inputs rather than service output. I knew that if I could achieve this it would be a huge gain – for taxpayers and service users alike... As part of the information revolution, we decided that standards for every service should be published, both as a benchmark for improvement and to show the public what they could expect. So too, and in clear, comprehensive detail, should results. I wanted to see reports on performance placed in public libraries and newspapers. These would show, on a range of key measurements, how local services were doing. Relative success would be a source of pride. I intended also to provide incentives for good performance, through more performance related pay. Relative weakness would be a point of pressure on failing management to upgrade standards. Ideally, there should be financial sanctions for service failure. What is more, I wanted improved complaints procedures and to ensure that members of the public got redress, and explanation, an apology or even compensation when things went wrong", (Major, 1999, p. 251).

While Major refers to the Citizen's Charter in the above extract, it is plain to see how it contained the principles of NPM methods, described earlier in this chapter. The Citizen's Charter begot the Patient's Charter, from which came the concept of league tables. Mullen wrote that,

> "The acceleration of the use of League tables - openly published comparative data for public services - was very much part of the Citizen's Charter. Major did not invent these, but he increased the use of them and made them more well-known", (Mullen, 2006).

At the time of its introduction, the right-leaning think tank, The Adam Smith Institute, published a report which stated that,

> "The Charter revolutionizes the relationship between the citizen and the state by turning it into one of explicit and enforceable contract", (Madsen, 1992, p. 61)

Madsen continues to express hope that the charter will be a beacon for the world,

> "a Citizen's Charter for public services could well become the normal means by which most countries seek to control an overgrown and unresponsive public sector" (1992, p. 10).

Mullen comments that in the early 1990s, the Charter allowed the Major government,

> "to develop the ideas of neo-liberalism in particular in connection with those parts of public service which could not in the immediate future be privatized, due to practical difficulties and political opposition".

He argued that the concept of a Charter (be it for Citizens or Patients) allowed the government to show publicly a certain responsiveness to fears about deteriorating public services. It strongly suggested that,

> "if services were unsatisfactory, the government were doing something about it, and that the fault lay not with the government but with the non-customer orientations of public service workers, a culture defended by trade unions, left wingers and other usual suspects" (Mullen, 2006).

The neo-liberal ideology of the Charter was adopted by the subsequent Labour administrations under Blair and Brown. Major, writing in his 1999 autobiography, expressed his pride that elements of his charter initiative had been adopted by New Labour. Writing about league tables in his autobiography he wrote,

> "Few would now question" that "standards should be publicly set and measured", while "before 1991, such a system was considered unthinkable" (1999, p. 261)

2.4.2 The concept of Choice

Aligned closely to the concept of the engaged patient was the concept of patient choice. For a patient to be *engaged* required the consumption of data – in Major's

scenario these were provided through the publication of data sets outlining the performance of general practices against measures such as waiting times for an appointment or staff: patient ratio. The *engaged* patient would consume such data sets and would use them to make an informed choice about which practice they wished to be register with. Central to this model were several assumptions:

- That patients were aware of such data sets
- That the data sets measured and recorded the things that were important to patients
- That they knew how to access them; that they knew how to understand them and interpret them relative to their lives
- That patients would act on the data
- That patients had the means and the facilities in their local area to do so

This final assumption is key to the patient choice model and depends upon a surplus of supply of general practices in an area to enable choice for patients wishing to change registration with a general practice.

The market model definition of the concept of choice and its enactment, depends upon the provision of surplus of supply. This in turn, enables a *choice* to be made as consumers decide which product suits them best. The concept of choice when applied to health care stumbles when it reaches the factor of the provision of surplus in the market. Without surplus in the system, the concept of choice cannot exist or be exercised (Ferlie, 2010; Stevens, 2011).

2.4.3 The internal market

One of the main concepts behind the introduction of the internal market in 1990 was that money or funding would follow the patient. Hence, good hospitals, measured by the new performance indicators (and later good general practice's measured by QOF) would be rewarded through the mechanism of patient choice. Some have suggested that it was never made clear what would happen to those hospitals or practices that were not rewarded via the mechanism of patient choice. Arrow wrote in 1963 that,

> "a competitive healthcare market is grounded in the expectation that some hospitals or surgeries will go bust" (Arrow, 1963).

In practice, no hospital did go bust as a result of patients exercising their choice. This might be interpreted as signalling an indication that governments realized it was too costly to allow hospitals to fail and that there was not enough supply to meet demand. By 2012, Andrew Lansley, the then Secretary of State for Health announced,

> "In October, Health Secretary Andrew Lansley announced that the Department of Health would provide ongoing support to a small number of NHS Trusts with historic Private Finance Initiative (PFI) arrangements that were unable to demonstrate the necessary long-term financial viability" (DHSC, 2012)

Institutions had to pass four tests before the government would release emergency funding.

> "Any Trusts that can satisfy the rigorous tests will have access to financial support of up to £1.5 billion in total over a period of 25 years. Some of this funding will be available from 2012/13 from within the Department of Health's budget. Alongside this, Trusts must have in place local plans to achieve long-term financial balance, which will require other factors to be addressed, while continuing to deliver the best possible services for NHS patients. The funding will be provided in a transparent way that represents the best possible value for money for taxpayers" (DHSC, 2012).

In April 2020, the government announced that it was writing off all NHS debt (amounting to over £13bn). Such an announcement supports the critique that the internal market in the NHS cannot and does not operate like any other market in a financial, neo liberal sense, mainly because the mechanisms of supply and demand in the NHS do not operate like they do in pure retail or financial markets.

> "In April 2020, the Health Secretary announced that over £13bn of NHS debt would be written off and converted to public dividend capital (PDC). This was part of a wide range of financial measures the Government brought in for health and social care during the current pandemic.
>
> All the loans that are being written off are internal debts between NHS trusts and the Department of Health and Social Care (DHSC). This means it is a

transaction within the DHSC and does not change overall public borrowing. It is not a cash injection, and additional funding for COVID-19 will be provided to trusts through emergency and other funding rather than this write-off.

From April 1, 2020, there will no longer be any interest charged for these loans. The debt will be converted into equity, known as public dividend capital (PDC). While PDC does not need to be repaid, it incurs an annual cost as a return on the investment. This is currently set at 3.5% of the relevant net assets of the trust, and this money goes from trusts to the DHSC" (The Health Foundation, 2020).

The concept of the engaged patient proved popular in policy circles. It reached prominence in the Wanless Review in the early noughties, commissioned for the Brown government and then later by the King's Fund and the London School of Economics (Wanless, 2002, 2004, 2006, 2007). Writing the first review in 2002, Wanless was commissioned to project a view of how the NHS might look in 2022. To do so, he created three possible scenarios of how the NHS could look in 2022.

• solid progress – people become more engaged in relation to their health: life expectancy rises considerably, health status improves, and people have confidence in the primary care system and use it more appropriately. The health service is responsive with high rates of technology uptake and a more efficient use of resources.

• slow uptake – there is no change in the level of public engagement: life expectancy rises by the lowest amount in all three scenarios and the health status of the population is constant or deteriorates. The health service is relatively unresponsive with low rates of technology uptake and low productivity; and

• fully engaged – levels of public engagement in relation to their health are high: life expectancy increases go beyond current forecasts; health status improves dramatically, and people are confident in the health system and demand high quality care. The health service is responsive with high rates of technology uptake, particularly in relation to disease prevention. Use of resources is more efficient (Wanless, 2002, p.35)

Some have referred to the fully engaged scenario as the Rolls-Royce vision of the NHS (Moore, 2002). While others labelled the report,

> "a pawn in the Chancellor's political manipulations" (Halpern, 2002).

The point relevant to this chapter is the focus on the individual patient at the centre of all three scenarios. The most cost-efficient scenario (fully engaged) depends on the patient making good choices (by which Wanless means economically efficient), being IT literate and self-motivated to engage regularly and consistently with good diet, healthy behaviours, and exercise. There are numerous examples in the literature that point to how sections of the population who experience structural disadvantage economically and socially, are limited by their circumstances to engage and participate fully with healthy behaviours, as envisaged by Wanless (Modood et al., 1997).

Thus, the patient has two functions in the brave, new Wanless world. First, they must be fully engaged and participate in decisions about their health and healthcare as well as be responsible for keeping themselves fit. Secondly, they must ensure they are up to date and literate about the latest health care statistics and performance ratings about their local health care providers. They must then exercise choice about where to receive their health care.

It falls to the patient to reward or punish health care providers with their patronage. In this ideal-type model, the patient choice of service provider performs the fatal or non-fatal blow of keeping high performing quality providers in the market and punishing poorer performing providers with closure.

2.4.4 GPPS and the engaged patient

The policy context that witnessed the development and introduction of the GPPS is the same as that which formed the background to the introduction for the QOF. The GPPS conforms to the principles of NPM techniques through its creation and provision of auditable data, which is made public to facilitate and enable active and engaged citizens to make choices within the primary care system. The making public of the information allowed the state to talk about enabling 'patient choice' in general practice. By individual patient's exercising choice about the practice at which they registered, the role of the state became one of regulator of quality of services and provider of monitoring information.

When it was launched in 2006, the GPPS represented,

> "the largest ever survey programme of patients registered to receive primary health care, inviting five million respondents to report their experience of NHS primary healthcare" (Roland et al., 2009a).

When the QOF was first introduced the Patient Experience domain was worth a total of 100 points. Each QOF point was worth £77.50 in 2004, "rising to £127.29 for 2010/11, and then to £130.51 in 2011/12" (GPC, 2018). 70 points were available for demonstrating the use of surveys in the practice. 30 extra points were available for demonstrating the length of consultations. There was an incentive payment for practices who could show that routine consultation bookings were available for 10 minutes or more (Roland, 2004).

During negotiations, it was decided to reward practices for demonstrating that they surveyed their patients and for showing that they had acted on the results. However, payments would not be linked to the results of any questionnaires. When QOF was first rolled out, Roland wrote that the target of this domain was to 'engage family practitioners in the process of discussing the evaluations of their patients, rather than to focus on the questionnaire scores' (Roland, 2004)

2.5 GPPS and the CQC

NPM techniques aim for a scaling back of the role of the state. The state moved from a provider of services to a regulator of services, and later in 2012, to a promoter of services (Pollock & Price, 2012b). To perform its role as regulator, the state must have data. If the data does not exist, it must be created. Instruments such as the QOF and the GPPS create data by which practices will be audited and measured.

To create a nationally reliable database of patient experience the Department of Health commissioned Ipsos-MORI to design a survey of general practice patients. The survey would be reliable and comparable at a national level. The GPPS was derived from the GPAS (GP Assessment Scale) which was developed in the US in 1998 (Mead et al., 2008). It was then adapted for the UK and became the GPAQ and was one of two questionnaires that GPs could administer as part of an early QOF.

In 2006, the GPPS was launched as a postal questionnaire and was sent to approximately 2% of patients registered with a general practice in England. It was

administered by Ipsos MORI, an independent, external market research consultancy. The results were sent from Ipsos MORI to NHSE and then to the practices. This might explain why practices felt removed from the GPPS data. Prior to the GPPS, practices had exercised a degree of control over which patients were invited to complete a survey and results were analysed by the practices themselves. The GPPS removed the process of asking patients about their experience from the domain of the practices. When first introduced, it attracted 70 QOF points. While unpopular (the medical profession remained sceptical of patient survey tools) it was viewed by many as an annoyance and without power, other than the monetary value of its QOF points.

In England, regulatory inspections of health and social care are provided by the Care Quality Commission (CQC), which was established in 2009 when the two previous regulatory bodies responsible for monitoring health and social care were merged. Following the establishment of the CQC there was a series of high-profile failures within institutions providing health and social care, gaining a lot of media and public attention. Some of the highest profile cases to hit the headlines included:

- “Excess deaths and poor care at Stafford Hospital, an acute hospital run by Mid-Staffordshire NHS Foundation Trust — in June 2010, the UK government announced there would be a public inquiry.
- patient abuse by staff at Winterbourne View private residential hospital for people with learning disabilities — this was exposed by a BBC television documentary in May 2011; and
- the July 2011 financial collapse of Southern Cross Healthcare Group, a private provider of health and social care services — at that time, it was the largest provider, with 31 000 residents in 750 care homes.”, (Allen et al., 2020).

The CQC received criticism from the National Audit Office (2011) the House of Commons Health Committee (2012) and the Dept of Health’s performance and capability review (2012) for these high-profile failures of hospital trusts.

In response to the failings and criticism it received, the CQC introduced a new inspection system. Its aim was to “make better decisions about when, where, and what to inspect by using information and evidence in a more focused and open way’,

(2013). Inspection of GP practices was introduced in April 2014. Part of the new inspection system was the development of a collection of indicators which would be used to decide which practices would receive an Inspection visit from the CQC. The new system was called Intelligent Monitoring (IM) and was introduced for general practice in April 2014. The IM for general practices included 33 performance indicators. Eight of these (in 2021) were taken from the GPPS. In total, the 33 indicators encompassed questions asking about patient satisfaction, the management of chronic conditions, prescribing, disease prevalence and emergency hospital admission rates.

The performance indicators were used to group practices into potential risk bands based on expected indicator values. These ratings were then used to prioritise CQC Inspection visits. If a practice failed its Inspection visit, then the CQC could enforce closure. Intelligent Monitoring has been deeply unpopular amongst general practitioners and their practices. Recent work has cast doubt on the ability of the IM indicators to accurately predict the outcomes of Inspection visits. The IM indicators were particularly poor at "identifying the practices most in need of inspection, that is, those that received a rating of 'inadequate' or 'requires improvement.' There were 172 practices with an 'inadequate' inspection rating, and none were predicted correctly (0.0% accuracy)" (Allen, n.d.).

2.6 The development of the QOF tool

The negotiations that led to the final QOF took place over 18 months and involved the British Medical Association (acting as the doctor's representatives), the NHS Confederation (representing NHS Management which acted on behalf of the government) and a small group of academic advisers. The profession accepted that variation existed within general practice at a national level and the government was prepared to commit funding in return for improvements in quality standards. The British Medical Association negotiated that family practitioners would no longer have to provide care outside normal office hours, nor for certain additional services termed, 'enhanced' services such as the treatment of drug dependency.

The first QOF was launched in 2004 and contained 1000 'points' available to general practices. The points were spread across three domains: clinical care, practice organisation and patient experience. The points translated into funding and were

distributed at the end of the financial year after the total QOF score had been declared. Each point was worth £70. Since its introduction in 2004, the amount of 'points' available to practices has decreased. In 2019, 559 points were available to general practices operating in England.

Another key function of the QOF was that it allowed the government of the day to give GPs a pay-rise. By 2018/19 the General Practitioners Council (GPC) commented that,

> "The QOF point value for 2018/19 is £179.26 in England, £172.88 in Wales and £162.12 in Northern Ireland. In England, most general practices derive 12-15% of total practice income from QOF, and GMS and PMS practices receive about £685 million a year through QOF. Other income to practices comes from the capitation global sum (about £85 per patient per year) and payments for delivery of specific services. Payments are weighted by list size and measures of disease prevalence. QOF is therefore an essential part of practice funding which supports the employment of practice staff as well as the day-to-day activities of the practice" (GPC, 2018).

At the time of its introduction, GP recruitment and retention was approaching crisis levels. A retirement crisis was also looming on the horizon. The government needed to make general practice a more attractive career option for junior doctors as well as retain general practitioners already in service.

The QOF can be viewed as originating from the new public management model for a series of reasons. Most obviously, it introduced a payment for performance element into the GP Contract which had not existed previously. A second reason to locate QOF firmly in the NPM project is its ability to produce data at a national level. This data is used to monitor, categorise, rank, and measure the activities of English general practice and its staff. Chapter 3 discussed the central role that data performs in the new public management model. Crucial to this, is the generation of new forms of knowledge which then become the only form of knowledge that is deemed acceptable to demonstrate evidence of accountability having been rendered. This is perhaps, QOF's most important role when seen from the perspective of policy analysis – that it generates and produces the only form of measurable data which is

accepted as evidence of accountability given by English general practices to the state.

2.7 Summary

This chapter has argued that the QOF and the GPPS should be viewed as forming part of the NPM approach to the NHS and were designed to establish, facilitate and accommodate NPM principles into the structure of the health sector. The chapter asserts that GP fundholding fell under the category of NPM methods because it sought a shift in responsibility from the centre towards individual GP practices. This tied into NPM methods because it sought the shrinking of the role of the state. Such methods included the establishment of accountability into public services coupled with a narrative that placed patient choice at the heart of the NHS as well as a decoupling of the role of the state with that of provider of services. The 2012 English Health and Social Care Act finally broke the link between the role of the state as one of provider of services when it established the role of the Secretary of State for Health as being the promoter of services (Pollock & Price, 2012b).

Linked to this, was a need to introduce competition - achieved fully in the 2012 Act which saw the establishment of the Any Qualified Provider mechanism - which placed health care providers in direct competition with each other (Long & McLean, 2011). The establishment of the principle of accountability in general practice was realised fully in the form of the QOF, but initiatives such as Payment by Results and Practice Based Commissioning, can be viewed as early first steps towards shifting responsibility for the management and commissioning of services away from the state towards general practitioners. Thus, ‘any shortfall in provision’ could be ‘attributed to bad local management rather than bad central government’ (Speed & Gabe, 2019, p. 35).

The chapter demonstrates how NPM methods and practices were championed by the Thatcher government in the late 1980s - most notably with the introduction of the internal market - and continued by John Major’s subsequent governments which proceeded the implementation of the NPM agenda. The chapter looked at the introduction of The Citizen’s Charter and the closely related Patient’s Charter which sought to make explicit the contracts between individuals and institutions. While ridiculed by the Left at the time, the impact of key NPM concepts such as

performance monitoring and pay for performance, have proved to be long-lasting and have transformed the way that the state defines its role in a modern state. The chapter explored how the NPM mantle was continued under the Blair administrations. It was Blair who extended the idea of League Tables (a feature of the Citizens Charter) to hospitals and commissioned the Wanless Reports, with their emphasis on the role of the engaged patient.

Alongside a redefinition of the role of the state as a requirement of NPM, the role of the patient has also been examined in this chapter. To accommodate the NPM transformation of the NHS in England, a shift in the concept of the role of the patient was required. The patient had to occupy a role akin to that of a consumer in an open market. This represented a major shift in how patients were viewed by the system and by themselves.

Accompanying the rise in policy circles of the insistence on making performance data public – the chapter examined the insatiable appetite of NPM for auditable data. The production and generation of auditable data was discussed with reference to Strathern (2000) and Rose & Miller (2010).

The following chapter explores the literature review that was undertaken. The chapter identifies gaps and explains how these shaped the research question.

Chapter 3 Literature Review

3. Introduction

This chapter presents the findings from a scoping review of the literature conducted at the start of the research and a policy analysis review which was carried out at a later stage in the project timeline. This chapter will outline the methods used and the findings from the first scoping review. It will then move on to deal with the policy analysis review. The chapter will conclude by reflecting on how the findings from both the scoping and policy reviews informed the study design and the selection of methods.

3.1 The scoping review

At the start of the research, the initial area of interest was to investigate what the relationship was (if any) between the QOF score for each practice which measured its overall quality and the overall patient satisfaction score taken from the GPPS via what was then Q28 (now Q26). The thinking behind this came from a paper by Asprey et al (2013) which investigated the statistical relationship between a practice's QOF overall quality score and its overall patient satisfaction score. The research by Asprey et al became a key paper for my research and is discussed in detail later in this chapter. At this early stage in the research, my interests were to investigate if clinical quality in a general practice (measured by QOF) was linked to patient satisfaction (measured by Q28 on the GPPS).

To locate the literature on this topic it was decided to undertake a scoping review (2005). Scoping reviews offer several advantages for research interests such as mine over more traditional methods of conducting a systematic review which would not have suited my research interests.

Arksey and O'Malley found in 2005 that there was a multiplicity of literature/evidence reviews in use. There was a lack of definition concerning which ones were suitable for particular studies. In 2005 they attempted to gather the many different types of reviews in use at the time and suggest that there was room for the scoping review.

> "Whilst criticisms have been levied at both 'traditional' and 'systematic' review methods we contend that there is no single 'ideal type' of literature review, but rather that all literature review methods offer a set of tools that researchers need to use appropriately. To that end the scoping study is one method

amongst many that might be used to review literature", (O'Malley, 2005, p. 20).

They contrasted the scoping review with a systematic review, arguing that both served different research needs.

> "So, what might we consider to be the main differences between a systematic review and a scoping study? First, a systematic review might typically focus on a well-defined question where appropriate study designs can be identified in advance, whilst a scoping study tends to address broader topics where many different study designs might be applicable. Second, the systematic review aims to provide answers to questions from a relatively narrow range of quality assessed studies, whilst a scoping study is less likely to seek to address very specific research questions nor, consequently, to assess the quality of included studies", (O'Malley, 2005, p. 20)

Arksey and O'Malley identify four reasons why a scoping review might be appropriate. The first two that they identify might be seen as the first stage of a study which might culminate in a full systematic review. The last two might be viewed as a methodological enquiry in their own right. The fourth reason they identify is most apt for the aims of my research.

> "To identify research gaps in the existing literature: this type of scoping study takes the process of dissemination one step further by drawing conclusions from existing literature regarding the overall state of research activity. Specifically designed to identify gaps in the evidence base where no research has been conducted, the study may also summarize and disseminate research findings as well as identify the relevance of full systematic review in specific areas of inquiry. However, it is important to note that identifying gaps in the literature through a scoping study will not necessarily identify research gaps where the research itself is of poor quality since quality assessment does not form part of the scoping study remit", (2005, p. 22)

In keeping with the principles of the scoping review methodology (O'Malley, 2005) my approach to the literature and my fieldwork has been iterative. The iterative

approach to fieldwork alerted me to a theme from the literature that I wished to investigate further: the policy context that led to the development of the two tools of interest, the QOF and the GPPS. In recognition of the need to examine the policy context that helped shape the two tools, it was decided that the inclusion of literature on the topic of patient choice should be added to the review. It was decided that a policy analysis review of grey, policy literature and professional journals would be undertaken. The results of this review are discussed in the second section of this chapter.

Having decided upon a scoping review the outlines of the search criteria were established. Searches were conducted using the following keywords: quality; patient voice; QOF; GPPS; patient satisfaction; patient choice; patient experience; staff satisfaction; staff morale and general practice. The following databases were searched using the keywords listed above:

ASSIA Applied Social Sciences Index and Abstracts (ProQuest)

BMJ Journals

CINAHL

Embase

HMIC Health Management Information Centre (OVID)

House of Commons Hansard archives (1995 -)

IBSS International Bibliography of the Social Sciences (ProQuest)

JStor ebooks and journals

Proquest Social Sciences collection

SCOPUS (Elsevier)

ScienceDirect Journals (Elsevier)

Social Policy and Practice (OVID)

Sociological Abstracts (ProQuest)

Web of Science

Dates of the scoping review were decided in consultation with my supervisors and were set to include the years preceding the introduction of QOF (2004) and the GPPS (2006) as well as the years following their establishment in English general practice, 1980 – 2022. The 1980 start date of the literature search was chosen because I wanted to include papers detailing the policy context of the introduction of the two instruments as well as papers evaluating their impacts. References of papers were hand searched for further articles.

This next section introduces the main themes generated from the scoping and policy analysis review. The searches generated several themes which I have grouped together. The first group deals with the introduction of QOF while the second group addresses the introduction of the GPPS.

3.2 Findings from the scoping literature review

Introduction of the QOF into general practice in England

This section will introduce the themes most relevant to the research question.

3.2.1 The definition of clinical quality determined by QOF

QOF defines one version of the concept of clinical quality through operationalising its overall QOF Score. It does this through the prioritising of selected long-term conditions and the setting of a quota of QOF points. If a practice 'hits' the pre-specified target for each long-term condition, then achievement points set on a sliding scale are awarded. Practices decide how, or even if, they want to aim to achieve maximum QOF points. While QOF is a voluntary scheme it has always had high participation rates. In 2019/20 the participation rate was 96.2% (Quality and Outcomes Framework, 2019-20, 2020).

The choice of which long term conditions are included in the QOF and which methods of management are to be rewarded is a decision which is contested each time the QOF indicators are chosen and/or dropped (Ashworth & Kordowicz, 2010). Choosing which long-term conditions to include in the QOF is not a value-free process. The political choices involved in the annual selection of QOF indicators is a theme of the literature review and is discussed in the Theory and Discussion chapters. A body of literature which documents the debates that occurred during the development of QOF focused on how indicators were chosen, and which long-term conditions were given priority. It demonstrates how QOF was designed in

conjunction with the NHS and the General Practice Council (GPC) (a sub-committee of the British Medical Association). Today, NICE contributes to the formation of new evidence-based indicators for inclusion in QOF (Lester, 2008; NICE, n.d.). The architects of QOF decided which indicators would be included to efficiently manage certain long-term conditions within general practice. This finding invites consideration of the theme of increasing political and state involvement in English general practice, and in particular the GP consultation. Such involvement would have impacts on the relationship between GPs and their patients.

3.2.2 Unintended consequences of QOF

Alongside the set of papers outlined above were a group of articles which asked questions about what the unintended consequences of QOF might be for general practice, patients and staff. In a key article addressing potential problems stemming from the Quality and Outcomes Framework the authors raise three important points (Heath et al., 2007). First, they draw attention to the fact that even evidence-based interventions will cause harm to some groups of the population and noted that risks of harm increase with age. The authors argue that QOF encourages clinicians to follow a standardised process which may not be appropriate for the patient sitting in front of them during a consultation, especially if the patient belongs to a vulnerable group such as older people or has a complex health profile.

This criticism of QOF speaks to the fear that QOF and performance measurement incentives represent an approach to medicine/management characterised by 'medicine by numbers' or what others have referred to as a 'tick box' exercise (Shore & Wright, 2015). Heath et al argue that QOF may 'stifle innovation' (2007, p. 7). While the QOF interventions may be evidence-based, the authors argue that any doctor knows that giving two patients the same treatment will have different outcomes due to underlying factors such as age and morbidity to name a few. Their critique of QOF is that it has the potential to,

> "diminish the responsibility of doctors. To give just one example, the failure to make any allowance for age means that doctors are encouraged to overtreat hypertension in old people with the danger of causing fainting, falls, and fractures." (2007, p. 1).

While other authors in the literature have commented on the effects of a tick-box exercise resulting in practices chasing the money, Heath et al's concerns are that it might lead to the risk of overtreatment amongst patients for whom a standardised intervention may not be appropriate.

3.2.3 Increasing inequalities

Their second important critique of QOF is that through its financial mechanism, QOF may exacerbate health inequalities. QOF allows practices to *exempt* some patients from being included in their QOF data, through exception reporting. Practices can use exception reporting for patients who are difficult to manage and/or treat. This means that these patients will not be included in the practice's QOF submission. Heath et al, argue that this might encourage practices to offload difficult patients via exception reporting. This means that those patients are excluded from QOF and may be at an increased risk of becoming hidden or forgotten about, as the practice concentrates efforts to achieve QOF points. Others argued that exception reporting should be viewed as a marker of quality in general practice (Hopayian, 2013). Hopayian writes that if more doctors practised patient-centred medicine, then exception reporting would be higher.

> 'GPs who practise patient-centred, evidence-based care will, inevitably, have higher exception rates. As outliers, they should expect a visit from their PCT hit squad.'(2013, p. 315)

Hopayian goes on to describe how when their practice received a visit from their local PCT they viewed the visit with a sense of pride. Hopayian makes the distinction between evidence-based medicine and evidence-driven medicine. He argues that QOF encourages evidence-driven medicine, which places it in opposition to patient-centred care.

> "Yet what is practised is evidence-driven medicine. Practitioners push interventions shown to be effective usually without involving patients and often without stopping to consider if the effect is worth it. .... In the belief that patients are being informed, doctors tend to give the positive aspects of an intervention more than the drawbacks." (2013, p. 315).

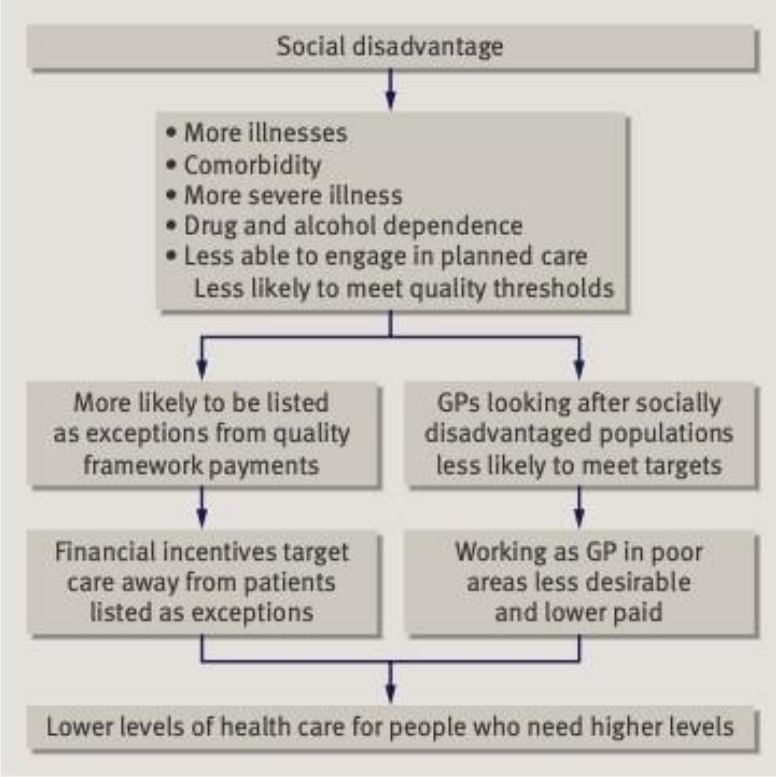
Hopayian continues to argue that the more GPs practice patient centred care,

> "… the more your patients will choose not to accept the things that QOF rewards. In the bureaucratic returns they are listed as dissenters. The choice of this term brands them as rebels against medical orthodoxy rather than individuals exercising their rights. To me, warranted exceptions are the consequence of patient-centred care, an indication of evidence-based not driven medicine, a mark of quality practice. I doubt very much that they would ever attract their own QOF points." (2013, p. 315).

The theme that QOF might exacerbate inequalities was generated from the literature. Other authors considered whether practices in areas with low deprivation would find it easier to achieve higher scores than those practices working in areas with high levels of deprivation (Ashworth, n.d.; Ashworth et al., 2005, 2011; Ashworth & Jones, 2008). It is widely documented in the literature that areas with high levels of deprivation experience poorer health outcomes (Barr et al., 2017; Bécares et al., 2012; Dixon et al., 2012; Modood et al., 1997).

Heath et al raise the issue that practices in areas with high deprivation will have to work harder to achieve the same performance as practices in less deprived areas. This may lead to a loss of staff morale which in turn makes it harder to recruit and retain staff in deprived areas, contributing further to poorer quality of care in deprived areas. Heath et al call this the 'policy of inverse care in the quality and outcomes framework' and describe it below in the table.

Tbl 1: Policy of inverse care in the quality and outcomes framework



(Heath et al., 2007, p. 7)

3.2.4 Does QOF work?

A further theme generated from the literature review was seen in papers focussing on evaluating whether QOF had 'worked' (McCartney, 2016; Sharvill, 2016; Spence, 2016; Steel & Shekelle, 2016). These papers concentrated on asking whether QOF had delivered improved quality of care for those long-term conditions it sought to manage? While this question is not directly relevant to my research question, it is of interest to my study in terms of how general practice staff feel about QOF. Whether practice staff think QOF is worthwhile or not might influence how it is delivered in practice. If they feel that QOF delivers a better service to patients, then this may

contribute to improved staff morale. In 2008, Roland published an article arguing that while QOF had achieved much since its introduction, it was too early for a verdict (2008). In the article Roland highlights some of the early successes of QOF.

> "Since the QOF was introduced, quality of care shows further improvement. For asthma and diabetes, care is now improving more rapidly than before the contract. For coronary heart disease, where care was already showing major change, the improvement has continued at the same rate" (Kontopantelis et al., 2007).

Roland argued that early gains in quality improvement should not be attributed solely to QOF. He noted that much of the groundwork for improvements in clinical quality and management of long-term conditions were laid in the 1990 GP Contract, although at the time they had modest impacts.

> "Care was already improving rapidly in the years leading up to the new contract. So, for heart disease, for example, the percentage of patients with controlled blood pressure rose from 47% to 72% between 1998 and 2003, and the percentage of patients with cholesterol within recommended levels increased from 18 to 61% in the same period. The roots for these improvements go back a decade or more. Audit was introduced as a compulsory part of the 1990 GP contract and seemed to have a modest impact at the time. But what happened during that decade was that GPs gradually started using electronic records, they got used to comparing their care with others, and many GPs employed nurses to improve the care of chronic illness. So, when the QOF came along, much of the infrastructure for quality improvement was already in place, and GPs were able to respond rapidly to the new incentives." (Roland, 2008)

Roland suggested that the structural foundations for improvements laid in the previous decade helped to explain the high achievement scores that many practices found themselves achieving in the first years of QOF. This theme (the long roots of performance management in UK public services) was discussed in greater detail in chapter 2 which traces the roots of initiatives such as QOF and the GPPS back to the 1992 Major administrations.

3.3 The impact of QOF on practice staff

This theme is extremely relevant to my research question. It includes three strands which I will discuss in this section.

3.31 Theme 1: An increasingly biomedical model of general practice?

1) A group of papers outlined concerns that QOF would lead to a more biomedical model of general practice being implemented as practitioners were encouraged to focus on following templates rather than listening to patients. (Chew-Graham et al., 2013; Edgcumbe, 2010a; Freeman, 2006).

3.3.2 Theme 2: Impacts on the workforce and staff morale

i) Linked to this theme was the concern that QOF would result in the practice workforce becoming more stratified, as practices reorganised to deliver QOF (McDonald, Checkland, & Harrison, 2009; Nelson et al., 2018).

j) Several papers considered the relationship between the GP profession and the rise of the 'new managers' and how this changed the relationship and balance of power between the two (Baeza, 2005; Exworthy & Halford, 2002).

k) The theme of an increased workload brought about because of QOF for practice staff emerged strongly from the literature review. Many of these papers emphasised the impact this had on GPs, which was frequently referred to in the literature as *GP burnout* (Jeffries D J., 2009). Other authors considered the increased work burden on nursing colleagues as well as GPs (Gemmell, 2009)

l) Linked to this topic were themes surrounding the recruitment and retention crisis amongst the GP workforce (Alderwick & Ham, 2016; Irish & Purvis, 2012; Owen et al., 2019; M. Roland & Everington, 2016).

3.3.3 Theme 3: The patient experience of QOF

1) Some authors considered this topic from the perspective of how payments affect patient consent when considered in relation to QOF. These authors argued that if patients are unaware of the monetary value of QOF, then consent cannot be considered to have been given by the patient (Robinson, 2012; Williamson, 2017).

2) Few authors considered the impacts of QOF on the patient's experience and if it had changed because of QOF (Checkland et al., 2008).

3) Some authors investigated the theme of how staff satisfaction might impact on patient satisfaction (Szecsenyi et al., 2011).

I will deal with these three themes in the next section. Some of the papers discussed in this section sampled clinician staff only, for example GPs and Senior Nurses, occasionally the Practice Manager was included. When papers sampled beyond clinician staff, it is noted.

3.4 Theme 1: An increasingly biomedical model of general practice?

The first group of papers deals with the theme from the literature that QOF would result in a more biomedical model of general practice being adopted, compared with the pre-QOF era (Checkland et al., 2008; Norman, Russell, Merli, 2016).

Norman et al argued that due to QOF's treatment of long-term conditions separately, GPs and general practice staff would be incentivised to focus on single symptoms, representing a move away from the Balint holistic approach (Balint, 1957; Edgcumbe, 2010b) or Armstrong's 'autobiographical medicine' model (Armstrong, 2003). They argued that QOF was not able to deal with patients presenting with multi-morbidity (2016).

The authors conducted their research with two training general practices in England during the QOF year 2013/14. Both practices were required to achieve both pre-established standards of care and high QOF achievement scores to qualify as training practices. Participant observation methods were used to collect data along with one-to-one interviews with practice staff. Staff interviewed included GPs, nursing staff and managerial staff (2016, p. 80).

The authors argued that the introduction of QOF has had three major impacts on general practice in the UK. These included the commodification of patients; QOF as currency and valuing commodities. They argued that 'the interface between patients and care providers has been commodified' (2016, p. 77). It is the identification of what they identify as the first and second impacts of QOF that is of interest to my research question.

They argued that QOF has encouraged general practices to reconstruct the relationship between a practice, its staff, and its patients. They argued that 'attaching

money is a powerful tool for reshaping healthcare services by commodifying patients themselves' (2016, p. 83). In their paper, they quoted a GP participant.

> 'Now patients are walking bags of money that you have to get money off...by doing certain tasks...instead of a patient that you should be just saying," We've got (a) problem and need to...' and that's a danger, you know." (2016, p. 81).

The authors argued that QOF fundamentally changed the way general practices and staff interacted with patients. Under previous arrangements, GP Fundholders cared for patients by administering a limited budget, which they held. QOF, the authors argued, encouraged practices to 'make' money 'by exploiting potential economic gains, for example, by doing certain things instead of others because they are more lucrative.' They suggested that QOF fostered a 'profit-oriented' approach towards the treatment of patients. For this reason, they argued QOF should be understood as vastly different from previous contract arrangements that had existed between the state and the medical profession prior to 2004 (2016, p. 84).

This new profit-oriented approach, the authors argued, led to practices focusing on the most lucrative QOFable conditions. Clinicians, and the whole practice, were incentivised to concentrate on particular conditions and symptoms, rather than treating the patient as a whole entity (2016, p. 84). The authors raised some important insights into how QOF operates in reality – as reported by the research participants (GPs, nursing staff and managerial colleagues).

The authors contrasted this impact of QOF with previous contracts made between the medical profession and central government which they argued allowed for general practice staff to treat the patient holistically. The authors did not argue that this always occurred, but they make the point that it was possible under previous contracts. This, they argued, provides the main contrast with the QOF. They considered that under the QOF, practices were forced to alter the way they viewed, and treated patients.

Edgcumbe wrote about concerns that QOF would distract the GP from the patient and damage the Dr-patient relationship further in a world of increasing multimorbidity and time pressures on appointments:

> "How is a modern doctor to notice his patients with the many distractions on offer? There is the intrusiveness of the externalised agenda with QOF targets flashing up on the computer screen, and prescribing warnings when a medication is deemed too expensive. Then there is the increased demand, with higher consulting rates. Patients' problems are more complicated as well, with a greater range of treatments and technologies on offer" (2010a).

Checkland et al (2008) conducted research with two general practices in England and Scotland designed to investigate how both practices had implemented QOF and how these changes might have affected the care delivered to patients. They interviewed a full range of staff members at each practice, including GPs and clinicians, reception and administrative staff. They concluded that they,

> "observed changes in all the practices that will result in patients experiencing a more biomedical, disease-orientated type of care" (2008, p. 798).

Despite these observed changes, the authors found that GPs in the practice case studies maintained that they still provided holistic, patient-centred care to their patients. The authors identified three ways they argued this,

> "These claims varied in substantive content, but centred upon three areas: a metaphorical 'protected space' within the consultation, in which they continued to be patient focused in spite of other pressures; an ideal of complexity that contrasted complex, generalist, patient-centred medical work with more routine, specialised, medically-focused work done by nurses; and the maintenance of an overview of patient care that allowed them to claim knowledge of the whole." (2008, p. 799).

How GPs perceive themselves and what they do within the general practice team is important to my research question in terms of its relevance to staff morale. This is one of the themes that will be discussed later in this section. It also speaks to the next theme to be discussed which is their role in the practice team, relative to other job roles.

3.5 Theme 2: Impacts on the workforce and staff morale

The first theme in this section concerns the view that QOF is a threat to the professional autonomy of general practitioners (Checkland et al., 2009; Grant et al.,

2009; McDonald, Checkland, & Harrison, 2009; McDonald, Checkland, Harrison, et al., 2009; Nelson et al., 2018). Such articles highlighted fears expressed by some frontline staff (particularly GPs) that QOF would intrude on the autonomy of the GP in the consultation room and into other aspects of their role. Fears were described by respondents that QOF represented a version of 'tick-box' general practice with the implication that the role of general practitioner was reduced to one of following a template (Heath et al., 2007). During the first year of QOF, the DH financial forecast predicted that the mean practice achievement score would be 750 points (NHS Digital). The majority of practices achieved 900 points. This was seen by some in the GP profession as a vindication of their role and hard work (see fieldwork in Chapters 6 and 7). However, Roland (2008) argued that much of the groundwork for success in the management of long-term conditions had already been laid in the decade prior to the introduction of QOF.

Grant et al argued that QOF redistributed the workload within the practice team (2009). They argued that as a response, the professions would engage in professional self-identity work to maintain professional clarifications. Grant et al argued that GPs would delegate tasks to nurses, and in turn, nurses would delegate tasks to HCAs (health care assistants) (2009). Grant et al's work is relevant to my research question as it highlights the impacts that QOF has had at an organisational and institutional level. The authors employ an ethnographic approach to their study investigating the impact of QOF on professional boundaries in UK general practice. They argued that,

> "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." (2009)

In the same study, the researchers examined the interface between professions and how these were observed, performed and reconstructed by the research participants in their daily lives. They argued that both GPs and nurses employed 'dual closure'

(1992) rhetoric to recreate ‘well-worn professional boundaries and clinical hierarchies between themselves and other professions.’ (2009).

The authors explained ‘dual closure rhetoric’ in the following way. They found that GPs and nurses used strategies of upward usurpation to talk about why hospital specialists could not perform a GP role, while nurses spoke about how GPs were not able to give the holistic care as well as the continuity of care, they were able to provide. The authors also found that GPs practised strategies of downward exclusion towards nurses to argue against nurses’ claims of specialist knowledge by describing them as ’task-orientated’ roles.

Grant et al (2009) drew on Friedson (1970, 1985) to interpret the effects of QOF on the general practice workforce. Their identification that QOF has created new managerial roles within general practice is understood with reference to Friedson’s theory that professions ’reinforce(d) and significantly extend(ed) an existing trend towards ’bureaucratization’ and ’professional restratification’ (Freidson, 1985). Freidson recognised that the reorganisation of the medical profession (witnessed in many developed nations throughout the 1980s) presented itself as offering all members of the medical profession an equal status. He argued that the new models of organising the medical profession, many of which took the principles of NPM as inspiration, portrayed an image to those outside the profession of collegial loyalty. However, Freidson argued that using formal standards developed by a ’knowledge’ elite within the profession which were to be enforced by another (administrative) elite would pose a threat to that loyalty amongst colleagues, as well as a greater degree of heterogeneity of the profession (1985). Grant et al’s work provided evidence to support this (2009).

In their research conducted in 2009, Grant et al argued that internal stratification was present within the general practice workforce. They posed the question,

> “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.” (Grant et al., 2009)

An earlier paper addressed the issue of professional hierarchies in general practice prior to the introduction of the QOF. Charles-Jones et al argued that in the years preceding QOF, general practice had undergone three decades of rapid reform (2003). The result of these reforms meant that the role of the general practitioner had shifted away from the management of short-lived acute conditions towards the management of chronic disease. Charles-Jones et al argued that because of the changing role of general practice, practitioners faced a 'complex and frequently conflicting set of agendas' (2003, p. 72). To manage such conflicts, Charles-Jones et al drew on Latimer's idea of the 'constituting of classes' (1997) as a way to understand how professionals manage such complexity. Latimer's 'constituting of classes' speaks to Grant et al's professional 'self-identity' work observed in their research several years later. This suggests that an answer to Grant et al's question, posed in 2009 asking whether internal stratification within practice teams could be here to stay, might be affirmative.

Linked to the theme of internal stratification as a response to imposed regulation and competing agendas is the second theme to emerge in this section: that of analysis of the rise of the 'new managerialism' class in healthcare systems and their relationship with the medical profession as well as how that relationship functioned in different healthcare settings (Baeza, 2005; Exworthy & Halford, 2002). While many viewed QOF as a threat to professional autonomy, Exworthy & Halford noted how the relationship between the two are nuanced. The authors recognised that the traditional juxtaposition between the two domains of professional and managerial class has a long history. Accompanying how we think about the two domains is an assumption that they are fundamentally different. The authors wrote that,

> "It is commonly assumed that the work managers do is quite distinct from that of professionals. This notion supposes that managers are committed to running bureaucracies, to establishing and applying rules. In this scenario, managers depend for their power and authority on their position in the bureaucratic hierarchy and on their knowledge of organisational politics and practice, acquired through experience in a particular organisation. By contrast, professionals are thought to be committed to the provision of expert services and advice, and to depend for their power and authority on specialist

knowledge which supersedes the confines of any single organisation." (Exworthy & Halford, 2002, p.1)

As health reforms have continued with regularity throughout the decades the authors recognised that the picture outlined above did not reflect the reality for many doctors who found themselves in positions of quasi-management roles.

> "Empirical evidence has also suggested that the roles are rather more blurred than the stereotypes suggest. For instance, professionals working in the public sector have commonly built careers in single organisations and moved into managerial roles as they climb the ladder. In some cases, for example, in local government, the managerial cadre has been composed almost entirely of professionals." (2002, p. 2)

Baeza investigated the relationship between GPs and hospital consultants and found from fieldwork with case studies sites, that the relationship between the two moved from a collegial one to a managerial one as a result of the health reforms imposed on the profession in the 1990s. Baeza suggested that researchers had,

> "…relatively neglected the impact that the various rounds of health reforms had had *within* the medical profession." (2005, p. 2, emphasis in original)

While my research centres solely on general practice, Baeza's findings on the effects of health policy changes on the relationship between two sets of clinicians (GPs and hospital doctors) might hold relevance for my fieldwork analysis of relations between GPs and nurses in English general practice (Baeza, 2005). Extending the focus beyond primary care, Gabe and Exworthy (2019) investigated how the specialty of surgery was affected by the publication of mortality rates by named surgeons. Their focus was on how the specialty would accommodate the 'managerial gaze'. They argued that re-professionalisation had occurred as many surgeons took on managerial roles. This supports the call for an updating of the professions literature to accommodate the developments of quasi-managerial roles clinicians take on.

3.5.1The increased workload of QOF

At first glance the QOF appears to be a simple tick-box exercise involving tasks to be completed during consultations and management of record-keeping by administrative staff. However, papers returned by the literature review pointed to

enormous changes in the way practices organised themselves and their staff. This resulted for some staff in a significant increase in workload (Gemmell, 2009).

The issue of 'burnout' amongst GPs was not born with the advent of QOF – it has been a longstanding feature of the profession (Anagnostopoulos et al., 2012; French et al., 2001; Hall, 2019) dating back to the 1950s. The Collings Report published in 1950, detailed what one Australian doctor found in his report on the state of English general practice. Collings wrote that,

> "the overall state of general practice is bad and still deteriorating' ("The Collings Report," 1950)

He continued to note that in industrial areas where demand is usually greater than rural areas, he found that general practice had,

> "reached a point where, despite the efforts of the most conscientious individual doctors, it is at the best a very unsatisfactory medical service and at the worst a positive source of public danger." ("The Collings Report," 1950)

Reasons for the demand for general practice appointments have been discussed and debated elsewhere (Gallagher et al., 2001). The policy analysis literature review examined some of the reasons why QOF was developed and introduced. The recruitment and retention crisis in general practice received much attention in the literature search which covered the years 1980-2022. As well as being viewed as a tool designed to raise quality standards, QOF might be understood as a political response to the looming shortage of general practitioners in England (Roland, 2020). QOF was seen as a vehicle to deliver increased GP salaries and it was hoped to persuade more junior doctors to choose general practice as a specialty. Conversely, for some it had the opposite effect.

Some leaving the profession cited the addition of QOF to an already overburdened general practice landscape as a reason (Hall, 2019). Adding the demands of QOF to an already brief GP consultation may have increased stress levels for some. To make matters worse, as well as not being able to treat all the patient's concerns, GPs found themselves having to ask about topics for which the patient had not even

sought help. One study investigating the effects that QOF had on general practice quoted a GP who reported such an experience with a patient,

> 'There have been one or two occasions where I went through the cholesterol, the depression, the CHD, and everything else', one GP reported '… and the patient said "Well, what about my foot then?", "What foot?", I replied." (Campbell, 2008).

Gubb explains such an incident as being a predictable unintended outcome when,

> "the QOF has put an agenda in the clinician's heads that is not necessarily consistent with the patient'' perceptions." (2009)

This added to feelings of dissatisfaction on the part of both the GP and the patient as both found themselves discussing topics which might at times seem irrelevant to the consultation.

A counter-argument could be made that while QOF may have made the consultation feel less natural in its' flow, actions such as taking regular cholesterol measurements and asking about depression for example, resulted in better care outcomes for the patient. Nolan, writing in 2017 supports this view of QOF - that it might not be perfect, but it has undoubtedly raised standards and made GPs' lives easier as they seek to deliver improved care.

> "QOF is no Brussels. It isn't the bureaucratic monster it once was. QOF data is easy to code and track, and most of the data is collected by NHS England automatically. QOF has shown it can reform too: in recent years the more clinically dubious indicators have been retired, and those that remain are evidence based and not nearly as intrusive.
>
> Today's QOF is a smooth, well-oiled machine that integrates with every primary care software platform. For GPs this means QOF has found its rightful place in our world — the bottom right corner of the screen. The population searches that we use to track how we're doing force GPs to take a step back from individual patient needs to deliver more equitable care at a population level. Local schemes, without the support from major software platforms, tend not to integrate as smoothly, which inevitably leads to more time wasted wading through spreadsheets and notes." (Nolan, 2017).

Nolan notes that there is always room for improvement and offers suggestions for ways QOF might be improved but argues against doing away with it all together.

QOF enables 'opportunistic' events in the general practice consultation. For example, when a patient comes to see a GP about a swollen knee, under QOF, the GP should take the opportunity to ask about any of the QOF reminders popping up on their screen. On the one hand, this may feel very awkward for both parties, but it is these opportunities that (the policy literature argues) pushes up clinical quality in the management of the long-term conditions included in QOF (Buckman, 2006; Gillam et al., n.d.). Nolan asks what general practice without QOF might look like,

> "We know that when financial incentives have been removed from quality indicators, performance levels decline. Many practices would no doubt keep the QOF prompts on their clinical system, as reminders of good practice. But with no 31 March deadline they would likely spend less time chasing up those hard to reach patients, thereby widening health inequalities." (Nolan, 2017).

3.6 Theme 3: The patient experience of QOF

Some authors tackled the topic of how the introduction of QOF had affected the patient experience (Checkland et al., 2008; Paddison, Saunders, et al., 2015). Checkland et al noted that QOF placed a burden, not just on staff, but also on patients (Checkland et al., 2008, p. 795). The authors argued that as QOF deals with disease labels, a particular burden is placed on patients with multi-morbidity as they will be called separately to several different QOF clinics. For patients this might mean, several calls about different issues and requests to attend the practice two or three times per week. It is not known yet how this is understood and experienced by the patients.

> "Such systems have the potential to place a burden on the patients concerned, particularly those with more than one medical problem who may receive multiple letters calling for them to attend several different clinics. They also represent a move away from a traditional system in which patients themselves are free to decide when they wish to attend. Patients are being constructed as passive, disease-bearing objects who need to be prompted

and reminded to attend for care or visited at home if they do not respond."(Checkland et al., 2008)

Paddison et al (2015) found that patients with multimorbidity reported reduced satisfaction with their practice experience than patients with single or no morbidity. Their research considers several reasons behind such a finding including that patient's with multi-morbidity are not served well by health policies designed to serve single issue patients:

> "These needs are not well served by a system of healthcare delivery that is informed by evidence-based guidelines designed for patients with a single condition, and health policy which is framed around the management of a single condition. A 10 min appointment, standard in many general practices in England, may be inadequate for a patient with multiple long-term conditions and complex care needs. Patients in some surgeries are specifically requested to limit their appointment to one condition/medical query, and to make a second appointment for any further conditions. Such organisational practices are unlikely to be conducive to a positive patient experience and can result in a very fragmented experience of care and increased burden of treatment for the patient who is required to make multiple appointments." (Paddison, Saunders, et al., 2015, p. 8)

Related to the patient experience was a topic raised by Williamson (2017) which tackles the issue of consent and the QOF. Williamson argues that unless patients are made fully aware of the financial incentives received by the practice through their performance on QOF then full consent cannot be considered to have been given. Williamson writes that when QOF was introduced:

> "When the QOF was implemented, it slotted into GPs' customary practice. GPs had been in part paid for work done as items of service. Paying them to take specific courses of clinical action — pay for performance — seemed to many GPs merely an extension of that system, especially as they considered its clinical standards high and consistent with professional values." (Williamson, 2017, p. 250)

Williamson continues to write that,

> "…presumably GPs saw no need to tell patients about the QOF's financial incentives. But they overlooked the lessons from the scandals, that patients must be given information relevant to their decisions about consent. Sparing patients distress (beneficence); making decisions on their behalf (paternalism); concealing some wider objective, for example collecting organs for study or improving practitioners' competence; protecting reputations or institutions; securing personal gain; or simply saving time and trouble, are invalid as reasons for withholding relevant information." (2017, p. 250)

Williamson reports that in conversations with patients hardly any have any knowledge of the financial aspects of the QOF and how their practice is rewarded for performing certain actions.

> "All were surprised or dismayed when I then outlined the financial angle. In our conversations, some patients told me about their experiences of the QOF, once they realised that some of their care had probably been affected by it." (2017, p. 250)

The issue of consent and QOF is important in many ways, but the aspect I am interested in, and which is relevant to my study is how it might affect the Dr/Patient relationship.

3.7 The impact of the GPPS on general practice in England

This section outlines the themes generated from the policy analysis review concerning the introduction of the GPPS into English general practice in 2006. The policy context leading to its development and introduction were discussed in chapter 2. Briefly, the GPPS replaced the General Practice Assessment Survey (GPAS) and the General Practice Assessment Questionnaire (GPAQ) which had operated previously and were administered by practice staff themselves. Prior to the introduction of the GPPS, authors had long investigated the topic of how patients rated their experiences at their local practice (Baker, 1990).

Papers were analysed which investigated a range of topics including high acceptance of the practice survey by patients (Ramsay et al., 2000) to ways in which

the survey could be shortened by concentrating on three factors revealed to be key to patient responses: access, patient-centredness and nursing (Mead & Bower, 2002). Bias was revealed via mode of response (Bower & Roland, 2003). These papers highlighted some of the issues that were discussed in relation to the existing modes of collecting patient experience data which were not systematic prior to the QOF.

Papers were analysed which investigated the concepts of patient satisfaction and patient choice. The literature review returned articles which argued that the concept of patient satisfaction is ill defined which leads to challenges in measuring and implementation (Rubin et al 2006). The concept of patient choice is analysed from the perspective of challenges to implementation, including decentralisation and the limitations that the local health landscape may impose on attempts to deliver patient choice (Exworthy & Frosini, 2008).

The General Practice Patient Survey (GPPS) was introduced in 2006. It was linked to the QOF due to some of the GPPS questions being included in the QOF Indicators, such as measures of patient experience. During the year 2005/06 a total of 100 QOF points were allocated to patient experience indictors in QOF. During 2006/07 the total points available for the Patient Experience Indicator rose to 108 (Baker, 2009). Thus, there were many points allocated to the Patient Experience domain. Until 2010/11 practices were able to administer the survey themselves. It was only after this time, that the administration of GPAQ was given to Ipsos MORI, which meant that for the first time, it was completely independent from GP administration.

When it was introduced, the GPPS was purported to be a mechanism that would enable patient choice. For example, when selecting a general practice for themselves and their families' patients would turn to the practice's GPPS scores to help them decide if it was the right practice for them. It was launched as a way of enabling members of the public to access information about their local practice and to see how other people had rated it in terms of patient experience and satisfaction.

In 2014, the Clinical Quality Commission (CQC), the body responsible for monitoring standards in health care – introduced a new system of practice inspection which included measuring and monitoring quality in general practice. It was called the

Intelligent Monitoring (IM) system and was linked to the GPPS through its inclusion of responses to eight questions in the GPPS. The questions taken from the GPPS which are included in the evidence tables for Intelligent Monitoring in October 2021 are listed below.

Tbl 2: Indicators taken from the GPPS for inclusion in CQC Intelligent Monitoring, Jan 2015

Indicator ID	Name	Question Number in GPPS
GPPS004	The percentage of respondents to the GP patient survey who stated that they always or almost always see or speak to the GP they prefer	**Q9**
GPPS014	The percentage of respondents to the GP patient survey who stated that the last time they saw or spoke to a GP, the GP was good or very good at involving them in decisions about their care	**Q21**
GPPS 015	The percentage of respondents to the GP patient survey who stated that the last time they saw or spoke to a GP, the GP was good or very good at treating them with care and concern	**Q21**
GPPS020	The percentage of respondents to the GP patient survey who stated that the last time they saw or spoke to a nurse, the nurse was good or very good at involving them in decisions about their care	**Q23**

GPPS021	The percentage of respondents to the GP patient survey who stated that the last time they saw or spoke to a nurse, the nurse was good or very good at treating them with care and concern	**Q23**
GPPS025	The percentage of respondents to the GP patient survey who described the overall experience of their GP surgery as fairly good or very good	**Q25**
GPPS001	The percentage of respondents to the GP patient survey who gave a positive answer to 'Generally, how easy is it to get through to someone at your GP surgery on the phone?'	**Q3**
GPPS023	The percentage of respondents to the GP patient survey who were 'Very satisfied' or 'Fairly satisfied' with their GP practice opening hours	**Q25**

(Care Quality Commission, 2015)

Tbl 3: Indicators taken from the GPPS for inclusion in CQC Intelligent Monitoring, Oct 2021

Indicator ID	**Name**	**Question Number in GPPS**
GPPS26ii	**Healthcare professional listening to patients**	**Q25**
GPPS26iii	**Healthcare professional treating patients with care and concern**	**Q28**

GPPS29	**Confidence and trust in healthcare professional**	**Q28**
GPPS31	**Positive experience of GP practice**	**Q30**
GPPS28	**Being involved in decisions about care and treatment**	**Q27**
GPPS01	**Ease of getting through to GP practice**	**Q1**
GPPS22	**Overall experience of making an appointment**	**Q20**
GPPS08	**Patient satisfaction with GP practice appointment times**	**Q6**
GPPS15	**Satisfaction with appointment offered**	**Q15**

(Care Quality Commission, 2021)

The CQC holds the power to close a practice if it deems it to be below standard. Such a decision would be based on many factors, one of which might be the practice's GPPS scores, but including data from the GPPS in the new IM system, meant that practices suddenly had a reason to pay (more) attention to the GPPS.

The reception of the Intelligent Monitoring system by general practice is beyond the scope of this thesis, but it was not well received by some working in general practice who viewed it as yet another attempt by central government to use the 'stick' against general practice (McCartney, 2014). Responses to it echoed some of the feelings expressed by general practitioners to QOF when it was introduced in 2004 – namely that the government did not trust general practice and general practitioners. Once linked to the CQC's IM system, results from the GPPS became more significant to practices and thus were harder to ignore. Within the literature there has been debate about the relationship between the GPPS and the Intelligent Monitoring system. A paper by Tallet et al (2020) investigated the link between patient responses on the GPPS and CQC inspection of practices. Their research found that there were,

> "Limitations to the use of GPPS data for predictive analysis. This is a likely result of the majority of CQC inspections of GPs resulting in a 'Good' or

> ‘Outstanding’ rating. However, some GPPS questions were found to have value in identifying practices at higher risk of an ‘Inadequate’ or ‘Requires Improvement’ rating, and this may be valuable for surveillance purposes” (Tallett, 2020, p. 1).

The relationship of the GPPS to CQC inspections is beyond the scope of this thesis. It is, however, relevant to my research from the perspective of how general practice staff perceive the relationship. This perception may influence how they feel about the GPPS. It is of relevance to note that since the GPPS was taken out of QOF (2012) and handled by Ipsos MORI who subsequently hand the results directly to NHSE, there has been an ‘arm’s length’ relationship between general practices and the GPPS.

In the next section, I examine some of the key points to emerge from the literature review which began to draw attention to some of the problems (as authors saw it) with data from the GPPS being used to monitor and measure quality in primary care.

3.8 Does the General Practice Patient Survey really capture patient satisfaction?

One of the questions that the GPPS asked of patients was that they rate their overall satisfaction with their last visit to their practice (Q28 at the start of this thesis, later Q26). As explained earlier in chapter 1, patients can choose one of five options ranging from Very Satisfied to Very Dissatisfied. Patients may answer this question based on a visit that occurred up to 18 months previously. The delay in time between a patient’s last visit and their rating of it in the GPPS struck many in general practice as unfair. Some argued that practices were being judged on what a patient might (or might not) remember from a visit that may have occurred up to 18 months ago. To compound anger further, the GPPS data is anonymous, hence practice staff felt it was doubly unfair, as they had no way of knowing who the patient was and with whom they had consulted at their last visit. Those who took this view argued that the patient might have seen a locum who only worked at the practice temporarily. They also argued that some patients have difficult relationships with their general practices and might wish to express a grudge. These factors, amongst others, would bias the patient’s response to Q28/26 on the GPPS.

An important paper published by Salisbury et al (2010) critiqued the GPPS on the grounds that its results might provide misleading data. The authors set out to explore 'whether responses to questions in surveys of patients that purport to assess the performance of general practice doctors reflect differences between practices, doctors or the patient's themselves' (2010). They found that 'at least 79% of the variance on all measures occurred at the level of the patient, and patients' age, sex and ethnicity and housing and employment status explained some of this variation' (Salisbury et al., 2010). Salisbury et al's 2010 paper deftly illustrated the doubts that many frontline professionals held concerning GPPS and the way it captured data. For those who contested how reliable it was to ask a patient up to 18 months after a consultation how satisfied they were with their consultation, Salisbury et al's paper provided evidence for their case. Salisbury et al's work showed that a patient's response could be attributed to factors that had nothing to do with their consultation or patient experience.

3.9 Is there a causal relationship between the concepts of clinical quality and patient satisfaction?

This topic has been rightly investigated in the literature mainly from a quantitative perspective and lies beyond the scope of this thesis. Its relevance to my research lies in the theory that underpins the concept that patient satisfaction is linked to quality improvement, through the mechanism of public accountability, that of new public management theory. The operationalising of this mechanism is what is relevant to my study, in the form of QOF and the GPPS in English general practice and the impacts they have had on practice staff and patients.

The first literature review returned papers that critiqued the central tenet of new public management theory that holds that public accountability of a service will stimulate quality in the market. Translated to the world of English general practice and the QOF, this presumed link became the link between quality and patient satisfaction. The mechanism for improving quality is public accountability. A series of papers tackled the existence of such a link (Reeves & Seccombe, 2008).

One key paper, published in 2013 was authored by Llanwarne et al (2013). Llanwarne et al recognised that the two concepts of clinical quality and patient experience are used to evaluate generic quality in healthcare. Their research found

that although all the correlations between clinical quality summary scores (from the QOF) and the patient survey scores (from GPPS) were positive, 'most were statistically significant, the strength of the associations was weak" - the highest correlation coefficient was 0.18 while more than one-half were 0.11 or less. The authors argued that the weakest correlations were found between clinical quality and interpersonal aspects of care. They argued that these two concepts should be treated separately 'to give an overall assessment of medical care' (2013, p. 467).

Their work demonstrates the problem of assuming that the two concepts are linked causally, without investigating the strength of the link. It poses an immediate question, if the relationship between the two concepts is weak why has it received such a privileged position within policy circles?

3.10 What do patients want from general practice?

The critique of the GPPS and its methods of measuring and defining patient satisfaction prompted authors to focus on what patients want from their general practice. Patient satisfaction is relevant to my research question but does not form the focus of it. I will deal briefly with the key articles from this area of literature.

While not directly related to my research question, the matter of patient voice and experience is relevant because the research question seeks to investigate how the two tools have impacted upon patient and staff experience.

The importance of the patient's voice being heard during the consultation and its impact on health outcomes was identified from the literature review. If patients are not given time or feel able to voice their concerns during a consultation this may result in poorer health outcomes. Compliance with GP advice or medication adherence may be weakened as a result (Barry et al., 2000; Britten et al., 2004). Studies on what patients want from their general practice consultation routinely list the same factors: ease of access; continuity of care and opportunity to see preferred clinician (Paddison, 2015; Paddison, Abel, et al., 2015).

Patients are not particularly skilled at judging clinician capability (Tallett 2020). One paper demonstrated that amongst an older population (65yrs +), patients' judgements about the clinical quality of the care they had received were not good indications at predicting clinical quality when measured using technical measures (Rao et al., 2006). Coulter suggests that patients do not want to judge the clinical

skills of their health professional, they want to assume that when they visit a practice, the health professional has up to date and reliable knowledge (Coulter, 2005, 2010).

3.11 Relationship between patient feedback and practice development

The literature review returned a paper by Asprey et al (2013) which investigated how practice staff experienced the GPPS in relation to their practice. Their results found that practice staff did not act on the patient feedback data contained in the GPPS data. Reasons given by staff included querying its internal validity and reliability. Their paper brings attention to an assumption made in policy circles that was used to justify the creation and introduction of the GPPS into English general practice in 2006. The GPPS was supposed to lead to practice improvements aimed at increasing patient satisfaction via the mechanism of patient feedback.

For patient feedback to inform practice development, several assumptions were made by policy makers about the way feedback data might be employed by those for whom it is intended. First, an assumption that patient feedback (as collected by the GPPS) is accepted as valid by practice staff. Second, an assumption that once received, practice staff will act on the feedback and use it to inform practice development.

Asprey et al conducted interviews with GPs, nurses, and practice managers about their experiences of the GPPS in 2013. Their research found that the GPPS results were contested by the majority of those interviewed as being statistically reliable or valid. They found that respondents did not use the data to inform practice development around patient satisfaction. The authors highlight a distinction between a tool's objective and subjective validity. They argue that while the GPPS established its objective validity through transparency over its statistical methodology, the tool failed to establish any subjective validity amongst those who received it. The paper argues that "results are only useful if they are accepted as credible and appropriate by those for whom they are intended" (2013).

Asprey's paper discussed how linking aspects of the GPPS to the QOF (which linked it to financial incentives) heightened staff distrust of the data and made it less likely that practice management would use the data to enact changes. This touches on the topic of the use of financial incentives in organisations. Often the introduction of, and use of, financial incentives can have the opposite desired effect, leading to distrust

amongst those for whom they are supposed to incentivise (Bowles, 2016). This highlights the sensitivity required when using financial incentives when designing and implementing policy. The feelings of distrust appear to have been heightened when indicators from the GPPS were included in the CQC's Intelligent Monitoring assessments in 2014. Although as discussed earlier, the relationship between the GPPS and CQC Inspection visits is not strong and Allen et al demonstrate that IM ratings do not strongly relate to inspection ratings (Allen et al, 2019).

The relevance of this finding from the literature review to my study centres around how practices and staff understand and respond to the GPPS data. For example, does it affect the way they perform and think about their work?

3.12 The limitations of patient satisfaction and patient choice in relation to the GPPS

As well as providing feedback on patient experience to GP practices, the GPPS aimed to provide patients with statistically robust data so they could make an informed choice about which general practice to register with (http://www.gp-patient.co.uk/learn). As the Asprey (2013) paper demonstrated assumptions were made about how practice staff would respond to, and act on, the GPPS data, assumptions were also made about how patients access and act upon service performance data. In order for patients to use the GPPS they need to be first aware of it and understand how to use it. Suddaby & Viale (2011) noted that,

> "professions disseminate new standards of performance and behaviour, which appear to be in the public interest but in formats that tend only to be understood by professionals."

The concept of patient satisfaction is relevant to this investigation. The literature review identified that there is a lack of definition of the concept (Williams, 1994; Speight, 2005; Turris, 2005; Ng & Luk, 2019; Anufriyeva et al 2021). Williams noted in 1994 that the concept of consumer satisfaction and attempts to measure it were increasing across society. He linked this to the increasing interest in patient satisfaction and ways to measure or capture it. Williams argued that if measurement were to be effective, a definition of the concept was necessary which was, in his opinion, lacking. Speight (2005) noted the proliferation of surveys and tools to measure patient satisfaction the field suffered from a lack of definition of the concept and what it meant to patients and staff.

Turris (2005) critiqued the concept from a feminist viewpoint and argued that without a “deeper understanding of the values and beliefs that informs our approach to researching patient satisfaction, researchers will be reacting to the most obvious indicators”. This would result in a failure to understand the issues that form individual experiences of healthcare. Turris (2005) argued that the “concept of patient satisfaction [had] roots in the consumer movement of the 1960s”. Ng & Luk (2019) argued that in 2019, there remained a lack of a formal definition of the concept of patient satisfaction. Anufriyeva et al (2021) conducted a systematic review of papers published since 2008 investigating the concept of patient satisfaction. They concluded that there remained a need for the development of a unified standard toward satisfaction measurement and that once developed a combination of tools to measure patient satisfaction should be conducted routinely.

Others have argued that the focus on the clinical encounter between patient and doctor is too narrow if we are to understand the concept fully. Bleich (2009) investigated the World Health Survey (2003) conducted across 21 European countries to answer the question of “what determines people’s satisfaction with the health care system above and beyond their experience as patients?”. Bleich argued that “people’s satisfaction with the health system depends more on factors external to the health system than on the experience of care as a patient”. Bleich’s analysis only accounted for 17.5% of the observed variation in satisfaction with the health care system. They suggested that other factors could account for the remaining variation. “However, based on the results of previous research, we strongly believe that factors like the portrayal of the health-care system by the media, the discussion of the system by political leaders, or even national events, such as war or the performance of national football teams, may be partly responsible for the remaining variation in satisfaction with the health-care system”.

These papers demonstrate that the lack of definition of the concept of patient satisfaction persists despite being noted in 1994 (Williams). Perhaps resulting from the lack of definition is the proliferation of surveys and questionnaires attempting to measure the concept. These results from the literature review are relevant to my research because they provide a long view of the context into which the GPPS was introduced as one more attempt to measure patient satisfaction.

Some of the papers discussed above noted the link between the rise in the concept of consumer satisfaction and the concept of patient satisfaction (Turvis, 2005) and (Speight, 2005). This draws our attention to the topic of the construction of the concept of patient satisfaction in the context of NPM policies that were being introduced in the UK from the 1980s onwards. The concept of patient satisfaction is relevant to discussions of NPM polices in healthcare because it links to the concept of patient choice.

Several authors have examined the rise of the concept of patient choice in policy outputs which increased under the Blair Administration in 2005, with the introduction of the Choose and Book policy (DH, 2005) and the introduction of Foundation Trusts.

The literature review returned several articles which focussed on the introduction of the Choose and Book initiative, introduced in 2005 under the Blair Administration. Choose and Book was a policy that allowed GP patients to decide (in consultation with their GP) their choice of secondary care provider. Several authors examined the concept of patient choice via this policy (Rosen et al, 2006; Warwick , 2007). Warwick (2007) argued that the initiative would not deliver any lasting change to patient choice because the choice of secondary care providers is limited by the local healthcare landscape, so choice in this instance would still be limited.

While the literature on the impacts of the Choose and Book initiative discussed the concept of patient choice, it was not directly relevant to my investigation as it focussed on the transition from primary to secondary care. My research focus remains on the earlier process of *if* patients feel they can exercise choice when choosing their general practice.

The literature review returned several papers examining patient choice in primary care, from the perspective of what is important to patients when selecting a practice (Rubin et al, 2006; Tan et al, 2015). Rubin et al (2006) investigated patient preferences when making a GP appointment. Adults at 6 GP practices in Sunderland were asked to complete a questionnaire. They found that speed of access was only relevant if booking an appointment for a child, while others would rather wait to see their preferred GP. People in employment would wait up to one day to see a preferred GP, while those with a long-standing illness would wait up to seven times longer to see their preferred GP. The authors concluded that policies that focus on

speed of appointment time, may not deliver increased patient satisfaction. The argued that for many, speed of access to appointment was outweighed by choice of GP and time and convenience of appointment time. This contrasts with much of the structural reform around patient choice, which focussed on delivering speed of access to GP appointments. Rubin et al's work is relevant to my research because it highlights the potential for a disconnect between what patients want and the focus of policies purporting to deliver patient choice.

Examining the concept of patient choice from a broader, structural analysis can be useful to understanding why patient choice has not been delivered in a standardised way across the country. Exworthy and Frosini (2008) argued that policies seeking to deliver patient choice were curtailed and restricted in its impacts by decentralisation policies, also being implemented at this time. The authors argued that,

> "the goal of these policies [patient choice and the introduction of Foundation Trusts] appears to be to stimulate self-sustaining incentives to continuous organisational reform and performance improvement through creating a pluralist model of local provision" (2008).

The authors argue that the local health landscape affects how much patient choice can be delivered. One of the factors that impacted on the delivery of patient choice in the early 2000s was the capacity within the local health landscape. The authors located the root of this in the decentralisation policies also being implemented at the time. They argued that decentralisation had been analysed from a a vertical dimension of the transfer of powers from central government to local organisations. They argued in their 2008 paper that the horizontal impacts of decentralisation on health landscapes had been neglected. They argued for attention to be placed on how local organisations and individuals exercised their power away from higher authorities and (re)organised within and between themselves. The Exworthy and Frosini (2008) paper is relevant to my research because it calls for attention at the micro level of the horizontal impacts of decentralisation on organisations in the local health landscape. This is useful to my research which seeks to take analysis to the practice level and investigate interactions within teams and with patients.

Peckham and Sanderson (2011) also investigated the impacts of decentralisation policies on the delivery of patient choice across England, Wales and Scotland. They

begin by noting the multiple meanings of the concept of *choice*. Like Exworthy and Frosini (2008) they note the link between the concept of patient choice and a focus on consumerism to deliver improved quality and choice in health care services. Peckham and Sanderson (2011) argued that,

> "In recent years, particularly during the time of the New Labour government post 1997, the development of UK policy across health, education and social care has been marked by a focus on consumerism as the route to modernisation of public services." (p.220)

The authors compared the different approaches governments in Wales, Scotland and England had taken to implementing decentralisation policies regarding patient choice. They found that England had focussed on individual choice in relation to choice of provider, while Scotland and Wales had focussed on a need to engage patients and public to improve services and performance through strengthening voice mechanisms. This conclusion echoed previous findings by Hughes et al (2009) who investigated the Welsh government's focus on facilitation of voice mechanisms for patient involvement in delivering improvement and choice.

The papers discussed above are relevant to my research because they demonstrate the significance that contextual factors can have on policy implementation and delivery. While the papers focus on national contextual differences, my research will use this insight to investigate practice level contextual differences and how these might impact on how patients experience choice of practice.

3.13 Defining concepts of measurement

Central to the criticisms levelled at the GPPS (Asprey et al., 2013) were arguments about the construction of the concept of patient satisfaction defined by Q28 in the GPPS. Areas of critique included questioning how reliable comparisons were between healthcare organisations (Lyratzopoulos et al., 2011; Roland et al., 2009b): how patients with psychological problems fared (Abel et al., 2011) through to questioning whether the GPPS results should be adjusted for case-mix (Paddison et al., 2012) and how ethnicity affected responses (Lyratzopoulos et al., 2012).

The litany of critiques aimed at the GPPS outlines a growing scepticism of official data recording patient satisfaction (Edwards., White., Elwyn et al., 2011) and consequently a disengagement with the data (Asprey et al., 2013). Distrust of the

GPPS amongst practice staff contrasts with their attitude to the validity of the QOF data. While not always popular with practice staff, the reliability and validity of the QOF data was not questioned by practice staff. Discussions were had over which indicators QOF should measure, but its statistical validity was accepted. It becomes even more interesting to consider why then, the GPPS data was not afforded the same level of acceptance by practice staff.

One explanation may lie in the issue of GP authority and control. The QOF data and subsequent achievement points reside (arguably) within the control of the practice team. If the practice wishes to invest staff time and resources in achieving maximum QOF points, then they can redirect resources in an effort to achieve this. The GPPS (it could be argued) transfers control to the patients. It is up to the patients to rate the practice. Aside from delivering care to its patients, the practice plays no role in the administration, data collection or analysis of the GPPS. Criticisms follow from practice staff around details, such as how far in the past patients are allowed to rate consultations (see above), but one essential difference between the QOF and the GPPS is a matter of control over the data and who holds it. Practices are more in control of the QOF data because they see it daily and can monitor progress against the targets. Reaching the targets is within the practice's control (in as much as is reasonable). Practices will also be aware of how they are performing against the QOF targets throughout the year. In contrast, the GPPS data is administered and analysed independently by market research organisation, Ipsos MORI. Practices receive their scores from the GPPS from NHSE. The process of performance against the GPPS indicators and receiving their practice score from the GPPS is handled externally to the practice. Thus, unlike the QOF, practice staff have a different relationship with the GPPS.

3.14 The Friends and Family Test

In 2013, the coalition government led by Cameron introduced the Friends and Families Test (FFT). In 2015 it was made compulsory for every general practice to offer it (https://www.nhs.uk/using-the-nhs/about-the-nhs/friends-and-family-test-fft/). While this thesis does not include the FFT in its scope, the FFT has received criticism among the academic literature (Bacon, 2014; Iacobucci, 2013; King et al., 2013; Kmietowicz, 2014). The selling point of the FFT is its offer of immediate

feedback. This stands in direct contrast to the GPPS, with its potential for feedback given about appointments up to 18 months previously.

The FFT is not welcomed by all practice staff. One study demonstrated how practice staff (GPs and practice managers) found its single question format unreliable and were hesitant to use it due to concerns about bias and the lack of a representative sample when they were aware that in some regions of the country, lots of people did not have a choice of practice (Manacorda et al., 2017). Experiences of the FFT may vary when interviewing practice staff other than GPs and practice managers.

The definitions of concepts such as quality and patient satisfaction have received plenty of research attention in the literature. My interest in the topic centres around how staff receive the concepts as used in the QOF and the GPPS. If staff do not give them credence, then my interest lies in how this affects how they perform their jobs.

4. Summary

The literature reviews provided a useful scoping of the main themes surrounding my research question. The literature review identified gaps in the literature.

The gap most relevant to my research question and the one I wish to pursue going forward is the understanding the whole-practice experience of the QOF and the GPPS. The literature review identified several papers which have sought to address this topic and this thesis will seek to build on them. A whole practice approach would seek to include staff from all roles within a general practice. Such a sampling approach could deliver findings that reflect the reality of modern general practice which lies in its multi-disciplinary composition. Without the inclusion of a broader range of roles within general practice, the literature risks becoming out of touch in its reflection of modern general practice in England.

There were few articles returned by the literature review evidencing the patient view/experience of the QOF and the GPPS. There are valid reasons for this including the fact that both tools are aimed at practice staff rather than patients, but I remain interested in how the tools have affected the whole practice experience so I will be looking to include patient experiences of the tools in my research. Linked to the patient experience of QOF is the topic of consent. This involves patients being made fully aware of the financial implications of QOF for their practice. This is a topic that was pursued in interviews when appropriate.

The theme of workforce stratification identified by Grant et al (2009) and Charles-Jones et al (2003) feels important to my research question. Related to this theme is the topic of whether general practice has moved towards a more biomedical model as experienced by patients and staff.

A further gap in the literature queried whether staff satisfaction was related to patient satisfaction. This links into the theme of staff stress and burnout described in the literature. It was also explored in fieldwork interviews when appropriate.

In relation to the GPPS, the literature review identified an area first investigated by Llanwarne - that of the relationship between the concepts of quality and patient satisfaction. My research intends to take Llanwarne et al's work beyond quantitative analysis and into qualitative fieldwork. This will enable findings that will help better understand how staff and patients conceive of these concepts in a world where QOF has been operational for over 10 years (at the time of fieldwork).

A further area that I will explore in my fieldwork in relation to the GPPS will be trying to understand how patients in my fieldwork understand the GPPS and how (or indeed, if) they use it when deciding which general practice with which to register.

The literature review returned papers which identified the problems of defining the concepts of patient satisfaction and patient choice. These two concepts are relevant to my thesis because they both relate to the patient's experience of their practice and the process of choosing (if indeed that is the appropriate word) a general practice with which to register. I will include these topics in my fieldwork with patients and staff.

Chapter 4 Theory

4.1 Introduction

This chapter presents an overview of theories that will inform the analysis of my fieldwork research. In this chapter I introduce the analytical framework I will use as a theoretical lens through which to analyse my fieldwork. The chapter then moves on to present some of the key theoretical discussions relevant to the research question. The chapter concludes with some thoughts about how the analytical framework I have chosen will take the analysis to a certain point, beyond which I may have to draw on other theories which are presented in this chapter.

4.2 Choosing a theoretical lens: Shore & Wright's Analytical Framework

Shore & Wright published a paper in 2015 titled 'Audit Culture Revisited'. They conducted their analysis at a global macroeconomic level and followed the Big Four accountancy firms (Deloitte, Price Waterhouse Coopers, Ernst & Young and KPMG (Shore & Wright, 2015, p. 426). In the paper, they introduced several key points alongside their definition of what they identify as 'audit culture',

> "the widespread proliferation of (these) calculative rationalities of modern financial accounting and their effects on individuals and organisations that we call 'audit culture'." (2015, p. 412).

The paper introduced their analytical framework which, they argued, captured the five effects of audit culture at a macro-economic level. It is this analytical framework that I propose to use as my theoretical lens when investigating the effects that QOF and the GPPS have had on UK general practice since their introductions in 2004 and 2006 respectively. I have chosen to do this because I view the QOF and the GPPS as forms of audit. They seek to measure performance ('quality' and 'patient satisfaction') and make the results public. Through this mechanism general practices and their staff are held to account by the state, the public, colleagues, and managers. I argue that the QOF and the GPPS constitute forms of audit and I propose to use Shore & Wright's Analytical Framework to approach my fieldwork and analyse findings from it.

This next section takes some time to introduce and explore in detail the analytical framework developed in the 2015 paper.

Shore & Wright grouped the effects of audit culture into five categories. These are “domaining”, “classificatory”, “individualising and totalising”, “governance” and “perverse” effects (2015, pp. 425–426). This chapter will outline the five effects identified by Shore and Wright in their 2015 paper. A further section will consider how they might, or might not, relate to my research.

The first effect Shore and Wright identify as an effect of ‘audit culture’ is the *domaining* effect. They write that domaining effects,

> “illustrate how the introduction of audit and ranking into a new organizational context radically reshapes that environment in ways that mirror the values and priorities embedded within the audit technologies themselves.” (2015, p. 425)

The domaining effect can be seen in situations when audit practices are introduced into an organisation for which it was never intended (for example the public sector) and it reproduces itself. Power, writing earlier, identified the same effect when examining the historical context of the audit tool. He suggested that when audit ‘breaks its boundaries’ for example, when audits beget audits to monitor the original audit, he termed it the ‘audit explosion.’ Audits create their own mini-audits to monitor the overall audit and so on, and so on. This is what Shore & Wright meant when they referred to audit’s ability to produce a ‘runaway effect’ (2015, p. 425).

The second group of effects identified by Shore and Wright are the *classificatory* effects. These effects “highlight the fact that indicators and statistics are never neutral” (2015, p. 426). This group of effects illustrates the highly political process of knowledge creation. Questions such as which activities are measured by targets, which are not, what data is chosen to represent the ‘official’ (and therefore only) way to measure progress - are all political decisions and are never value-free. Who gets to make them, who gets to measure 'progress’ and who gets to decide whether accountability has been given is also a political process? This group of effects draws our attention to the Foucauldian inspired observation that the appearance of political neutrality is often an indication that power and political processes are in operation (Shore & Wright, 2015, p. 421).

The third group of effects titled *individualising and totalising* refers to the way that once these classifications and rankings have been introduced into an organisation, they re-order “both whole populations and individuals” in the way that everyone and

the whole organisation is repurposed to deliver the target(s). Shore & Wright write that,

> "Key to the success of this process is the neat, simple and efficient way in which it achieves its effectiveness – at minimal cost and effort to the organisation," (2015, p. 426).

In their 2015 paper, they give an example of this effect in action. Shore & Wright argue that when the international standing of universities was turned into performance rankings, it had effects at three levels. Firstly, it transformed the whole higher education sector as it placed them all in competition with each other. Secondly, each higher education institution refocused itself on achieving the targets. Lastly, every individual in each institution is impelled to deliver the target or concentrate on 'what counts' (2015, p. 426).

Governance effects form the fourth category in the analytical framework of Shore & Wright. They argue that audit culture brings with it a new form of moral accountability. One that has coercive tendencies. They argue that such coercion can be seen in the way that audit dictates that "organizations must represent themselves in terms of the narrow, predetermined script of expert assessors," (2015, p. 426). Elsewhere Strathern (2000b) refers to this as the "tyranny of transparency,". Shore & Wright also argue that these methods of 'opening up' organisations for scrutiny and inspection, is a way of extending the presence of the state, also referred to by Mitchell (2018) as the 'state effect'.

The final category in the analytical framework is that of *perverse* effects. Shore & Wright argue that this category applies to what happens when 'governing by numbers' is taken to extremes and may result in 'decision making that is amoral or outcomes that are immoral" (2015, p. 426). They argue that an example of a perverse effect of audit culture is the increased stress and pressure that staff find themselves under to deliver the targets.

While their framework is not a perfect fit with my research question - for example, it is aimed at a macro-economic analysis of the audit effects of the big five accountancy firms - it represents the only framework I have found that attempts to understand the effects of audit culture in one place and within one analytical model. As such, it offers an opportunity to test any themes that might come from my

fieldwork against the framework. It will allow me to see if any of the themes from my fieldwork fit their framework. Of equal interest will include themes that do not fit into one of the five categories identified by the framework accompanied by questions of why they do not fit and what this might tell us about the field of study my thesis investigates.

I will use Shore & Wright's (2015) analytical framework as a tool to think about my research as analysis proceeds. It will prove useful in the early days of analysis and will help to order findings in the initial messy stages of data analysis and collection (Geertz, 1994). Once fieldwork has begun, the framework will be useful to compare themes as they emerge from the data and to think about how to categorise them. For example, do they fit into Shore & Wright's framework? Their analytical framework offers the best path with which to begin my analysis. Beyond that, I will use the other theorists detailed in this chapter to enable me to better interpret any findings that do not fit the framework. It is the aim of the research question to analyse the effects of audit culture in English general practice. Those themes which do not fit Shore & Wright's 2015 framework may reveal something specific about how QOF and GPPS have impacted staff and patient experiences in UK general practice. Differences between my findings of the effects of audit culture and those of Shore & Wright will be interpreted with reference to their global macro-economic gaze in contrast to my focus on local, small-scale organisations. Differences in the findings may point to things that are unique about UK general practice.

In summary, I will proceed with data collection and will employ Shore & Wright's analytical framework to categorise and analyse the findings. I anticipate that it will prove invaluable in the early stages of data analysis. If analysis reaches the point where the framework no longer speaks to my data, I will use the theories discussed below to arrive at an interpretation of my fieldwork. I intend to use a multi-disciplinary approach to the theoretical literature to give myself the best chance of interpreting the data as fully and sensitively as possible.

4.3 Theoretical perspectives on audit culture

4.3.1 Relevance of social anthropology

I approached the search for a theoretical fit for my research question by thinking about what I wanted to find out. I wanted to investigate how a policy change directly

affecting general practice in the UK by central government had been actioned, interpreted and performed by those working in general practice. I was also interested in how patients understood and experienced these changes as recipients of primary care services. I was interested in cultures and how they, and the people living them, evolve and adapt in response to change. I have a social anthropological background. Social anthropology is a discipline which is founded on attempts to understand cultures and those who live them from their perspective(s). As such I found it a good starting point from which to begin my search for a theory that would help me understand and interpret change in UK general practice culture resulting from the introduction of QOF and GPPS.

I began by scanning the theoretical literature for theories that I thought would be most helpful in attempting to answer my research question. I particularly wanted to begin the process of understanding all staff experiences on how working lives have been affected by QOF and the GPPS. To do so, I turned to social anthropology.

Social anthropology was built on the methods of participant observation. The slice of social anthropology from which I have borrowed most for this doctoral research centres on the discipline's insistence that the researcher must try to capture all participant experiences if they are to attempt an accurate portrayal of the fieldwork. This remains the case even when asking questions about topics, or of individuals, who may seem irrelevant to the research question. For example, a researcher wanting to learn about male initiation rites amongst the Merina of Madagascar in the early 19th century would do well to also enquire about female initiation rites if they are to gain a full understanding of the way that Merina culture understands, actions, and performs the transition from childhood to adulthood (Bloch, 1986).

I applied this approach to my research by interpreting it to mean that to gain the best understanding possible of how QOF and GPPS have affected staff and patient experiences of general practice, I would need to interview staff from all job roles in the practice. I would also need to include as many patients as possible to better understand their experiences of receiving primary care delivered in the context of QOF and GPPS. My approach is explained in more detail in the Methods chapter which follows.

4.3.2 Work environment as work culture

Social anthropology investigates cultures, including those who live and create them. An anthropologist would view a working environment as a culture. This is because it is a pattern of behaviours practised and shared by a certain population (Strathern, 1997). A work environment is a culture and is relevant to an anthropological inspired investigation into how that culture might adapt in response to the introduction of new factors. Routines develop and individuals adjust behaviours to accommodate the aims of the organisation. My research aims to investigate how organisational change (in response to the QOF and the GPPS) impacts on the culture of four case study general practice sites in the UK, through the experiences of staff and patients.

4.4 Concepts from the theoretical literature on audit

During the search of the theoretical literature on audit culture several concepts relevant to my research were identified which will be discussed in this section. Each concept will be presented along with the main authors who have written in this field.

4.4.1 Coercive accountability - A new form of ethics?

Looking for theoretical critical analysis of new cultures in social anthropology (using search criteria described in the previous chapter) I came across a volume of edited essays on audit culture (Strathern, 2000c). The essays focus on the effects of the introduction of audit culture and performance targets into higher education in the 1990s and the resultant effects this produced. Many of the points made and arguments constructed are relevant to my research, 20 years later, and the context of UK general practice in the early 2000s.

Strathern was among the first to identify the new forms of accountability as a form of power using an anthropological perspective. She argued that the concept of accountability in the context of new public management models, should be understood as a cultural shift in how we think about public institutions and their role in society. While there was a burgeoning literature about the effects of indicators and measurements in the public sector (Faucett, 1994) there was not a great deal that analysed the changes in the context of English general practice from a cultural anthropological perspective. Strathern argued that these new forms of accountability should be viewed as culture ‘on the make’ and argued that,

> "That there is culture on the make here is evident from the concomitant emergence, and dominance, of what are deemed acceptable forms. Only certain social practices take a form which will convince, one which will persuade those to whom accountability is to be rendered – whether it is the government or the taxpayer/public - that accountability has indeed been rendered. Only certain operations will count. Hence, as far as higher education is concerned, some rather specific procedures have come to carry the stamp of accountability, notably assessments which are likened to audit." (Strathern, 2000b)

Several authors from the theoretical literature (Douglas, 1992; Power, 1997b, 2004) identify that a result of imposing targets on professions has been to make those involved feel coerced into giving account, or a justification of their activity. Strathern notes that a consequence of the growing popularity of the concept of accountability during the mid to late 1980s and early 1990s has been that it is very difficult to resist. Accountability is a popular notion which seems, at first glance, to be a value-free and neutral concept. As such, Strathern argues that it is almost impossible to refuse to participate in something which states its aims as making institutions open to scrutiny. It is framed as a democratising project - one in which, previously closed institutions are forced to present themselves and a narrative, to the public or regulatory bodies. Strathern argues that the concept of accountability quickly becomes coercive and refers to this as 'the tyranny of transparency',

> "The practices in question bear on academics in their everyday lives. They thus have direct consequences, and in the view of many, dire ones, for intellectual production. Yet as an instrument of accountability, holding out the possibilities of a globalizing professional consensus, audit is almost impossible to criticise in principle – after all, it advances ideals that academics generally hold dear, such as responsibility, openness about outcomes and widening of access." (2000b, p. 3)

The effects of coercive accountability on the workforce emerged as a theme several times in the literature review (Hall, 2019; Vahey et al., 2004). Strathern invites us to view the concept of coercive accountability using a critical theory lens which places the issue firmly within the context of the new public management (NPM) literature,

examining as it does, power relations between the state, its employees/contractors, and the public gaze.

4.4.2 Self-Regulation

Linked to the notion of being monitored and coercive accountability is the Foucauldian concept of self-regulation (Foucault et al., 1988; Giddens, 1991). Foucault's, Discipline and Punish argued that the modern state had to transfer its aim of controlling citizens via their physical bodies to controlling them through social rules and self-regulation to produce docile, compliant bodies (Foucault, 1995). Using Bentham's Panopticon model of the Victorian prison as a metaphor for state control, Foucault argued that through the possibility of constant surveillance, prisoners in the Panopticon would be forced to instil what he termed self-regulation. Prisoners in the Panopticon prison model would not know when they were being observed/monitored by the prison guards, hence it was in their interests to always display socially sanctioned behaviour. Foucault argued, that over time, prisoners in the Panopticon would learn to curb or adapt their behaviour to fit the social norms of the prison. This is what Foucault meant when he used the term self-regulation. It could be argued that it is an aim of the modern state to exact socially sanctioned behaviour from its citizens, with the least amount of effort. Foucault argued that the modern state (in contrast to a feudal state which was geographically smaller in which it was impossible to monitor everyone's behaviour) needed to instil a system of social control that would be effective on a mass scale, in the most efficient manner. Some theorists who take a Foucauldian perspective argue that new public management with its emphasis on measuring and quantifying, represents a way to achieve control and efficiency on a mass scale. Shore & Wright argue that the imposition of performance targets "encourage(s) people to think of themselves as calculating, responsible, self-managing subjects"(2015, p. 421). The constant monitoring demanded by those carrying out incentive-based work speaks to Foucault's concept of self-regulation. Strathern and other theorists whose analysis has taken a view of accountability culture as being characterised by coercion, speaks directly to the Foucauldian concept of self-regulation and how it plays its role in a political project which aims to increase the reach of the state while simultaneously appearing to reduce its role. If citizens self-regulate then the state can move from its role of provider of services to one of regulator of said services (Pollock & Price, 2012b).

I am interested in this notion and how it might apply to general practice staff. For example, will staff who have delivered QOF since 2004 have become so conditioned to working in a QOFable way that they do it now without thinking? After more than 10 plus years of QOF, will it have become so ingrained in staff routines that they now cannot imagine working without it? Results from the literature review indicate that QOF and the GPPS are extremely unpopular with practice staff. Yet if Foucault's concept of self-regulation and self-governance is correct, fieldwork may reveal that QOF and the GPPS have become so ingrained, or are now performed as second nature, to practice staff that they could not imagine doing their jobs without QOF or GPPS. The concept of 'power at a distance' (Rose & Miller, 2010) and Foucault's self-regulation may be useful when analysing the fieldwork interviews. It is possible that one result of using a more inclusive sampling method than those used by research articles in the literature review, is that fieldwork might reveal different staff views of QOF and the GPPS than are currently represented in the literature.

4.4.4 Power at a distance

Mary Douglas, a social anthropologist noted that we only check when we mistrust (Douglas, 1983). Power notes that it is through the concepts of account giving and checking,

> 'that the fabric of normal human exchange is sustained. These accounts only become objects of explicit checking in situations of doubt, conflict, mistrust, and danger. Only then do we check restaurant bills carefully, make sure that children have put on their car seat belts." (Power, 1997a, p. 1)

Power continues to note that it is 'Trust that releases us from the need for checking" (1997b, p. 1). The concepts of trust and checking can also be linked to Foucault's notion of self-regulation. Strathern commented that Douglas' point highlights the more sinister side to habits of checking and account giving.

> "Checking up on people can thus carry sinister overtones. But some governments (and the UK is an example) have discovered that if they make explicit the practices whereby people check themselves, they can ostensibly withdraw to the position of simply checking the resultant indicators of performance. Their intervention has already taken place: in the social adjustment which corporations, public bodies and individual persons have

> already made to those self-checking practices now described as evidence of their accountability to the state." (2000c)

This highlights the political role that apparent routine or administrative changes can have on individual lives. What appears to be apolitical, for example, a simple change in an administrative form concerning how data is collected, may conceal complex power relations. A Foucauldian theoretical lens would have us consider that power lies in making something appear apolitical (Foucault, 1995) Shore & Wright argue that the discipline of social anthropology has,

> "recognised that seemingly mundane routines often have the most profound impacts on the manner in which people are governed. Whether it is awarding smileys for customer satisfaction for the cleanliness of airport toilets, collecting points to win the Walmart Employee of the Month certificate ...enumeration and classification lie at the heart of such everyday forms of management." (2015)

This links to Strathern's commentary that the new politics of accountability is dressed in the language of common sense and values that most people would not or could not find fault with, for example, the principles of openness and transparency. As Strathern and Foucault bring to our attention, behind the seemingly good intentions, there may lie more sinister intentions. Some characterise these effects as the unintended consequences of the explosion of the tool of audit into the public sectors (Gubb, 2009; Lester et al., 2011; Morgan, 2014; Weyer et al., 2008).

4.4.5 Accountability

Strathern highlights the key role that the notion of 'accountability' plays in the transformation of institutions adopting new public management techniques (2000c). Institutions, and individuals had to adjust to a new form of control that ensured they had to account for their actions. Making institutions accountable for their actions (and any public money received) and in turn, making that information public is central to the NPM project. While NPM is associated, correctly, with the Thatcher administrations, it was the Major government that took the first steps in implementing it into public life in the UK (Mullen, 2006). The concept of accountability became a popular tool with the public, promising to force previously 'closed' institutions and organizations to open up and give account of themselves and their performance. It

had a populist element to it and was framed (by the Major and Thatcher administrations) as a way for the taxpaying public to hold large institutions to account, in what was framed as a democratising project.

Writing in the context of change in higher education in the 1990s, Strathern argued that the consequences of such a coercive turn of events included not just individual academics justifying themselves and their research output, but of the whole institution, which was forced to deliver an account of their performance over the past three years. Strathern recognised that the act of choosing to make something visible is necessarily accompanied by choices about what is rendered invisible (2000).

4.5 Choosing what to measure

Central to Shore & Wright's (2015) paper is the concept of the power that lies behind the selection of what is measured. This is linked to their concept of 'perverse' outcomes, which might be interpreted to mean that performance measures may miss important aspects of work. Hippisley-Cox et al (2007) wrote about how following the NPM drive to measure and deliver accountability, might result in 'missing the wood for the trees' in the context of English general practice. They argued that the QOFs focus on clinical outcomes did not account for the 'soft' work that GPs performed in every patient interaction. This has recently been echoed by Heath (2021) who argued that British general practice has been over measured, and needs to be allowed to 'rewild'. Heath (2021) argues that we should 'resist the temptation to measure'.

4.6 Professions and deprofessionalisation

Central to the discussion of new public management literature is the topic of professions. Most relevant to any discussion of the medical profession is Freidson's The Profession of Medicine (1970). Freidson's contributions to the sociology of professions has been categorised into three major contributions by Brint (1993). Firstly, he argued that Freidson introduced a new concept of professions rooted in the social organisation of occupational labour markets. This differed from previous attempts to define what made professions different to occupations that had previously been made in the sociological literature. There had been much debate over how to define a profession. One approach had been to identify a series of distinctive traits that would define a profession. However, there was no consensus about what those traits were. The second approach argued that a historical approach

identifying occupations undergoing a process of professionalisation should be used. The third approach to the problem of definition argued that in the face of no consensus on traits – the usage of the term should be employed. The nominalists argued that investigation should centre around how society used and employed the term at a given time. This phenomenological approach argued that the term professions should be investigated as a folk category.

Freidson did not adhere to any of the three approaches outlined briefly above. He took issue with the ideal that professionals were defined by their devotion to the public good and the ideal of public service. He argued that the ideals of control over examinations and ethical standards were 'useful fictions protecting the autonomous sphere of action of licensed practitioners' - (1993, p.262). He also argued that any definition based on the process of professionalisation was meaningless because the end point of the process was still not defined. He was more sympathetic to the phenomenological approach of investigating defining it as a folk category. Brint writes that,

> "In Freidson's view, nothing precludes the simultaneous treatment of professions as a folk category and as a real (or analytically identifiable) form of social organisation." (1993, p.262).

For Freidson professions are formed in response to labour market organisation. Freidson defined professions as,

> "those occupations exercising the capacity to create exclusive shelters in the labour market for accepted practitioners through the monopolisation of educational training and credentials required for the attainment of economic opportunities in the market." (Brint 1993, p. 262).

Thus, for Freidson the essential characteristics of a profession centre around 'a link between tasks for which a demonstrable market demand exists, training provided by the educational system for the performance of those tasks, and privileged access of trained workers to the market for the demanded tasks' (Brint 1993, p.262). Such a definition relies heavily on the higher education sector to produce the professionals to meet the labour market need. It is this attainment which provides one of the essential characteristics of professions. Freidson wrote,

> "Professions are those occupations that have in common credentials testifying to some degree of higher education and that are prerequisites for holding jobs. Higher education presupposes exposure to a body of formal knowledge, a body of professional discipline." (1985, p.xii).

Freidson did not consider regulatory bodies or professional associations to be professions. For Freidson, the defining characteristic of a profession is its link to the higher education establishment. It is therefore crucial that 'a plausible case be made that advanced training is required for the competent performance of the tasks in question' (Brint, 1993, p. 262).

This point is crucial to my research. Reactions to the QOF amongst most GP partners interviewed in papers returned in the literature review were (almost) consistently negative. Most of the negative reactions centred around comments that QOF was akin to 'telling us how to do our jobs' or 'GPing by numbers' (Lipman, 2006). Using Freidson's analysis of the essential defining characteristics of professions, it becomes possible to understand just how challenging a proposal, such as QOF, is to clinical professionals. The suggestion that their role could be reduced to a tick-box exercise threatens the status of their professionalism. This may explain in some part why QOF evoked such strong reactions amongst clinicians. If their access to power and control rests on admission to the profession requiring a degree – then being told by central government how to do your job via a spreadsheet may be experienced as a challenge to their professional autonomy. While Freidson argued that a defining characteristic of professions is its link with higher education, he also understood the key role and function that professional bodies fulfilled. He argued that they played a role in credentialling the licensing of professionals. Brint writes that Friedson's analysis demonstrated how the "organised professions reproduce themselves through their privileged influence over the credentialling system" (1993, p.264).

Brint argues that the second contribution that Freidson made to the contribution of the sociology of professions was through his analysis of the spheres of professional control that result from knowledge monopolies and gatekeeping. Friedson is clear in his argument that these powers (as he identified them) - knowledge monopolies and gatekeeping – are a consequence of the 'market shelters' professions enjoy in the

labour market (1985). As well as identifying powers that professions enjoyed in the structure of the labour market, Freidson also identified what he called countervailing pressures that served to curtail some of the powers the professions enjoyed. Both points are relevant to my research, and I will discuss both in the next section.

Knowledge monopolies, Brint suggests, allow professions to enjoy perhaps the most fundamental power – that of control over how their work is accomplished. Brint writes,

> 'This control over work, or technical autonomy, is the most fundamental and widespread power of professionals. Technical autonomy creates a sphere of activity in which the individual worker, not the organised hierarchy, is sovereign under normal conditions." (1993, p.266).

The power to choose how to perform your role is a privilege afforded to professions only. Within the medical profession, general practice is unique in this area. It is the only area of medicine where doctors are generally alone with their patients and able to make decisions about their patients, without consultation with colleagues, if they so wish. Against this context, it is clear to see how for some GPs, QOF would have felt like an intrusion into their professional domain. Crucially, Brint argues that the power to control how you do your job is a privilege that distinguishes professionals from the proletariat and the bureaucrats. QOF, with its templates that offer step by step guides on how to diagnose and treat patients during a general practice consultation not only appears to threaten such professional expertise but also threatens to take away the thing that separates them from the proletariat and the bureaucrats.

Knowledge monopolies also afford professional bodies the privilege of securing a vital role in any performance-setting activities. Academic elites within the professions prescribe standards or norms to which practitioners are subject. Freidson argued that this power – to play a leading role in setting standards and norms – often leads to minimal performance standards. He argued that the less competent practitioners would 'band together' to keep standards at a lower level(1985). Anecdotally, when QOF was first introduced, I worked as a PCT employee tasked to implement it across North London. On our first visits to assess GP practices on their QOF development, we were told to 'go easy' on them and that the first year of QOF was

designed to be a ‘gentle’ roll-out so as not to alarm GPs. This anecdote lends credit to Freidson’s argument, advanced above, that professional standards are kept low, because of the power exercised by professional elites.

The other major power that Freidson identified as resulting from a profession’s market shelter is that of gatekeeping. Freidson’s definition of gatekeeping was that professions have institutionalised control over access to desired resources (Freidson, 1970). In the case of general practice, the GP or clinician who sees the patient controls access to further treatment possibilities as well as the ‘sick role’ (Parsons, 1951). Parsons argued that a person who was sick was not able to perform their social duties and was deviating from social expectations. Parsons argued that the sick role performs a social function by legitimising the deviation. He argued that there were four components of the sick role, described here by Lupton,

> “ill persons are exempted from the performance of social obligations which they are normally expected to fulfil; they are not blamed for their condition, and need not feel guilty when they do not fulfil their normal obligations.; however, ill people must want to try and get well – if they do not, they can be accused of malingering...The patient is therefore placed in the role of the socially vulnerable supplicant, seeking official verification from the doctor that she or he is not ‘malingering’.” (1994, p.7)

While Parsons accurately identified crucial functions of the sick role, his Functionalist approach has been critiqued by many for the lack of critical analysis of the power imbalance in the doctor-patient relationship (Turner 1995).

The gatekeeping role of general practice has received much attention in the literature. Freidson rightly identified gatekeeping as a power that arises from the market shelter that the medical profession enjoys. However, the gatekeeping role is a function that primarily involves the patient. For the purposes of my research QOF and the GPPS may not affect gatekeeping aspects of general practice. I suggest that from the patient’s perspective, QOF and the GPPS will not have affected patient's experience of gatekeeping in terms of access to the Parsonian sick role (1951). On the contrary, patients might have found that their experience of general practice has become more medicalised because of QOF. For example, a patient may book a consultation with a GP because they are experiencing symptoms of depression.

During their ten-minute consultation, rather than find themselves discussing the topic for which they booked the appointment they may find that the GP/clinician is preoccupied with taking their blood pressure or other such things (that unbeknown to the patient) result in QOF points for the practice. I suggest that the gatekeeping role of general practice has not been affected by the introduction of QOF and the GPPS. I suggest that both tools have wrought changes that have been felt more keenly by the staff of general practice rather than their patients.

In Freidson's analysis, the powers that professions enjoyed (outlined above) were constrained by what he called countervailing controls. In his analysis many of these originated from the political domain. Countervailing controls operate to restrict the powers the professions enjoy. One such power identified by Freidson was that of interpersonal power over a client. For example, professionals who serve high status clients may find their advice is ignored – or their interpersonal power is reduced. Similarly, professionals serving lower-status clients may find their advice is heeded – or their interpersonal power is increased. In each case the countervailing force is the status of the client. In respect to my research, this is interesting because the role of the GPPS may be relevant here. Whether or not, the GPPS has any consequence for the GP or not, its existence represents a way in which the patient is able to give feedback and pass a judgement or rating of their experience at the practice and as such could be viewed as a threat to the GPs traditional sphere of interpersonal power on their patient. This raises the issue of, for a countervailing power to be effective, it must be listened to by the dominant power. In the case of the GPPS, the study will investigate how much attention is paid to it by the practice team. Light responded to Freidson's professional dominance model by arguing that professional dominance in itself is a countervailing power. Viewed as such it enables us to understand,

> "professional dominance in a historical perspective and in a field of forces whose interrelationships are important to consider, even when latent. This is one of many kinds of markets outside the classic competitive market that we are coming to recognise. Among them, it is one the of most highly structured and involved in cultural capitalism." (Light 1991, p.505)

Light views the drive for professional dominance to operate across various institutions, including the political sphere and beyond to the public. He argues that patients will be able to exercise their power as consumers.

Writing in the 1980s when the ideas of technocracy (rule by technical experts) had been popular since the 1970s, Freidson argued that the power of technical experts was limited and would take second place to political views and public opinion. He identified that crucially, professions did not control the economic or political sphere in which expert knowledge was deemed useful in public life. These countervailing controls were used by Freidson to counter theorists writing at the time who - in Freidson's opinion - overstated the power of professions (such as Foucault and those inspired by him). Freidson's work also spoke to those who (in his opinion) understated the power of professions and wrote about deprofessionalisation. Brint wrote that,

> "Freidson's analysis shows spheres of professional power that are far more extensive than theorists of professional decline were willing to admit, spheres that are at the same time much more circumscribed than theorists of professional hegemony are able to admit." (1993, p.269).

While professionals do not control the economic or political context in which they operate, they have historically enjoyed control over their clients and been able to fulfil their job in the way they see fit. Brint argued that Freidson's contribution allows us to identify the factors associated with greater or lesser power enjoyed by the professions.

Lastly, Brint argues that Freidson's work provides a defence of professions from critics who claim that their influence and power are "unnecessary, harmful or both' (1993, p.1). At the time that Freidson was writing, there existed two dominant theoretical positions concerning professions. One argued that a process of deprofessionalisation was underway. Theorists taking this view argued that professions were losing power and their knowledge monopolies and gatekeeping powers would be eroded until they were obsolete. Theorists taking this position included (Chin, 2001; Gough, 2001). An alternative view posited that a period of professional hegemony was underway and would continue. Those taking such a

view included theorists such as Foucault (1973) and Illich (1976). Brint wrote that Freidson found theorists espousing this position to be,

> ‘not so much wrong as wrongly one-sided; they detect evidence of weakness, but they miss evidence of professional power.” (1993, p. 271).

Freidson found the position of professional hegemony or dominance less convincing. He calls into question the structure that would be required to deliver the sort of professional control and/or dominance that some of the theories describe. He wrote that,

> “the reality seems sufficiently fluid and complex to call into serious question the value of such grand and colourful words as technique, social control, hegemony, domination, or monopoly of discourse.” (1985, p.230).

Since the late 1960s, Freidson argued that all professions, but especially the medical profession had been subject to increased regulatory controls. While some saw the increased external regulation as evidence of deprofessionalisation, Freidson maintained that the new regulatory environment “poses no comprehensive or consistent threat” to the professions because it did not touch what he regarded as the real basis of professional power. He went on to argue that while deregulation and external oversight have not limited the nature of professional power, he argued that it has changed the nature of professional power. While central government may have attempted to control the professions through an environment of increased oversight and external regulation, Freidson viewed the effect of this as increased stratification within the profession. Enabling the advancement of the position of administrative staff, without touching what Freidson identified as their true power base, the ability to credential and control the supply of future cohorts of professionals.

Freidson has been hugely influential in shaping the theoretical debate about professions and identifying their power base. It will be interesting to see how his theories – written in the mid 1980s – might apply to my research and data. Perhaps my research investigating staff experiences of external regulation might speak to his theory about how professions adapt to the changing regulatory environments as well as stratification within the practice workforce.

4.7 The audit explosion and the power of the idea of audit

Running throughout the theoretical literature on audit emerged a theme that many authors commented on – it centred around the notion that audit and its accompanying practices (performance monitoring, targets etc) have taken over or have come to dominate our work environments and working lives particularly in the public sector.

Power, a professor of accounting, has charted how what he describes as a medieval bookkeeping tool – audit – 'broke its boundaries' of the discipline of accounting and is now established in almost every aspect of our lives and working environment. Power presents an historical perspective of audit - in an attempt to explain how this happened - describing its origins as an ancient book-keeping tool dating back to the 12th century (Power, 1997b).

> "Auditing in one form or another has existed as long as commercial life itself: even the earliest forms of writing seem to have been accounting documents. …an ahistorical model of the demand for auditing was considered: when the economic resources of one party are entrusted to another human nature is assumed to be weak, untrustworthy and in need of some kind of check. In short, the need for principals to monitor agents gives rise to auditing. Because of the remoteness and complexity of the subject matter of auditing, principals are unable to do this monitoring themselves and requires the services of an auditor." (Power, 1997b, p. 16)

Power writes that,

> "the earliest financial audits seem to have been oral in form and judicial in structure. The auditor would stand in judgement over a party giving the account: hence the original 'aural' meaning of auditing in which the aim was to establish the trustworthiness of agents." (Power, 1997b, p. 16)

Importantly, in the 1930s the concept of the 'modern selective audit' emerges, forced upon the auditor 'by virtue of an expansion in the volume of business of companies' (Power, 1997a). The need to verify larger and larger volumes of work instituted the need for internal systems control. This enabled the auditor to test the system rather than each individual transaction. Power writes that the emergence of systems control

auditing marks an important moment in the concept of the relationship between auditor and what is being audited.

> "It at this point that the audit process begins to disengage itself from the transactional realities which underly these control systems: the system becomes the primary auditable object." (Power, 1997b, p. 20)

Power constructs a convincing argument that once the tool of audit is transported to an industry for which it was never intended (in his view, anything that is not the discipline of accountancy), it will break out of its boundaries and take over the new industry, prompting what he calls 'the audit explosion'. The audit explosion can be seen, Power argues, in the way that performance targets and measures have now become commonplace in almost every industry sector, particularly within the public sector. Power wrote that this 'explosion' has consequences which have not yet been fully examined or understood. It is this change in workplace cultures that affects the working lives of millions of employees that prompts Power to call for a critical analysis of what the effects of audit culture have been on society and individual's lives.

Attempts to understand why audit has become so established, and in many cases entrenched, in fields and sectors for which it was never intended is addressed by some authors in the theoretical literature. Power argues that the vagueness of the term audit has aided its 'explosion' into fields other than accountancy. Shore & Wright highlight the usefulness of its vagueness in their 2015 paper. They note that the term means many things to many people and takes many forms depending on who is carrying out the audit. Power argues that its' malleability is what has made it so adaptable to both public and private institutions.

Relevant here is Rose & Miller's useful distinction between programmes and technologies (2010). They argue that programmatic or normative elements of audit relate to the ideas and concepts which shape the mission of the practice. For example, the 'broad goals' are formulated and it is assumed that the practices can deliver these goals. Power writes that it is at this level that,

> 'a certain abstract ideal of what auditing is intended to achieve subsists in policy discourse, a vagueness which allows the idea to percolate into different policy arenas and to become attached to different goals.'

Power argues that this 'level of programmatic appeal to the idea of audit and the level of audit technology are only loosely coupled" (1997, p.7) He identifies the power of audit lying in this 'looseness'. Indeed, it is the 'looseness' between the idea of audit and the tools to accomplish it which makes the idea of audit so powerful. He argues that,

> 'The power of auditing is the vagueness of the idea and to comprehend the audit explosion it matters less what different audit practices 'really are'...than how the idea of audit has assumed such a central role in both public and private sector policy.' (1997, p.7)

Rose & Miller's technologies or operations are the actual concrete tasks that are necessary to achieve the broad goals. Power argues that this is where the tools of the trade are crafted, debated, and improved. Power writes that at this level the efficiencies of the techniques are debated, commenting that even audit techniques are audited. He also notes that,

> 'Technical practices cannot be disentangled from the stories which are told of its capability and possibility.' (2000, p.7)

To add further to this theme Cohen wrote that,

> "practices are carried out for reasons quite different from their accompanying stories. Incompatible stories are used to justify the same practice." (1985, p.185)

Power notes that technical routines are loosely coupled to the stated aims they are intended to serve. Or keeping up with Rose & Miller's terminology, the technologies may not deliver the programmes. This may become relevant to my work when trying to understand how practice staff understand the relationship between the stated aims of QOF and the GPPS with the targets which supposedly deliver the aims. For example, will they see a connection between delivering a better standard of care when they are prompted to interrupt a consultation to take a patient's blood pressure, when that patient has come to see them about a sore knee? Or do they see the link between the satisfaction of the patient sitting in front of them and the GPPS scores the practice receives up to eighteen months after the consultation? Rose & Miller's

identification of the separateness of the programmatic and the technical may be especially useful to my research.

The notion of the malleability of the concept of audit coupled with a vagueness about the tools to achieve it speaks to themes that emerged from the literature review. The literature review demonstrated that for both QOF and the GPPS, the aims and methods of each are highly contested by those working in the profession. The literature review did not encompass patient's views on the aims and methods of either tool. I aim to include patient views on the aims and methods of each tool from my fieldwork if relevant and appropriate.

4.8 Enabling or coercive bureaucracy

The literature review presented a negative view of the effects of bureaucracy (via QOF and the GPPS) on general practice. Most of the literature concentrated on the views of those who felt that QOF was restrictive and coercive and limited their ability to treat the patient in a holistic manner. Other literature focussed on the views of doctors who felt that their professional judgement was being questioned by central government. Borys and Adler (1996) authored a paper in which they drew attention to the literature on bureaucracy. They argued that it fell into two categories, either the view that bureaucracy was helpful and enabled people to do their jobs or another view which portrayed it as a negative development, bordering on coercion.

In their 1996 paper they argued that,

> "this divergence reflects the fact that while research to date has focused on the impact of different degrees of formalization, it has paid insufficient attention to different types of formalization. If we interpret formalization as an organizational technology, we can draw inspiration from recent research on the design of equipment technology to differentiate two generic types of formalization - formalization designed to enable employees to master their tasks, and formalization designed to coerce effort and compliance from employees. The attitudinal outcomes are likely very different." (Adler and Borys 1996, p.1)

Most of the theoretical literature I have referenced in this chapter concentrates on the negative impacts of audit culture. Borys & Adler's paper is interesting because it offers the possibility of a positive impact of the dominance of audit and the culture of

measuring that exists. Their paper ends with a look forward to how their insights of understanding both sides of bureaucracy might aid the development and implementation of future target setting amid organisational change. It is important to note that Borys & Adler's paper investigates 'formalisation' as defined by role specifying functions of formalisation. They are not addressing performance related target setting. When analysing their identification of the enabling aspects of bureaucracy and formalisation it is important to remember that their analysis did not include performance related pay or targets. These developments (performance related pay and targets) featured later in the development of NPM policies in the UK public sector.

4.9 Policy implementation and power

There exists a large body of literature on policy implementation. One concept that may be particularly useful to my study is that of 'street level bureaucrats' (Lipsky, 1980) and Bourdieu's 'low-level bureaucrats' (1999). Both approach the topic of implementation from the perspective of analysing power and how it works and where it resides. Lipsky and Bourdieu identified that power resides in many places throughout the implementation cycle. Bourdieu identified the low-level bureaucrat in his ethnographic study of how social welfare schemes are implemented and delivered in Paris in the 1980s. He and his team found that the low-level bureaucrat (civil servant) on the front line exercised crucial power as they decided who would receive (or not) the state benefit. Lipsky echoed this finding when he argued that,

> "Public service workers currently occupy a critical position in American society. Although they are normally regarded as low-level employees, the actions of most public service workers actually constitute the services "delivered" by government. Moreover, when taken together the individual decisions of these workers become, or add up to, agency policy." (1980).

While this study will not argue that GPs or health professionals could be viewed as low-level bureaucrats, the analysis of power on the front line might be very useful for my study when I investigate how the QOF is delivered to patients and how the GPPS is received by practice staff.

4.10 Summary

There is a wide and rich breadth of literature that has centred on medicine, examining it from various disciplines. This chapter has sought to explore those writings and authors who have investigated medicine as culture (Lupton, 1994); medicine as social control (Foucault, 1973; Turner, 1995); the power of the medical profession (Freidson, 1970, 1985) as well as other social theory perspectives. I have also looked to the writings of academics from disciplines ranging from organisational behaviour theory (Adler & Borys, 1996) to social anthropological insights into how a 'new' culture of audit impacts on public sector institutions (Shore & Wright, 1999, 2015; Strathern, 1997, 2000c). I have chosen to take this insight and apply it to general practice.

A Foucauldian lens offers insight into the effects of audit culture that highlights the workings of power through routine, administrative adjustments to the daily working lives of millions. Echoing a Foucauldian perspective are writers such as Rose & Miller who understand the effects of audit culture as extending the power of the state into the very structural framework of institutions and individual lives in its demands for accountability. Power concentrates on the role of audit as an ancient book-keeping tool which (through the introduction of NPM methods adopted by governments throughout the 80s, 90s and noughties and which continues today) broke its boundaries from the discipline of accountancy and came to dominate and rule the public sector as well as nearly every other sector today. Strathern's lens brings to the forefront some of the more sinister effects that audit culture has brought with it. Her analysis emphasises the way that audit coerces individuals and organisations into making themselves accountable through the guise of the public good. Strathern's analysis brings our attention to how audit when introduced into institutions for which it was never intended, changes organisational cultures and remakes them in its own image.

There is much to gain from an eclectic approach to theoretical 'borrowing.' While being mindful of differences in the origins of the different theories it is beneficial to approach my topic fully aware of the theoretical background. I have chosen to proceed with my research using Shore & Wright's analytical framework as it offers the best vehicle with which to attempt to answer my research question. However, my investigation will continue to be informed by the richness of the theoretical literature

explored in this chapter. Lupton wrote that “The potential exists for the different theoretical approaches and research methodologies to incorporate elements from each other to meet their own deficiencies, and perhaps, in the process, to weaken the boundaries that tend rather artificially to separate them.” (1994, p.18)

It is with optimism that I approach my field of investigation, the English general practice, armed with a diversity of theoretical analyses borrowed from varying disciplines. The English general practice has had scant anthropological inspired research attention in my area of investigation. This is the reason the thesis borrows so widely for its theoretical inspiration. It will be interesting to learn and understand which theories/theorists speak most clearly to the area of patient and staff experiences of QOF and the GPPS.

Chapter 5 Methods

5.1 Introduction

This chapter will present the methods I have selected to use in the study as well as the reasoning behind their selection. The chapter will also detail the methods that might have been used but were discarded. Again, the reasons behind their de-selection will be explained. There are several methods that might have been used while conducting this research. Each one would have had an impact on the fieldwork and its interpretation. It is the role of the investigator to make decisions about which methods are employed; to be clear about why they have been chosen and to understand and explain how those choices have shaped the research. Alongside this, I hope to demonstrate an awareness of how methods which were not selected for the project might have shaped the research and findings.

Methods were selected for their ability to collect data in the field that would be relevant to the research question: How were staff and patient experiences in English general practice impacted by the introduction of the Quality and Outcomes Framework and the General Practice Patient Survey?

5.2 Research Principles

Chapter 4, Theory, highlighted the importance of including a social anthropological perspective in the data collection process. This translated into a determination to interview as many roles as possible within each practice case study. I also wanted to remain 'close' to the data as it was collected, and it was decided that an iterative approach would be taken to data collection and analysis. Due to the timing of the project, data collection and analysis were conducted simultaneously across the four practice sites so thematic analysis at one site informed interview preparations at another case-study site. In this sense, the fieldwork phase was fluid and reflexive. Findings from one site were able to be tested or probed at another site.

The thesis uses polar type sampling (explained in detail below) to select four case study general practice sites (Eisenhardt, 1989; Eisenhardt & Graebner, 2007). Once recruitment and the ethics process had been completed, semi-structured qualitative interviews were conducted on site and via telephone with staff members and patients. The methodology and reasons behind choices made are explained in detail in the rest of the chapter. Each time a choice about the study design was made, it

was done so with consideration of how it would help to answer the research question. First, the chapter outlines the two theoretical approaches in the epistemological tradition, before proceeding to describe the approach selected for use in this study.

5.3 Methodology

5.3.1 Theoretical approaches

There are two modes of thought within the epistemological tradition, positivist /objectivist, and interpretivist/social constructionism. Positivists hold that the researcher can collect and analyse data independently, or objectively. A positivist position would argue that a single 'truth' or 'reality' exists and that through research, the investigator can arrive at it. Positivism has traditionally been linked to research in the natural sciences. A researcher with positivist presuppositions conducting an interview would be trying to ascertain what really happened in a situation. If other interviewees provided a differing account, the data would be deemed suspect (Schwartz-Shea, Peregrine & Yanow 2012).

An interpretivist or social constructionist stance, by contrast, is about meanings. It has its origins in the hermeneutical tradition, meaning the interpretation of text, originally biblical texts. A researcher taking a social constructionist position would recognise that people create (construct) their own realities and experiences, and that one person's experience of an event may be markedly different to another person's. Neither is 'right,' the researcher seeks to understand the meanings behind each person's experience. It is the differences between each person's experience that are of interest to the interpretivist researcher. According to the social constructionist view it is the differences that suggest what is meaningful about the experience to each person (Berger & Luckmann, 1991). The interpretivist researcher is seeking to 'tell about society' (Becker 2007).

Interpretivism can tend towards post-modernism and relativism. A post-modernist stance would suggest that researchers cannot be sure of any knowledge because all of it is subjective, i.e., created by the researcher, and research is reduced to the status of 'story telling.' While the post-modernist approach recognises the role of the individual's experience, it does not recognise or account for power. A true post-modernist approach to a project such as mine would seek to include all views (as do

I) and seek to document all views of staff in each case study (as do I). However, where we part company is that a post-modernist approach to my project would present all those views as representative of the experiences of staff and patients at a practice (as will I) but would not seek to interpret those views, using a theoretical lens to try to understand what it means for the field, policy, and practice. For this reason, a post-modernist approach is not adopted in this thesis.

My approach to the analysis of the data is a social-constructionist one that maintains that the experience of an individual will be different to that of someone else's experience of the same event. My research adopts the position that it is the role of the researcher to understand and represent these experiences, while searching for themes or findings within them. The value of an anthropological approach to data collection and analysis is key here. Tett writes,

> 'We live in an age when so many of the intellectual tools we use encourage us to solve problems in a pre-directed, top-down, and bounded manner. The method of scientific, empirical inquiry that emerged in seventeenth-century Europe champions the principle of observation but typically starts by defining the issue to be studied or problem to be solved, and then develops ways to test any conclusion (ideally in a repeatable manner)",

Tett continues to argue for an anthropological approach to investigating current social issues.

> "Anthropology, however, takes a different tack. It also starts with observation. But instead of embracing rigid prior judgements about what is important or normal, or how topics should be subdivided, it tries to listen and learn with almost childlike wonder. This does not mean that anthropologists only use open-ended observation; they also frame what they see with theory and hunt for patterns. They sometimes use empirical methods too. But they aim to begin with an open mind and broad lens."

Tett acknowledges that this approach can be annoying,

> "for scientists, who typically seek data that can be tested and/or replicated on a large scale. Anthropology is about interpretation and sense-making; it typically looks at the micro-level and tries to draw big conclusions. But since

> humans are not like chemicals in a test tube…this deep open-ended observation and interpretation can be valuable; particularly if we keep an open mind about what we might find." (Tett, 2021)

This approach will suit the analysis of qualitative interviews conducted with a range of different people within a general practice team as well as some of the patients the team serves. My research is looking for differences and demands a methodological framework that can cope with difference. Through a process of interpretive data collection and analysis, the project aims to arrive at an understanding of how the QOF and the GPPS impacted on, and how staff and patients experienced them in English general practice during 2016/17.

In the next section I will discuss the study's research design. Data collection and analysis methods will be discussed, as well as methods which were deemed not to be the best fit for the research question and project.

5.3.2 Research design

The aim of my research design is to enable the collection of data using robust and reliable methods to answer the research question:

Yin writes that the case study design is best suited for answering research questions which begin with a 'how' or 'why'; situations over which the researcher has no control, for example, a laboratory or clinical trial environment and questions that investigate a contemporary phenomenon (Yin, 2013, p. 14). My research aims to fulfil all these criteria. My research question asks how QOF and the GPPS have impacted the working lives of staff and patients in English general practice; I have no control over the research setting – the general practice; to answer my research question, I need to speak to individuals about their daily experience. Consequently, I have chosen to use a multi-case study design to conduct the research.

The first stage of the research design requires the selection of case study sites. The sampling of English general practices will be aimed at selecting a mix of case study sites that complement each other as well as seeking to encompass a range of characteristics in the field, for example, a rural and/or urban setting.

During the initial stages of the thesis, I was interested in critically analysing the relationship between clinical quality and patient satisfaction. This was inspired by

Asprey's paper (2013) which sought to outline the relationship between clinical quality and patient satisfaction. I became interested in matching a practice's overall QOF achievement score with its overall patient satisfaction score (taken from the GPPS). Practices which enjoyed both a high overall QOF score, and a high GPPS overall patient satisfaction score would indicate that when clinical quality was high, patient satisfaction would follow the upward trend obediently. My initial investigations demonstrated that some general practices had high overall QOF achievement scores combined with exceptionally low GPPS overall patient satisfaction scores and vice versa. This indicated that high clinical quality (measured by QOF overall achievement scores) might not be linked to patient satisfaction. Conversely there was another outlier group with high GPPS overall patient satisfaction scores coupled with low overall QOF achievement scores. Both groups (although in opposition to each other in terms of characteristics) indicate that clinical quality (in these cases) is not linked to patient satisfaction. I was interested in why these groups existed and what their existence meant for new public management theory that identifies patient/consumer experience as key to driving improvement and being inextricably linked (Mullen, 2006).

5.4 Quantitative sampling model

A quantitative model was developed with a colleague at IPSOS Mori to enable the sampling of general practices at national level. It is described in detail in Appendix 10. In this chapter it is described briefly alongside the development of the sampling strategy.

The quantitative sampling model was developed in response to criticism of the GPPS and the QOF in the literature. This criticism focused on what was perceived to be the 'unfairness' of the two instruments. Some argued that it was possible for a practice to receive a low score if they had a 'one-off' bad year. A practice may have experienced difficulties with recruitment or perhaps the GPPS had been sent to patients who had bad experiences with the practice. The literature describes GPs who felt that these factors might give a practice a poor GPPS score on Q28, and this would not be a fair reflection of the practice team's effort to improve other areas of the service. It is established in the literature that practices in deprived areas have poorer overall OQF scores and lower patient satisfaction scores than practices in less deprived areas. Before the days of QOF, evidence shows that these practices

experienced poorer health outcomes than those practices in wealthier areas with lower scores of multiple deprivation (Ashworth, n.d.; Ashworth et al., 2011; Bécares et al., 2012; Modood et al., 1997).

The model is designed to counter such criticisms of the QOF and the GPPS. We proposed to use a three-year average of QOF overall scores and the raw scores of the GPPS multiple choice responses to Q28. We then used a shrinkage estimates model to eliminate as much variation as possible. This method is explained in full in Appendix 10 and ensured that when practices were identified as potential case study sites, we were as confident as we could be, that they were the right practices for the task. For example, when we selected a practice because it had low patient satisfaction GPPS scores and high QOF overall achievement scores, we were as confident as possible that this was the case and not just an aberration resulting from data reporting during a highly atypical year. By using a three-year average and a shrinkage estimates model, we were able to select practices confidently.

The second part of the study design consisted of qualitative interviews conducted at case study sites with practice staff and patients.

5.5 Qualitative data collection

5.5.1 The case-study method

Case-study research methodology has been used in the social sciences since the early part of this century (Platt, 1992). It is best suited to answer research topics with questions which begin with how or why? Yin recommends that it is best suited to conducting research in situations in which the researcher has no control over behavioural events and topics where the focus of the study is contemporary and not historical (Yin, 2013).

Case studies have been used across the social sciences including anthropology (Whyte, 2012) political science (George & Bennett, 2005) psychology (Bromley, 1986)) and sociology (Feagin et al., 1991; Hamel, 1992) (Hamel, 1992) (J. C. Mitchell, 1983). The methodology has a history of use among the practicing professions ranging from Business studies (Dul & Hak, 2007); (Piekkari et al., 2008) and Public Administration (Agranoff & Radin, 1991).

The need for a case study approach becomes relevant when the researcher wants to study a ‘case’ while retaining a ‘holistic and real-world perspective’ (Robert K Yin 2014, p.4) The case study provides a method for studying complex social phenomena in-situ, or as it is happening in its real-world context.

5.5.2 Critiques of the case-study method

Yin (2014, p.7) addresses what he refers to as a ‘misconception’ amongst some researchers, that the case study method should only be used as an exploratory tool in the initial stages of a research project. Yin argues that such a limited view of the case study method results from a ‘hierarchical’ view of research methods. The hierarchical view of methods places the Randomised Control Trial (RCT) at the top of the hierarchy and suggests that ‘experiments are the only way of pursuing explanatory or causal inquiries’ (2014, p. 7). A broader critique of the development of the hierarchy of evidence is given by Timmermans (2010). Yin argues that a full and appreciative understanding of all research methods requires ‘going beyond the hierarchical’ model.

There are many variations within case study designs available to the researcher. The study might follow a cross-case design similar to that adopted by Crane. Following analysis of nine separate case studies which all focused on different topics, Crane drew ‘generalizable conclusions’ in his final chapter that could be applied to many other public administration projects (Crane, 1998).

Epistemology and the case-study method

The case study design methodology is flexible enough to embrace different epistemological positions. For example, it has been used to investigate projects adopting a relativist or interpretivist approach, as well as those taking a more positivist approach. My research question demands an interpretivist approach. The case-study method enables this by allowing the acknowledgement of multiple experiences (those of staff and patients) leading to findings that are observer dependent (Yin, 2013, p. 17).

5.6 Interviews

5.6.1 Reflections on positionality

Before I discuss the choice of using semi-structured interviews, I describe below my reasons for starting this PhD and how this shaped my approach to conducting fieldwork.

I decided to apply for this PhD studentship because I was at a time in my career when I was ready to return to work full time yet needed something flexible to be able to look after my two young children. Prior to leaving full time employment to look after my children I had worked in the NHS for 8 years as a Public Health Information Officer and then a Public Health Manager at Enfield Primary Care Trust (2002 – 2009) in North London.

While in post as Public Health Manager I was tasked with what was referred to as the 'rolling out of QOF' to all our general practices in the borough. This involved close working with practices and their teams to work through the process of establishing QOF in their practices.

When I saw the job advert for the PhD studentship I thought it would be a good match for me because I wanted to return to studying and it was a topic about which I had some prior experience. I was also interested to find out how practices had responded to QOF almost a decade since my brief experience with it previously. I applied and was successful in my application.

When designing the study and the fieldwork phase I took the decision not to reveal my past working experience as a Public Health Manager in the NHS when recruiting practices and conducting interviews with practice staff and patients. I took this decision because I wanted to present myself as an academic, with an interest solely in finding out what their experiences of QOF and the GPPS were. I thought that if I introduced myself as a former employee of a Primary Care Trust, this might affect the way that respondents behaved in interviews with me. The challenges associated with conducting 'insider' research (Aburn et al, 2021) include "the potential for power differentials in relationships with participants, the risk of assumed understanding and the challenge for the researcher of managing emotional burden." Aburn et al (2021) also outline some of the benefits of conducing 'insider' research which they view as including, "…the ability to rapidly develop rapport with participants, and participation

as a cathartic and therapeutic process for participants." (2021,p.25). For my research, I was not a current 'insider' because I had not worked in the NHS for over 10 years at the time of fieldwork, yet there remained a risk that had I made known my past employment as a Public Health Manager, the challenge identified by Aburn et al (2021) of 'assumed knowledge' would have arisen in interviews with practice staff. I particularly wanted to avoid this risk (mainly because I was out of touch with QOF and general practice and did not have any current up to date knowledge gained from my past employment. The knowledge I had was gained from my research conducted for this PhD. I also wanted the interviewees to have to speak to me as someone who is a beginner in the field. This makes interviewees explain the obvious, or the things that are 'second nature' to them. From a Foucauldian perspective it is in the 'routine' that power often lies undetected. An anthropological technique is to get your interviewees to explain the mundane, often leading to people interviewees complaining that anthropologists ask 'stupid' questions, for example, 'why do you call your cousin, your cousin?'. Such a question may seem exasperating for the recipient but in answering, the respondent will explain the kinship structure of their group relations. If the respondent thinks they are talking to someone with that knowledge, the kinship structure will not be explained and outlined (Kulick, 2019). It was for this reason that I wanted to avoid any 'assumed knowledge' I had about QOF. This was not a deception, because I did not have any current knowledge about how QOF operated in modern day English general practice.

One way this might have happened could include practice staff seeing me as part of the Clinical Commissioning Group. Practices' relationships with the CCG are not uncomplicated and sometimes it is a relationship that is viewed with distrust on both sides. Several times in fieldwork interviews with staff, the CCG was referred to as if its role was one of *Big Brother* or of 'monitoring' practices. For patients, presenting myself as a former employee of a PCT might prompt them to think of me as trying to elicit information from them about the practice to report back. In both cases (practices and patients) I felt that disclosing my former employment status would cause a change in the relationship between myself and interviewee as well as alter the information they would feel comfortable sharing with me.

I did not see this as a deception because it was true that I was an independent academic researcher. When I undertook fieldwork, I had not worked for the NHS for

approximately 5 years. I had no role to report back to the CCG about the topics staff and patients had spoken about during interviews. My ethics approval forbade this and, in any case, I had no one to report it to, nor would I wish to. I did not disclose my previous employment because I did not think my experience of introducing QOF to general practices in Enfield in 2004 was relevant to my asking staff in 2015/16 about their experiences of QOF. I was only interested in their experiences – I was not interested in countering their experiences with my recollections from over a decade earlier. My research took a social constructionist approach to collecting data. This meant that whatever experiences interviewees told me about in an interview was relevant and accepted.

There are consequences to any decision and it is important to assess those of not telling interviewees of my past employment with the NHS and Enfield PCT. Telling practice staff may have resulted in them speaking to me, more as an 'equal'. They may have felt more at home in talking to me about QOF and would have assumed a shared knowledge existed between us. I may have collected more technical data and they may have spoken to me more as a professional equal. This may have impacted on the information they shared with me in the interview.

A further consequence should also be considered though. If I had presented myself as a PCT employee with a shared knowledge of how QOF worked in general practice etc, they may have spoken to me differently for some of the reasons outlined above. While useful, this can sometimes present its own problems. The anthropologist is often seen by the communities in which they work as 'rather slow' or as 'stupid' because they are always asking what seem like very stupid questions Kulick, 2019). But it is this method, that gets to the very heart of ethnographic inquiry. Asking the obvious questions of lots of different people often produces fieldwork data that you would not get if your respondent assumed you shared a common knowledge or language or expertise. This meant that respondents explained the basics of QOF to me -some of which I knew (but a lot which I did not). I learnt a lot from their explaining how QOF worked in their practice to someone (me) who did not know anything about QOF at Practice A. In this sense, it was not a deception. I did not know how QOF worked in their practice and this is what I was trying to find out in the fieldwork. I was searching for the details, for the things that

are so ingrained that people think they are not important. In anthropology, one is seeking to render the invisible, visible.

In my situation, it may feel that I was being dishonest by presenting myself as a *newbie* to QOF, but in all respects it was the truth. I had been involved in QOF in its first manifestation, at its introduction to general practice in 2004. I had no idea how it had developed, embedded itself (if indeed it had) or how general practices had responded to it and/or developed themselves to accommodate it since my brief involvement in it ten years previously. In this respect, I was out of touch and was very much a *newbie* to the world of QOF more than a decade later.

For this stage of the research, I used semi-structured qualitative interviews. Most of these were conducted on a one-to-one basis but to be flexible and sensitive to staff time some interviews were conducted with two or three staff members at once. Where this occurred, this was always at request of the staff members. Typically, this occurred in a job share situation.

Similarly, when working with patient respondents I was flexible and offered interviews at their convenience and according to their preferences – for example, they may prefer to be interviewed in a group or singly. All patient interviewees preferred to be interviewed alone. I understood this to be due to the sharing of what might be sensitive information or topics for some people.

In the next section I will justify my choice of the qualitative interview in this study and why it is the best suited method to gather empirical data for the research than other methods I might have used.

The qualitative interview as a research tool has many strengths. Patton writes that,

> ‘The purpose of interviewing is to find out what is in and on a person’s mind… to access the perspective of the person being interviewed… to find out from them things that we cannot directly observe.” (1990, p.278)

It also allows for meanings and understandings to be explored in relation to other aspects of a situation. Arksey & Knight (1999) write that,

> "Interviewing is a powerful way of helping people to make explicit things that have hitherto been implicit – to articulate their tacit perceptions, feelings and understandings." (1999, p.278)

The qualitative interview may also be managed to suit the topic, situation, or interviewee. For example, questions may be open (no interview guide is followed), semi-structured (questions are a mix between open and closed and the interviewer guides the discussion towards certain topics of interest) or closed.

Closed questions are useful for gathering administrative data and are good to be used at the beginning of an interview to put interviewees at their ease. These may be particularly useful when interviewing patients who feel nervous at the start of an interview. Closed questions offer interviewees a chance to settle into the interview with some 'easy' questions first. Using closed questions allows the interviewer to decide the range of answers available to the respondent and permits the interviewer greater control over the data gathering process (Arksey and Knight 1999, p.91). Use of such questions would be appropriate to a research question with a very tight focus but would not suit my research question.

Closed questions would not be suitable for the interviews I intend to conduct with clinicians and non-clinician staff at practice case-study sites, as well as with patients. I am seeking to learn about and understand their experiences of implementing QOF and working with the GPPS in their daily working lives. In an ideal situation, I aim for interviewees to feel relaxed and comfortable as they share their experiences with me. I want them to speak at length and freely about how QOF and GPPS impact their working lives as well as their experiences of being a patient. Much like Arksey and Knight quoted above, I hope for the interview to provide a space in which interviewees can reflect on their experiences and make what might have previously been implicit, explicit.

Like everything, there are drawbacks to using the qualitative interview method as a data collection tool. Briggs (1986) argues for a recognition of the interview as a 'communicative event' (1986, p.2). He argued that because the interview is an accepted 'speech event in our own native speech communities, we take for granted that we know what it is and what it produces' (1986, p. 2). Briggs argued that due to our 'unquestioned faith' in the interview as a research tool, we cannot fully interpret

the data it collects. This occurs during the data analysis process. During the interview the researcher steers the flow and focus of the interview. During analysis, the researcher views the data as a reflection of what is “out there” rather than ‘as an interpretation which is jointly produced by interviewer and respondent” (1986, p. 3). The failure to grasp that interview data is context-specific, rather than a description of the event being discussed, can lead to misinterpretation of the data. Briggs writes that,

> ‘By leaving the interview situation itself out of the analysis, we have cleverly circumvented the need to examine our own role in the research process.’ (1986, p. 4)

Briggs' examination of the interview and the researcher’s role in it has been useful when reflecting on interviews conducted to date and in thinking ahead to plan future interviews and analysis. I propose to protect my analysis of my fieldwork data from Briggs’ critique of the interview, by considering how my presence and role in the interview may have affected the ‘telling’ of the ‘story’ and how I interpret it when writing up. I aim to conduct my analysis of fieldwork data reflexively to include my role in the interview. This is especially important when interviewing patients and staff who are not senior team members. I will be introduced to staff and patients via the senior partners and the practice manager. Thus, there is a risk that I will be seen as part of senior management. To allay my association as part of senior management I will stress my independence as an academic researcher and the anonymity of the project.

Details of the interview questions and topic guides can be found in Appendix 2 and 3. The interview questions were piloted with colleagues prior to beginning the fieldwork.

5.7 Alternative qualitative data collection methods

This section will explore other qualitative methods that might have been used in this study. I hope to demonstrate how any of these methods would have produced excellent quality data, but in the end were not the most suitable when gathering data to answer the research question.

In place of using qualitative interviews the study might have used questionnaires. Questionnaires have many advantages, one of which is ensuring respondents are all

asked the same questions. This can be appropriate if the research question is about measuring a particular concept or attitude and it also makes data analysis easier as responses are more uniform, easily categorised which makes comparisons between respondents and questions easier and quicker to perform. Questionnaires also offer the benefit of being quick to complete (depending on how many questions are included) and in general one would expect more responses to be gathered than would be obtained through using in-depth interviewing. My research question specifically seeks the experiences of staff and patients of a general practice. In some cases, such experiences may be personal and might not be best shared through the medium of a questionnaire. If using self-administered questionnaires, the researcher does not have the opportunity to probe or adapt the questions according to the flow of the interview.

Ethnographic data collection methods would have offered an opportunity to gain in-depth insights into the workings of a general practice. However, the researcher would need to be on-site for months and would have to gain the trust of the practice and patients to be granted full access to the practice. While presenting enormous potential to gain deep insights, the research design and structure of the studentship did not allow for this level of immersion within the case study sites. It is unlikely whether a general practice would grant such a level of access to a non-clinical graduate student. General practice is characterized by clinical practitioners meeting with patients in private during consultations. It is unlikely that a non-clinical graduate student would be allowed to sit in and observe such highly private and personal consultations.

5.8 Why was an ethnographic approach not taken to fieldwork?

When applying for ethics approval I thought very carefully about how best to get the project accepted by ethics and then by practices, as well as how to ensure the project would still be able to answer the research question.

Of first importance was obtaining ethics approval to conduct the study. Next, the proposed research design needed to be accepted by general practices and lastly, I had to be confident that the methods proposed would return data that would answer the research question.

With these considerations in place, I decided that it was not realistic to apply to do ethnographic, participant research in general practices. I came to this decision for several reasons which I discuss below.

I hail from an anthropological background and am trained in the principles and methodologies of conducting ethnographic research. I knew that to conduct the kind of ethnographic research I wanted to do would involve spending several weeks at each case study practice. The time spent at each case study site would have to be the same to maintain rigour in the results. At the time of conducting the fieldwork it would not have been possible for me to spend several days or weeks away from home as I had two small children and was the sole provider of childcare. I also thought it unlikely that many practices would agree to me being present in the practice for days/weeks at a time. I did not think that I would be permitted to sit in on staff meetings. Gaining access to research sites is difficult, especially in the field of health care settings and general practice (Hammersley, 2019). I was an unknown, PhD student without connections to my case-study sites. For these reasons, and to give myself the best chance of having a successful IRAS approval, plus being allowed on to site, I decided to design the research based on semi-structured interviews with staff and patients conducted over a series of days at each practice. Some practices did not want me to be on site at all, and only agreed to the research if fieldwork was conducted by via telephone. Fieldwork was conducted pre-COVID-19 so the use of videocalls was not widely practised or known about.

In some instances, I did spend several days in the waiting room and reception areas of case study practices. This situation occurred when I had arranged interviews with staff and had several hours free in between each interview. During these times, I simply ‘hung out’ at the practice and chatted to staff and patients. In some sense this was participant observation but because I had not applied to conduct participant observation in my ethics application, I did not feel able to elaborate on findings sourced from these times. At case study sites where fieldwork was conducted wholly via telephone I thought it would not be robust methodologically to use a method that had not been applied to all case study sites.

Participant observation methods (if employed) might have allowed an insight into team meetings and perhaps to listen in on how QOF progression was discussed

throughout the course of the study. Such observations might have been made of clinician meetings as well as of the administrative team meetings. Participant observations would have offered one way of triangulating my findings, to complement the literature review and the fieldwork. It might have allowed me to test some of the research findings that came from the fieldwork interviews. For example, the apparent enthusiasm of the administrative team for watching the QOF spreadsheet go from red to green throughout the year – perhaps they were being too enthusiastic about QOF when they spoke to me in fieldwork interviews? Participant observation offers a method that the study might have tested these findings.

However, this was an interpretivist study which was interested in how practice staff thought about QOF and how it had shaped staff and practice development since its introduction. Triangulation was provided by continual comparisons with findings from other case study sites which consistently returned the same findings around staff experiences of QOF. The findings were strengthened by the consistency across case study sites, which had been chosen to contrast with each other. The method of cross-case analysis or polar type sampling is designed so that if a finding is found across polar type case study sites then its robustness is strengthened, because like has not been compared with like.

5.9 Ethics

The project was submitted through IRAS for NHS Ethics in May 2015. The NHS Rec Board deemed the project to be low risk, so it proceeded through the Proportionate Review Sub Committee of the NRES Committee Yorkshire & The Humber - Bradford Leeds in August 2015. The sub-Committee gave a Favourable ethical opinion of the research on the basis described in the application form, protocol and supporting documentation. The REC reference for the project is 15/YH/0381 and the IRAS project ID is 170245.

For each case study practice recruited, local Research and Design approval was obtained. Local R&D approval was granted for all practices recruited into the study. For each case study site this process was different. One area had a formalized network which managed applications. This process was similar to IRAS. The other

area was very informal and involved an email conversation with the local CCG who then granted approval.

While the project progressed through the NHS Ethics Approval system (IRAS) the review panel asked that patients be given the option of conducting the interview off-site (from the general practice) and in a private room to ensure confidentiality and a neutral setting. This will be offered to all patient interviewees.

5.10 Sampling

5.10.1 Quantitative sampling

To best answer my research question, I needed to develop a sampling strategy that would identify the most appropriate case study sites.

It was possible to use data from the QOF and GPPS datasets to pair a practice's overall QOF score (often used as an indicator of clinical quality) with a practice's result/score on question 28 from the GPPS (measuring overall patient satisfaction levels). Initial investigations showed that if a practice achieved a good score on QOF (70% and above) it would likely achieve a good score on Q28 on the GPPS (70% or more of patients rating their overall satisfaction level as Very Good, the highest rating possible)

Upon further examination it became apparent that there were two clusters of practices that did not fit the pattern of grouping in the middle. A small group of practices displayed high QOF scores combined with low patient satisfaction scores. Another set of practices displayed low QOF scores coupled with high patient satisfaction scores. This prompted questions such as why is this happening? and how can we understand it? Why is it that some practices deliver seemingly low rates of clinical quality (measured by their overall QOF score) yet continue to experience high rates of patient satisfaction? How are we to understand practices with high rates of clinical quality (measured by overall QOF scores) yet are experiencing poor overall satisfaction ratings from their patients (measured by Q28 on the GPPS)? My interest in these cases led me to search for a sampling methodology that would allow me to investigate these cases and attempt to answer some of the questions mentioned above.

5.10.2 Cross-case comparative sampling

Becker advances the benefits of sampling cases that at first glance make unlikely comparators. He advises the researcher to 'identify the case that is likely to upset your thinking and look for it' (1998). By doing so, he argues, we are likely to find the case that advances our thinking. Hughes adopted this approach to sampling when investigating the sociological concept of 'guilty knowledge'. He was interested in how different professions kept 'secrets' about their members. He devised a comparative study in which he sampled priests, prostitutes, and psychiatrists. While these groups appear disparate, Hughes argued that all of them, albeit under different conditions, keep professional secrets (1971). He argued that the analysis of groups that seemingly have nothing in common might lead to findings that speak to all of them. Findings that are unexpected and illuminating, which might not have been discovered if compared with similar type cases.

A paper (found through an iterative review of the management literature) that has been key to shaping my choice of research design and methods was authored by Eisenhardt and Graebner in 1997. The authors report a cross-comparison case-study method using polar type sampling (Eisenhardt., Graebner, 2007).

Eisenhardt and Graebner discuss polar type sampling as an extension of theoretical sampling. Theoretical sampling hails from Glaser and Strauss' (1967) work in which the authors recommend sampling from the field in order to test a theory, rather than sampling for the purposes of generalizing from the sample. Polar type sampling involves sampling at extreme ends of a population. Using such a method, the researcher ends up with two sample populations that are mirror opposites of each other, dependent on the measures used. The benefit of this is to force the researcher to look for patterns that may not be obvious at first sight. The researcher is forced to work hard and make connections within and between the two groups despite their apparent differences. In the process of doing so the researcher may uncover links that might not have been identified from a comparison of similar populations. It may also serve to strengthen findings if evidence is found from opposite ends of the sample population.

My study design used polar type sampling to identify and recruit case study practices. Two groups of practices that are mirror-opposites of each other were

sampled. One group consisted of practices with high QOF scores (80% and above) and high scores of 'Very Poor' satisfaction (8% and above on Q28, GPPS). The second group consisted of practices with low overall QOF scores (60% and below) coupled with very high scores of 'Very Good' overall satisfaction ratings (80% and above on Q28, GPPS). Agreeing the threshold of what constituted 'low' and 'high' criteria for both the QOF and the GPPS was done in consultation with my supervisors.

Question 28 on the GPPS reads as follows:

Overall, how would you describe your experience of your GP surgery?

- Very good
- Fairly good
- Neither good nor poor
- Fairly poor
- Very poor

Identifying and sampling case study practices

The second round of sampling (within each case study site) was qualitative and followed an inclusive whole-practice approach.

5.10.3 Quantitative sampling – First round

Identifying the practices for inclusion in the project presented some challenges related to the data. Data from QOF is collected daily at a practice level and collated on an annual basis before being published by NHS England. This process might take up to six months, so QOF data will not normally be available for the previous financial year until the following October. The data records practice activity for the indicators included in that year's QOF. The practice then receives a percentage to show how well it achieved against the QOF targets set for that year. QOF data is adjusted for variables such as practice size and demographics of the list size so that comparisons can be made. NHSE will not know the average list size until all the QOF returns are in at the end of the financial year. The monetary value of a QOF point is based on the average list size of a practice in England. For example, if a practice has a list size double the national average, then the value of the QOF point will be doubled.

Data from the GPPS has been shown to be reliable and valid (Roland et al., 2009a). Despite this, it is particularly unpopular with general practices and practitioners. Asprey et al explored the reasons for the distrust of, and unwillingness of practices to act based on the GPPS data (Asprey et al., 2013).

Reasons for the doubting of the GPPS dataset cited by GP respondents included the time-lag between when a respondent completes the questionnaire and their last visit to the practice. The respondent is asked to complete the questionnaire based on their last visit to the practice. This could have taken place a maximum of 18 months prior to completing the questionnaire. Other reasons given include the fact that the data is collected at an individual level (i.e., a respondent completes the GPPS based on their interaction with an individual practitioner) but the data is reported at practice level. Practices report that they do not know which practitioner the patient consulted with, or if the member of staff still works at the practice, for example it may have been a locum (Asprey et al., 2013). The anonymity and time-lag issue of the feedback is cited by GP respondents in the Asprey et al study as contributing towards their reluctance to undertake any practice development activities based on their GPPS score.

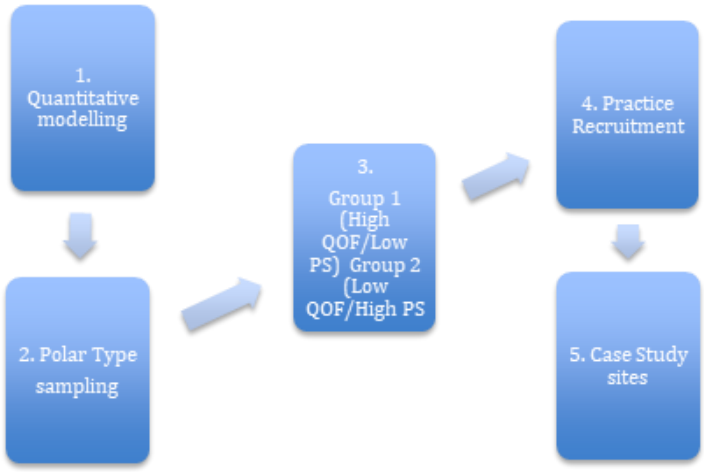
Other challenges when using raw data from both QOF and GPPS included the issue that both data sets report annually. To ensure that my project sampled practices that consistently had a high QOF score or high patient satisfaction scores, I decided to use a three-year average score for each practice taken from both their QOF score and their Q28 score on the GPPS. This solution meant that the project protected itself from sampling practices that had experienced a 'one-off' good or bad QOF/GPPS year.

A further challenge when using raw GPPS data to sample case study sites involved demographic variations between and within practice populations, making comparisons with other practices difficult (Llanwarne et al., 2013; Salisbury et al., 2010; Seddon et al., 2001). To address this challenge, I asked the GPPS team at Ipsos-MORI (who hold the GPPS contract) to refine the QOF and GPPS datasets to control for the following variables: age, gender, deprivation (by postcode) and ethnicity of respondent. These variables were identified by the literature review (see previous chapter) to affect respondent's reporting of their experiences of primary

care and satisfaction. The shrinkage estimates model used for this stage of the research is detailed in full in Appendix 10.

The fig below shows the stages of the first round of sampling.

Fig 2: First round of sampling - Stages 1-5



5.10.4 Results from the first round of quantitative sampling

The quantitative model produced two lists of practices. I took the top twenty from each national list and sent a formal letter inviting them to take part in the research (see appendix 11) and followed up with a phone call one week later. Most simply stated that they were too busy to participate. A few practices were in the process of merging with another local practice. In all cases I spoke with the practice manager, most of whom reported that they did not want to create extra work for their staff. Practice managers were very protective of their clinicians' time.

5.10.5 Case study recruitment

Four practices were recruited to the research project. Two practices are from the group with high QOF scores and low patient satisfaction scores. The remaining two practices are from the group with low QOF scores and very high patient satisfaction scores. When inviting them to take part in the study, their highest score was emphasised. For example, if they were in the very high patient satisfaction/low QOF

score group, they were approached because they had been identified as having very high patient satisfaction scores.

5.11 Practice A (High QOF, low Patient Satisfaction Scores)

I contacted the practice manager by email introducing myself and the project. I invited them to be involved as a case study and explained that I had selected them because of their high QOF overall achievement scores. I explained that we had used a quantitative shrinkage model which demonstrated that not only had they had one good year of QOF scores but that results from our model showed that they had a 3-year average of good QOF overall scores.

They invited me to meet with senior staff members following which they agreed to participate in the project. I was invited to attend a Patient Participation Group meeting in July 2016 and gave a short presentation about the project. Following the meeting I collected the contact details of the 8 patients present, all of whom agreed to be interviewed. Three patient interviews were conducted at this practice. One person moved country and the others, on reflection, changed their minds about being interviewed or did not respond to the follow-up phone calls.

Practice A is located in a major city in an area with high levels of deprivation. It is a busy practice with a diverse patient list. The practice had recently moved location from a small, run-down building into a new, modern multipurpose NHS medical centre. It was taken over by a Health Community Interest Company in 2013. When contact was first made, the practice had not yet moved to its new premises. The practice manager requested that interviews be put on hold until after the move. When fieldwork began the premises were very new and staff and patients were settling into their new practice accommodation.

The practice served a population with diverse ethnic groups. Its location has historically suffered from high levels of deprivation, but recent developments of several large, new apartment complexes were being built (with several already established blocks) and were changing the area's demographic makeup. Staff commented on how this had impacted on the practice. One staff member commented that opening hours had changed in response to demands from the inhabitants of the new apartment complexes. They needed appointments outside working hours as they worked full time. This was a new demographic for the practice

as it had traditionally served a population who may not have been in full-time work and therefore could attend appointments during the working day. The practice was adapting to the new demographic and revised appointment times represented one of the ways it was changing its offer to the local population.

Changes in the neighbourhood did not pass by without comment from practice staff who noted that the new apartments being built were designated as 'Help to Buy' and 'Affordable Housing' schemes. One respondent noted that even on such schemes the average salary needed to secure one of these properties was still beyond what most local people earned in the area. Practice A had a long history of being rooted in the community and fulfilling a role in the local community network by holding open days and family fun days with other local services such as the fire station (located in the neighbouring building). The staff were keen to convey this relationship with the local community, recalling how they would dress up and run a barbecue for the neighbourhood on such occasions. Local roots and staying connected with the patient population and local community formed a key part of the practice's identity.

5.12 Practice B - Low QOF, High Patient Satisfaction scores

The second practice to be recruited belongs to the low QOF/high patient satisfaction group. This practice is in the outskirts of a city in the North of England. It has a largely urban population list. Initial contact with the practice manager was positive. The practice manager expressed surprise when I told her that the practice had been selected due to its high patient satisfaction scores (measured by question 28 on the GPPS). The practice was unaware of question 28 on the GPPS and had not looked up their results. Instead, the practice manager was concerned about the practice's Star Ratings on the NHS Choices website. Consequently, I was able to pass on good news. This helped when discussing the practice's participation in the research. The practice manager confirmed by email the willingness of the GP Partners to participate in the project. Following this confirmation, I gained Research and Development approval from the relevant Clinical Commissioning Group. The practice had a longstanding GP partner who was extremely popular with patients. The practice manager informed me that many patients waited up to a month to see him and that he had cared for generations of the same families at the practice. Patients and staff at the practice all referred to this GP and his popularity with the patients during interviews. His popularity was cited with a sense of pride amongst his

colleagues and patients. I was interested to understand if the practice's high patient satisfaction score (measured by Q28 on the GPPS) was explained by the popularity of this one GP or if it might be interpreted as reflecting something more general about the way the practice was run and managed by the whole team.

I attended a staff meeting in November 2016 at which I introduced the research project. The practice Patient Participation Group had recently successfully contested their latest rating on NHS Choices of 'among the worst.' The rating had been revised and was currently rated as Good by the Clinical Quality Commission. It is interesting to note that the practice manager and team placed more significance on the NHS Star Rating system than the GPPS. The practice manager was protective of her staff team and mentioned to me that she had tried to shield her staff from the practice's poor patient satisfaction scores measured by the NHS Star Rating system. The practice's low Star Rating had been featured in the local press and staff morale was low as a result. It is interesting that Q28 on the GPPS was at odds with the Star Rating system. This worked in my favour in terms of recruitment because when I explained to staff that the GPPS gave them a very high patient satisfaction score interviewee's relaxed and seemed keen to participate in the research.

5.13 Practice C – High QOF, Low Patient Satisfaction scores

Practice C is a member of a 'super practice' organisation in the Midlands. It is one of five practices that had recently joined together and were now operating as a joint, multi-site practice. The practice list size ran into the thousands and staff worked across sites. The organisation was a few years into the new arrangement and staff were becoming used to their new colleagues and ways of working. The case study practice with which I was working had been selected due to its high overall achievement QOF score. Prior to joining the multi-practice organisation, the practice had been a well-established practice in the city. Its practice list represented an urban population with expected quotas of deprivation and age distribution. Its patient satisfaction scores were poor (measured by Q28 on the GPPS) and it was of interest to me to understand if high QOF achievement scores had been secured at the expense of patient satisfaction or if the recent merger into the 'super' practice configuration was responsible for poor patient experience which might improve once the dust had settled. Some of the GPs who took part in the research had been at the practice for the whole of their working lives and cared deeply about the practice, the

staff team, and their patients. The reorganisation was still new when fieldwork was conducted, and interviewees were generous in sharing their thoughts and experiences.

5.14 Practice D Low QOF, High Patient Satisfaction scores

The final case study to be recruited is the only single-hander, family practice in the research. This study was located on the outskirts of a large town and served a semi-rural population. The lead GP was joined by his daughter as a GP. The practice manager and practice nurse was the wife and mother. It was a practice run by one family. The practice had been selected because it had very high patient satisfaction scores (Q28, GPPS). When recruited to the study the daughter was unaware of this score and was delighted to hear of it. This reflects the experience of the other case study practice in the research with very high patient satisfaction scores which had also been unaware of the Q28 score in the GPPS. This raises questions of why general practice staff are not aware of the GPPS, Q28 score and why it is not used more widely. This case study was interesting because it allowed a peek into generational change in attitudes towards performance monitoring and new public management principles of organising and ranking organisations in a very public manner. The father (GP) who had established the practice was completely opposed to the QOF and the GPPS, while the daughter (GP) had accepted the new public management arguments that lead to increased accountability and that this would lead to improved performance. This was a small general practice with three members of permanent staff and one locum who was also interviewed. There were not any non-clinician members of the team. The father GP was very popular with the patients and seemed to have acquired a legendary following among them. It was a practice that was led by a charismatic GP personality.

I produced a bespoke report for each practice taking part in the project, detailing their engagement with the project. This would be useful for them when demonstrating their responsiveness to patient needs, a key requirement by which they are measured during a CQC inspection.

5.15 Qualitative Sampling within case study sites

5.15.1 Ethics and interviews

When recruiting patients, variation and heterogeneity was sought when possible. The ethics regulations meant that a minimum of twenty-four hours had to be given between a participant signing the consent form and conducting the interview. This applied to staff and patient interviewees. This was to allow for participants to change their mind if they so wished. It allowed for the possibility of the participant agreeing to take part because they might have been recruited in a group situation such as a team meeting, and later, upon reflection regretting their decision and wanting to retract their agreement to be interviewed. The twenty-four hour minimum period would allow them to be certain they wished to participate.

During fieldwork, I found this to be an obstacle to recruiting participants – particularly so for patients. To be in a situation with a group of patients usually took a lot of organisation on my part as well as that of the practice manager's. Usually, I found that after a ten-minute presentation, most patients around the table were keen to take part and wished to share their views and experiences. When I told them that the earliest, I would be able to conduct the interview would be the following day, I would often lose their interest. They did not know when they might next be in the practice and most were reluctant when I offered to meet them in convenient location, such as a local café. People were willing to participate immediately but did not want to be contacted the following day to set up another arrangement. The situation was more positive regarding staff. A twenty-four-hour delay was not such a problem for staff, as they knew when they would next be at the practice. Hence, interviews were arranged accordingly. This meant that in total, I conducted more interviews with staff than patients. Interviews with patients were conducted in person and via telephone. They were conducted pre-pandemic and before the use of Zoom and other apps was as widespread as it is today.

The study design adopts a theoretical position (Shore & Wright, 2015) described in chapter 3, The case study method can accommodate a theoretical investigation by allowing for a theoretical or purposive sampling method (Mays & Pope, 1996).

> "An alternative approach, often found in qualitative research and often misunderstood in medical circles, is to use systematic, non-probabilistic

sampling. The purpose is not to establish a random or representative sample drawn from a population but rather to identify specific groups of people who either possess characteristics or live in circumstances 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 approach to sampling allows the researcher deliberately to include a wide range of types of informants and also to select key informants with access to important sources of knowledge", (Mays & Pope, 1996, p. 109).

As outlined in the previous section, the quantitative model controlled for demographic variables in practice lists when sampling potential case study practices. To continue the rigour when sampling at case study sites, a purposive sampling method was employed.

5.16 Data Collection: Qualitative fieldwork

5.16.1 Staff interviews

When recruiting staff, efforts to interview staff across as wide a range of job roles as possible was made. The project was presented at staff meetings at two case study sites. At the other case study sites, details of the project, along with invitation to interviews were sent to the team via the senior partner GP who agreed to present it at a team meeting. This method delivered a good number of staff agreeing to be interviewed. Between five and twelve staff interviews were conducted at each case study site. In some cases, this represented the total practice staff team.

In the next section I present tables detailing how many interviews were conducted at each case study site, by job role, gender, and age group. Staff were asked to give their age by banding, shown below.

Tbl 4: Age Bands, Staff Participants

A	16-20
B	21-30
C	31-40
D	41-50
E	51-60
F	60+

Tbl 5: Practice A: Interviews conducted by job role; age and gender

Job Role	Number	Female	Male	Age Band
GP Clinical Lead	1	0	1	D
GP partner	2	2		1 D: 1C
GP Salaried	1		1	C
Practice Manager	1		1	C
Deputy Practice Manager	2	2		C
Patient Liaison Manager	1		1	B
Nurse Practitioner	1	1		D
Reception Manager	1	1		C
Healthcare Assistant	2	2	0	C
Total	**12**	**8**	**4**	

Tbl 6: Practice B: Interviews conducted by job role, age, and gender

Job Role	Number	Female	Male	Age Band
Apprentice Admin	1	1		A
Nurse Practitioner	1	1		E
GP Partner	1		1	D
Practice Nurse	1	1		D
Receptionist	1		1	D
Practice Secretary	1	1		C
Admin Prescriber	1	1		C
Reception Manager	1	1		C
Total	**8**	**6**	**2**	

Tbl 7: Practice C: Interviews conducted with staff by job role, age, and gender

Job Role	Number	Female	Male	Age Band
GP partner	2	1	1	D
Clinical Quality Director (GP)	1		1	C
Clinical Services Lead	1	1		C

Lead Nurse	1	1		C
Clinical Performance Lead (Admin)	1	1		C
Lead Advanced Nursing Practitioner	1	1		C
Total	**7**	**5**	**2**	

Tbl 8: Practice D: Interviews conducted with staff by job role, age, and gender

Job Role	**Number**	**Female**	**Male**	**Age Band**
GP Partner	2	1	1	1 F; 1C
GP Salaried	1		1	F
Practice Nurse	1	1		F
Reception Head	1		1	C
Total	**5**	**2**	**3**	

In total, 32 interviews were conducted with staff, this included twenty-one female staff and eleven male staff.

5.16.2 Patient Interviews

I was very aware that practice staff are busy. I did not wish to add to their workload. To encourage recruitment to the study, I had carefully outlined how I planned to recruit patients in a manner that would not add to the workload of staff. To protect practice staff time, I planned to recruit patient interviewees to the project by working with the Patient Participation Group at each practice.

Recruiting patients for interview through the Patient Participation Group introduces an element of selection bias to the sampling process. Patients who are members of the Patient Participation Group are volunteers, committed to the practice and prepared to give up their time to contribute towards practice improvement and ensuring patient voices are heard in matters of practice development. In this sense they should not be considered as typical practice patients. Due to the requirement to give up their time and attend meetings, members of Patient Participation Groups are usually retired or towards the end of their working careers with more disposable time.

All these factors mean that the patient sample would not be representative. This was acceptable for my project because I was not seeking to construct a statistically representative sample, yet it represents a definite limitation to my research.

Recruiting participants from the Patient Participation Group meant that they might be better informed about the practice and its development than non-members. They might also be more confident when expressing their views about the practice as they might be practised at having their voice heard at practice meetings with staff. They may also be confident speaking in public and challenging practice staff about issues important to the patient body. They may also have a more relaxed, informal relationship with practice staff than non- Patient Participation Group member patients and this may result in them feeling more comfortable when giving their opinions.

A challenge was to ensure that sufficient attempts were made to recruit widely amongst the practice's patient population. My solution to this challenge was to enquire about, and join, extra-curricular groups set up by the practice. For example, at Practice A, I joined the Walking group and the Gardening group, both met weekly and were run by patient volunteers. I also produced a flyer and a poster to be left at reception for patients to take as they wish. The aim was to make every effort to recruit participants beyond the PPG membership.

While every effort was made to recruit outside the Patient Participation Group as well as within it, I would not wish to give the impression that patients who were PPG members and who generously gave their time, and shared their experiences were not appreciated and valued.

The table below shows the number of patients interviewed at each case study site, with age and ethnicity information.

Tbl 9: Age Bands, Patient Participants

A	16-20
B	21-30
C	31-40
D	41-50
E	51-60
F	60+

Tbl 10: Patient Profile by Case-Study Site

	Number	Female	Male	Age	Ethnic group	Years at practice
Practice A	3	1	2	F	White British: Black Caribbean	4; 5; 30
Practice B	2	2		E	White British	15; 20
Practice C	2	2		F	White British	57; 35
Practice D	2	1	1	F	Asian/Asian British	-
Total	**9**	**6**	**3**			

In total, nine patient interviews were conducted. This was a disappointing result after a lot of work had been invested into attempts to recruit a larger sample. Engaging patients in research remains a problem for primary care – it seems that Patient Public Involvement still presents a challenge to researchers working in this area. "Despite sustained UK research policy advocating the importance of PPI, public contributions are often absent or minimal in reports of primary care research." (Berman & Bezkor, 2010).

Patients who were interviewed in my study were congregated in the higher age bands. This had some benefits in that it offered a deep source of knowledge about the practice (some had been with the practice case studies for many years), but it meant that interviews with younger patients were not conducted. The constraints placed upon recruitment of patients through my ethics permissions, played a large part here in presenting an obstacle to the recruitment of patients (of all ages) to the study. These are discussed elsewhere in this thesis. As a result, the findings from the study concerning patients are weakened, and should be interpreted as such.

5.16.3 Methods challenge: Interviewing patients about QOF and GPPS

When seeking to interview patients at the case-study sites I faced an interesting methods problem. The study seeks to understand the impacts that the introduction of

the QOF and the GPPS have had on the working lives of staff and on patient experience in English general practice. Some patients may have had experience with the GPPS through being selected to complete it, but the likelihood of those patients being recruited to the research is slim.

Furthermore, the QOF is a tool for general practice staff. It is highly unlikely that any patients will have heard of it and/or know what it involves and what it requires. This presents a methodological challenge of having to ask patients about how something has impacted on their experience at the practice, without them being aware of it (this mismatch between the amount of knowledge about QOF patients have compared with practice staff is discussed in Chapter 6). The solution decided upon, was to assume that while some patients may have an awareness of one or both data sets, I would begin fieldwork assuming a low level of awareness of both instruments amongst patient interviewees. I also decided to ask proxy questions – for example, I asked patient interviewees about their experience in the consultation and if they felt the reason they had come was addressed by the attendant clinician and if the clinician ever introduced new topics such as suggesting they take the patient's blood pressure, into the consultation. Furthermore, I asked patient interviewees how they felt about this. For example, did they find this annoying or distracting or did they view it as evidence of care and attention from the clinician. Opportunistic care (for example, the taking of blood pressure readings when conducting a consultation with a patient) is one way of attending to QOF disease registers as well as raising the quality of care within the practice.

Another approach might include an introductory paragraph outlining the details of QOF and GPPS and what they aim to do at the start of patient interviewees. A study, aimed at gathering patient views on the Quality and Outcomes Framework (QOF), took such an approach and began the interviews with an introduction to the Quality and Outcomes Framework (QOF) and how it works (Hannon, n.d.). The authors felt that this did not bias the data collected in the interviews. However, the aims of the Hannon et al study was to gather the views of patients about QOF. My study is seeking data that is slightly harder to grasp – people's experiences of their general practice at a snapshot in time when QOF is operational in general practice.

I was reluctant to become distracted by explaining the technicalities of the QOF and the GPPS during a patient interview. It might be confusing, and I did not wish to position myself as a managerial professional. This may serve to make them feel that they are 'failing' already at the start of an interview as they may find the concepts behind the QOF and the GPPS hard to grasp. I did not think it would produce a setting in which they would be comfortable, relaxed and feel able and willing to share their thoughts. I was interested in their experience of care received at their general practice and I did not think that whether they are aware of the QOF and the GPPS or not, would impact on their experience as a patient, even though it undoubtedly impacted the care they received. My proposed solution was that I would use my judgement when analysing fieldwork findings to judge whether the two tools have impacted on the care patients receive from their general practice.

The role of interviewer as possessor of more knowledge than the participant is one addressed by Simmel in his essay on secrecy (1906). Simmel discusses the differential distribution of knowledge in modern societies and recognizes that organisations are structured in ways that prevent some groups of people finding out or having access to certain types of knowledge. Becker recognizes this concept in his own fieldwork with university students on campus in the 1960s. While Becker knew more than the research participants about aspects of their university, he makes the case that:

> 'The reason they didn't know …was not that they were stupid or uneducated or lacking in sensibility, but that campus life was organized so as to prevent them finding out.' (1998, p. 100)

While the audit tools I am interested in are publicly available, and a case could not be made that any institution prevents people from finding out about them, it remains that many of my patient participants will probably never have heard of QOF and/or the GPPS. The respect for participants implied in Becker's approach to his participants is one that I aimed to adopt during my fieldwork and subsequent writing up.

The role of interpreting the interviewee's responses places the interviewer (and in my case) researcher in a position of power over the interviewee. I will try to interpret the respondent's meaning. The risk is that I interpret their words with my meaning. This

problem of interpretation is not new to social science methods literature. There is a large body of literature devoted to advising how to reduce researcher bias during the qualitative interview (Finlay & Gough, 2003; Polgar, 2000). However, even if the researcher follows the advice diligently, it is important to recognize that the risk remains. The goal of bias-free data collection and analysis is impossible to achieve, and some would debate whether it is desirable at all (Briggs, 1986).

One solution to this dilemma is to strive to be highly reflective in terms of my role as interviewer and interpreter of information. I kept a reflective journal detailing my responses and thoughts about all aspects of the project. There is not a perfect solution to this problem, but awareness of it before the process of data analysis begins may prove useful. It clearly highlights the responsibility that the researcher/interviewer holds.

5.17 Qualitative data analysis methods

Once fieldwork had been conducted, I used two approaches to analysing the data. These were the data-driven approach and the theory-driven approach. I shall deal with the data driven approach first.

5.17.1 Data-driven analysis

As already described in a previous section, my sampling design originated from Eisenstadt and Graebner's (2007) paper, which described a comparative case study analysis. The data is approached from a theory-free perspective. During the process of analysis, a theory is built from findings of the case studies. The authors recommend that the researcher adopt an iterative and reflexive relationship between their data and emergent theory. They argue that such a closeness between the researcher and their data will result in a truer relationship between researcher and data.

5.17.2 Theory driven data analysis

In theory driven research, the researcher begins with a theoretical framework. The goal of theory driven data is not to confirm the theory, it is to 'seek refutations that deepen a theory' (Burawoy, 1998). Burawoy considers his ethnographic work in Zambia's copper mines post-independence and argues for the social scientist to engage with theory through a series of 'refutations'.

> “In our fieldwork we do not look for confirmations but for theory's refutations. We need first the courage of our convictions, then the courage to challenge our convictions, and finally the imagination to sustain our courage with theoretical reconstruction. If these reconstructions come at too great a cost, we may have to abandon our theory altogether and start afresh with a new, interesting theory for which our case is once more an anomaly.” (Burawoy, 1998, p. 20)

> “Theory is essential to each dimension of the extended case method. It guides interventions, it constitutes situated knowledges into social processes, and it locates those social processes in their wider context of determination. Moreover, theory is not something stored up in the academy but itself becomes an intervention into the world it seeks to comprehend… This refutation, like any other, is not cause for theoretical dejection but an opportunity for theoretical expansion.” (Burawoy, 1998, p. 21)

The qualitative researcher is seeking anomalies or inconsistencies with their chosen theory. Once identified, the process of reconstruction may begin, whereby the theory must be reconstructed to explain the anomalies or inconsistencies. The core postulates of the theory should be left intact during the process of reconstruction (Burawoy, 1998).

The advantage of this approach to data analysis is that theories are not simply discarded when they do not fit. By reconstructing them to explain the anomalies it is hoped the theory can predict new areas, achieving the goal of truly progressive research.

The concept of reconstruction will be useful for my study because I am extending Shore & Wright’s analytical framework of audit cultures to a new field, general practice (2015). As a result, anomalies and inconsistencies may emerge which will test the framework. The theory and analytical framework may have to be reconstructed. Theory-driven approaches often use cross-case comparison methods as well as data-driven approaches.

My study adopts a theory driven approach (using Shore and Wright’s (2015) analytical framework to analyse the impacts that the QOF and the GPPS have had in

English general practice on staff and patient experiences) with a cross-case comparison method (Eisenhardt, 1989). I employ Burawoy's theory driven approach to refine the analytical framework of Shore and Wright (2015).

The case study findings were interpreted in reference to the analytical framework developed by Shore and Wright. As explained elsewhere in this chapter, it was hoped that through such refinement, or adjustment to the framework, that the case study findings would identify new and/or unique effects of audit culture when viewed in the context of English general practice and the tools of the QOF and the GPPS.

The study employed polar type sampling in the first round of quantitative sampling. This chapter has explained how this resulted in splitting practices into two data sets (High QOF/LOW GPPS Q28 scores) and the opposite, contrasting group. As discussed earlier in this chapter, this was done because the Eisenhardt and Graebner's method suggests that this polar type sampling method might produce contrasting findings. As the process of data analysis was conducted it became apparent that there were no distinctive differences between the two groups. This is discussed in more detail in the following two empirical chapters. This meant that as a result, analysis of data was not done in polar type groups. Analysis of data and presentation of fieldwork findings is conducted as a snapshot of each practice.

5.18 Reflections on recruiting practices

Recruiting practices has been difficult and lengthy. To recruit one practice takes months. Practice managers perform a crucial gatekeeper function, which serves to protect their GPs from extra work. It is a challenging time to approach practices and request access. General practice is undergoing a recruitment crisis, most practices are understaffed, and morale is low amongst GPs (McKinstry et al., 2007).

After conducting the first few months of fieldwork with the two practices, it became clear just how busy and overloaded with work general practices were. It was not surprising that so many did not want to add to their workload by participating in my research.

It was difficult to engage practice managers (in a phone conversation) when talking about research on patient satisfaction. Reasons for this may include that to date the GPPS is not popular with practice staff (Asprey et al., 2013) who reported the extreme unpopularity of the GPPS amongst GPs and practice staff. Reasons for this

include questions raised about the reliability and validity of the results as well as the time lag between when a patient last visited the practice and when they are asked to complete the postal questionnaire. In 2016 the Care Quality Commission (CQC) began including some questions from the GPPS in their assessment of a practice under their new Intelligent Monitoring System. While still unpopular with practice staff, such a development may make it even less popular as it will now be associated with the Care Quality Commission in the eyes of practices. The Care Quality Commission is not popular with practices as it holds a final and extreme power to recommend that a practice be closed. It is extremely rare that it would do so, but it can if it deems it necessary.

When writing up themes that were generated from analysis of the data, close attention will be paid to the language used. Following Braun & Clarke (2021) rather than discussing *emerging themes* I will use 'theme generation' and recognise that theme generation is an active and creative process, to which researchers are central. Braun & Clarke (2021) argue that thematic analysis should be recognised as 'theoretically flexible, not atheoretical' (p.338).

5.19 Summary

This chapter has sought to build a case to justify my choice of research methods to best answer the research question. I hope to have shown that the case-study approach will deliver a method that is flexible enough to probe participants and refine the theory of Shore & Wright and how it might apply to English general practice. It will also deliver an analysis of a case in its entirety, its real-world context. This will provide a rich context for understanding participant experiences of their general practice as members of staff and as patients.

Chapter 6 Differential impact of metrics on professional identity within general practice

6.1 Introduction

Chapter 4 outlined how QOF was negotiated between key actors and policy brokers from central government representing the Department of Health and general practitioners represented by negotiators from the General Practitioners Council which is the general practice branch of the British Medical Association. It also analysed how both the QOF and the GPPS were accepted by the medical profession and general practice patients.

This chapter presents findings from the fieldwork interviews and seeks to move the analysis from the central policy debates which saw the introduction of both sets of performance instruments discussed in the previous chapter - to the micro-level of investigating the impacts of the QOF and the GPPS on general practices, their staff, and patients. This chapter will present the findings from three years of qualitative fieldwork with four case-study general practice sites located across the UK. Details of the interview guides and topics are given in Appendix 2 and 3.

Staff and patients were asked about their views, experiences and thoughts concerning how QOF and the GPPS had impacted on how they worked or received care from their general practice. Patients were asked in a more general form about the care they received as many of them were unaware of the QOF (although when prompted, some did recall mention of it, but did not know what it was). Most had heard of the GPPS, some had even completed a questionnaire, but were unaware of what happened to their data once the survey was completed. While most patient respondents had trouble identifying what the Quality Outcomes Framework was or what the General Practice Patient Survey did, most were aware that their practices were being monitored, at some level, on their ‘customer service’ and performance. All patients were unaware that data from both sets of metrics (QOF and the GPPS) were publicly available, and further still, that this information could be used (and in the case of the GPPS was intended to be used) to equip and enable patients to make choices about which practice they ‘chose’ to register with.

The sampling design (discussed in detail in chapter 5) determined that efforts were made to interview all staff roles within each case-study practice. This included those

in partner and salaried clinician roles. Administrative roles were included ranging from apprentice receptionist through to practice manager roles.

While designing the study, I had (incorrectly) assumed that experiences of QOF and the GPPS would fall into two neat categories in relation to staff. One category would involve clinician experiences and a second category would involve non clinician staff roles. I also assumed that working to, and delivering QOF and GPPS targets, would be experienced uniformly by clinicians and in a similarly uniform way by non-clinicians. As discussed in detail below, some themes did fall into two neat(ish) categories between staff based on clinician and non-clinician status. Most though did not, and themes were not so tidily categorised. Rather than attempt to tidy up these themes, I have tried to remain true to the messiness of the data and present it here as it emerged from the fieldwork. Consequently, analysis may at times feel frustratingly messy but this, I believe, reflects the reality of general practice in England at the time fieldwork was carried out.

In line with this approach to the analysis of the data, I have grouped themes under meta-themes. These meta themes are loose and occasionally overlap. This is intentional. Each meta theme holds within it several related themes that appeared to belong together. This was the only attempt made to tidy the data for presentation.

The chapter will present all the emergent themes under the main theme of the differential impacts of metrics on the professional identity of staff in English general practice. This theme fulfils an umbrella function under which all the other emergent findings fall. I have chosen to organise this chapter around the differential impacts of metrics on staff professional identity because it represents a new finding in this field. It also allows me to demonstrate and attempt to explain why some of my findings contradict previous findings in this field. Organising this chapter around the main theme of professional self-identity of general practice staff necessarily means that patient experiences will not take centre stage. Some patient experiences are included in this chapter to accentuate a point raised by staff or to further an example given by staff. Patient experiences of the impacts of QOF and the GPPS will be detailed in full in the following chapter.

6.2 Enabling bureaucracy

Interviewees were asked to talk about their thoughts on QOF and the GPPS and how either had affected the way they worked or received care as a patient. As discussed in greater detail in the Methods chapter, this topic was posed differently for patient interviewees.

One meta theme to come from the data centred around an admission that QOF helped staff in their daily roles at the practice. For some roles (most notably those in the administrative sector) this was expressed more enthusiastically and spontaneously than amongst clinician interviewees.

6.2.1 Administrative views: Enabling bureaucracy

All staff interviewees, with varying degrees of enthusiasm, noted that QOF was helpful in their daily work. For some, it was a welcome intervention, making their daily work more manageable and focused. For others, it lent a sense of team building as colleagues worked together to 'hit' their targets. When targets were reached, respondents talked about a sense of team spirit and achievement. Amongst GP respondents, positive views about QOF were voiced in a quiet tone, perhaps an indication that the participant felt it was not acceptable to speak such thoughts aloud. This reluctance to speak about the helpfulness of QOF was not echoed in interviews with clinicians in nursing roles – who were quick to offer positive, unprompted comments about some aspects of QOF.

The administrative team in a general practice covers a multitude of roles and is used here to include any staff who are not clinicians (general practitioners or nurses). There was some discussion about whether to include health care assistants (HCAs) in the category of clinicians, but after seeking advice from colleagues, it was decided that HCAs should not be included as clinicians. Reasons given included that HCAs do not make clinical decisions and act under the supervision of a trained healthcare professional (personal communication). Roles covered by interviewees who were part of the admin teams included practice manager, deputy practice manager, patient liaison officer, receptionist, reception manager, practice secretary and admin prescriber and HCAs.

In contrast to the literature and trade press on QOF and GPPS in which QOF and the GPPS receive a negative portrayal as intrusions into the professional daily work of GPs, my fieldwork interviews with administrative staff revealed surprising insights. Respondents in administrative roles gave glowing reviews of QOF and its impact on their working lives at the practice.

Reasons why positive views of QOF were a surprise finding in this field might be explained by the lack of inclusion of the views of administrative staff on metrics and their effects, in previous studies. The GPPS was hardly mentioned by interviewees during the loosely structured interviews. This will be discussed in a later section. The rest of this section explores the views and experiences of the administrative staff at the four case studies.

Administrative staff were encouraged to begin by reflecting on how QOF affected their daily workload. It became clear, that for most, QOF formed a substantial proportion of their work. Some talked about how QOF gave a purpose to their job and how they could not imagine their role without it.

Quote 1:

Interviewer: I mean without QOF can you imagine what your day would be like?

Receptionist: Well, there wouldn't be ...there wouldn't be much of a purpose without it...I think. From the admin side of things, we aim for the highest percentage we can on QOF so I think it would be...it would be very weird without it...because we wouldn't really have anything to aim for. .... It gives you a purpose, yeah, to my job..." (Practice A: reception staff)

There developed a theme of how metrics fulfilled a purpose for the team, in that it gave them something to 'aim' for. Many spoke about how, while it could be stressful at times, it gave them a sense of team spirit and fulfilment when targets were finally met.

Quote 2:

> it's an achievement for the reception team, it's more of a personal achievement. They feel happy when they know they can see their targets are done. They feel happy or disappointed in themselves when they feel they've done it... (Practice A: Reception Manager).

The sense of challenge and achievement provided by working to a target culture was echoed by other interviewees in this group.

Quote 3:

> It depends on the month I think because the first few months, it will be bad. But as soon as it (spreadsheet) starts going green you feel a bit more, like, calm, and you come in and you're like 'ah it's ok we're getting there'. But yeah, when it is red it's like...I wouldn't say stressful that it affects you that much but it's like in the back of your mind that, right I need to get these patients...(Practice B: Apprentice reception staff).

When targets were met, or the spreadsheet had moved from red to green, a personal sense of satisfaction was expressed,

Quote 4:

> .. But it's like a sense of achievement doing it, because at the start of (the) year everything is red and then (we) aim for it all to be green by the end... and then if it is all green then you feel really good because you're like 'yay I've done it.' Practice B: Apprentice reception staff).

6.2.2 Contributing to quality improvement as a team

The theme that QOF offered a useful framework through which it was possible to drive up quality standards as well as being a way to structure one's workload developed across all job roles within the case-study practice teams. While this was expected from clinician interviewees, it was of interest that it was spoken about by administrative interviewees.

Much of the work of QOF is conducted and processed by the administrative members of the practice team. This involvement in the enabling of QOF to be performed by their clinician colleagues has led to a sense of administrative staff members being involved in the process of delivering improved quality standards. It is beyond the scope of this PhD to reflect on how administrative staff might have felt in relation to involvement in delivering quality standards to patients in pre-QOF times, but it might be argued, that by making admin teams responsible for specific targets that directly contribute to achievement of QOF points (for example, ensuring patients attend for annual reviews etc) that this has enabled those administrative team members to have a sense of ownership and contributing towards driving up quality standards. It could be argued that QOF has made this process of contribution explicit whereas in pre-QOF times, while this essential work was always carried out by administrative team members, it was not made explicit or was rendered invisible.

Quote 5, below from a deputy practice manager demonstrates how much they identify the framework of QOF as being key to their provision of quality care to their patients.

Quote 5:

> I mean, with QOF, what it's really given us is a structure. It's a framework, it's a structure...We still want that structure. We will have a certain structure, you know, to fall back on then, just to make sure that we're still providing a certain quality of care for our patients (Practice A: Deputy Practice Manager)

QOF with its templates and structured way of organising workloads has allowed the work of the administrative team to be recognised as an essential part of the provision of high-quality care.

Quote 6:

> Yes, I can see because it changes the focus for us in reception. And we are getting people in for their reviews. So, we are making sure people get the care they need (Practice B: Reception Manager)

An excerpt from an interview with a healthcare assistant illustrates how she views her role as making a difference and how that contributes to a sense of job satisfaction.

Quote 7:

> A lot of those patients, when we do the NHS health check, they are at higher risk of getting cardiovascular disease. And without us prompting them to come in, and sending them letters, that gets missed out and then they're just like normal people going around with high risk of, you know, cardiovascular disease. But they're not being checked. So, I think it does, I feel like we're making a difference. It is a nice feeling (Practice A: Healthcare Assistant)

6.2.3 QOF: an aide-memoire

Despite the widespread view of QOF in the literature and trade press as negative and contributing to GP stress and burnout, my fieldwork interviews delivered some honest views from clinicians about QOF and GPPS. Amongst some negativity about QOF and particularly GPPS, most admitted to finding QOF helpful. The most often heard theme was that QOF acted as an aide-memoire in a world where it was hard to keep up with information. Many clinicians (GPs and nurses alike) commented that they might not remember to do all the tasks in a consultation without the QOF alerts.

Quote 8:

> And that's the beauty of a computerised system. Having worked in a non-computerised service before 2000 or something like that, you know, I mean I wrote everything by hand. I used to despair because I couldn't remember everything, you know? (Practice D: GP partner)

Quote 9:

> So, if somebody is coming for blood pressure, I need to bring his blood pressure down, be it the QOF or not the QOF. So, what the QOF does, is it reminds me. And it tells me to ask those questions about smoking and cholesterol and stuff. I'm not sure if QOF hadn't been there if I'd have been

> still asking those questions. I'm sure I would have been. But now because it's a QOF and it comes (up) when you go into the system it still tells you what's pending on the QOF, then you do ask...It just ...it's just changed the way you do things (Practice A: GP, salaried)

Amongst GP respondents there seemed to be a wariness about expressing any positive views of QOF - in some cases, checking the confidentiality of the interview before they proceeded.

Quote 10:

> I think generally people seem to feel negatively about QOF. That's the feeling, so if you are talking about QOF it's 'ah you know' it's a pain and why do we have to do this? and you know, it is time consuming and it's costly sometimes... I guess we feel, you know, that people are always checking up on us to make sure you're doing the right thing... so there is genuine negativity about it, but I'm sure that when people are not talking to other people about it and moaning about it, that actually they do feel that there are benefits to it (Practice A: GP, salaried)

The hesitancy of voicing positive experiences of QOF was found across most interviews with general practitioners.

Quote 11:

> I'll be shot for saying it (but).... I mean I think we should be scrutinised; I mean obviously there is a level of scrutiny where you feel like your clinical judgement is being questioned but actually, I think it makes you a better clinician, you know? How do you know you are doing what you should be doing? You know? It just gives you a way to improving... I mean I'm not a huge fan of metrics either... but somebody just overseeing? I mean why not? (Practice A: GP, salaried)

Even with QOF becoming such an established part of daily life for every general practice in the country, GPs were hesitant and wary of expressing positive views of it. This may tell us something about the culture or acculturation of being a GP in

modern general practice. One respondent spoke about how it was likely that in private, GPs might admit that QOF is useful, but that the culture of speaking about QOF in public, amongst fellow GPs, deemed that it had to be complained about. This highlights the tensions between structural positions amongst GPs. Those GPs who have positions with the CCG or within the practice such as Clinical Lead on QOF, or senior management, speak positively about QOF and metrics without the hesitancy of GPs who do not hold management positions. This is not surprising, as those with CCG positions are already 'on board' the QOF/metrics 'wagon'. In this sense, positivity about QOF might also be interpreted as a proxy for career progression within a practice.

6.3 Bureaucracy is not experienced homogenously

A theme that featured in all staff interviews was that QOF brought with it extra work. With the extra work came pressure and stress. While most respondents spoke about pressure in their roles, fieldwork interviews revealed that some roles experienced more pressure than others, in relation to QOF. In other words, the stress of delivering QOF was not distributed equitably throughout the practice team. The roles of Practice Nurse and Practice Manager were identified by all staff interviewees as the roles that carry the heaviest work burden of QOF. For some team members, QOF was not a source of stress and hardly impacted on them. For others, it shaped their entire day, every day.

In contrast the General Practice Patient Survey, was hardly mentioned by interviewees. Staff interviewees had to be prompted to speak about it. When they did speak about it, it was dismissive, to confirm that it did not affect their work and that when the results were released, they generally ignored them.

6.3.1 The Practice Nurse role

Several interviewees identified the role of Practice Nurse when asked to speak about the burden of QOF work and where it fell on the team.

Quote 12:

> I feel, maybe because I've not had a personal vested interest in this kind of stuff - ....so (for) someone like a Practice Nurse who really has to have a

> handle on our performance it will be a very different ball game and absolutely... yeah it is important. So, I would say the stress is with the admin staff, because they have a very long call and recall list that they have to go through, obviously trying to get people in, you know care plans to be completed in an appropriate way ... I mean, (Practice Nurse), she is the one that holds this really, and her team" (Practice A: GP, salaried)

This excerpt demonstrates how for this respondent they had been able to remain detached from QOF. The fact that they were able to not "have a personal interest in this stuff" demonstrates that for some team members, they are able to pass on the stress of QOF to others within the team. This interviewee recognised that the stress of QOF lies with the admin staff and in particular the Practice Nurse role. This is interesting in terms of who benefits (financially) from QOF and when thinking about how QOF was negotiated in its development.

One interpretation might be that the GP profession ensured that they received the QOF payment but passed the burden and responsibility of the work on to administrative and nursing colleagues. It is also interesting, because as we saw in chapter 4, one of the key pillars of the new public management principles is accountability. One of the main reasons QOF was introduced by the Blair administration was to make the GP profession more accountable to the state. In return an increase in salaries in the form of the annual QOF payment was offered. My fieldwork reveals how the work of QOF falls largely to the Practice Nurse role and the work of providing evidence that accountability has been duly rendered, falls to the Practice Manager.

Another interpretation might be that while it appears to be the Practice Nurse and Practice Manager roles that have taken the heavy lifting of QOF, it is the GP partner(s) whose name(s) holds ultimate accountability for the performance of the practice. In many cases, the QOF payment is ploughed back into the practice in the form of increased staffing, perhaps in nursing and/or admin roles to support the Practice Nurse and Practice Manager.

Many of the QOF targets are focussed on the management of long-term conditions. One interviewee described how much of this work is nurse-led at their practice.

Quote 13:

> Because I find, I really find that, you know, that the long-term conditions are more the general practice nurse bag now more than - often it is a general practice nurse who is diagnosing, who is caring. So, we're nurse led in our long-term management conditions (Practice C: Lead Nurse)

In a smaller, family run practice, the practice nurse spoke about her workload and her relationships with the GPs in her team,

Quote 14:

> It's, I think it's towards, more on one person. It is shared, but sometimes the doctors are pushed as well, you know, they have to deal with the problem that the patient has come for and they haven't always got time to do the other bits. So, they're saying, "Make an appointment with the nurse. Sometimes you feel that they could do a bit more. It's all down to you doing it yourself. We do try to share, but then again, you know, I do get lumbered with a lot of it I'm afraid (Practice D: Practice Nurse)

6.3.2 Salaried GPs

Salaried general practitioners occupied an interesting position within the team in respect to QOF. Unlike their partner colleagues, the structure of their salaried position means that their salary is not dependent on the practice reaching their QOF targets. This is the same for all practice staff who are not partners. Salaried GPs are particularly interesting for my research because, while in this sense, they are in the same boat as the administrative staff (for example, their salary is not dependent on the achievement of QOF points) unlike administrative staff, they conduct patient consultations, and it is the site of the patient consultation that the most vociferous complaints have emerged from the GP trade press about QOF. These complaints typically involve concerns about interference in the consultation by QOF through questioning the clinicians' professional judgement. Some salaried GPs in my fieldwork reported this as a 'freedom' to conduct their consultations without being dictated to by QOF. Others may argue that it could be interpreted as a policy failure,

in that this group of staff (salaried GPs) are not incentivised to push to get as many QOF points as possible during every consultation. For their GP partner colleagues, this attitude towards QOF could be frustrating,

Quote 15:

> I think there's, from the salaried doctor point of view, there's a big variance actually. I think the older salaried doctors, so the ones who perhaps have been working for the last ten years or so, they are not as focused on QOF and the other targets that we've got, as partners are, because they're not driven by financial concerns about performance. But I think the older salaried doctor, the more experienced salaried doctors, tend to perform better for us as an organisation, than the new ones. And I think the new doctors coming into primary care at the moment are very much, you know, "I'm here to deliver a package of care, which is time-defined and on my terms and paid very well, thank you very much. And then, at the end of that, that's it, I'm off - (Practice C: GP Clinical Quality Director).

The view above, given by a GP partner about their (younger) salaried colleagues' approach to QOF was echoed in an interview with a salaried practitioner, who reported how his approach to QOF was determined by himself, rather than by pressure from colleagues. The reason given, was that there was no financial incentive related to QOF for salaried GPs, in contrast to their partner colleagues. Furthermore, this view was expressed with a sense of pride and as a proclamation of how he could offer better quality care than his colleagues who were motivated by QOF and what he interpreted as 'money'. By not being driven by the collection of the optimum number of QOF points, this respondent differentiated himself from his GP partner colleagues by being able to offer better patient satisfaction and higher quality care as a direct result of not being driven by the QOF.

Quote 16:

> ...you know it (QOF) becomes a tick box exercise, you know? and that's dependent very much, about how the clinician feels ...Oh if you're a Partner you're going to be more worried about the finances and you're going to want

> to tick it off. If you're a salaried then you're going to ...I mean, I, and I know one other, who have the attitude that we'll try to do it but if it hasn't been done... that if the thing hasn't been done, then it hasn't been done. And then we can't tick it off and we can't be persuaded into it because the admin staff, the management all want to push us into that because they are being looked at to meet the targets ... I mean there's no bonus. I mean the practice gets extra money but that doesn't come to me in any way (Practice A: GP, salaried).

The same interviewee continued to add,

Quote 17:

> But to some extent it's a personal choice for each clinician as to what they do... whether or not I meet QOF or not, it's not gonna come back and bite me - it's my own choice" (Practice A: GP, salaried)

The last quote from this participant illustrates clearly how the position of the salaried GP in the labour structure of the team, allows the role of salaried GP a degree of independence (if they choose to take it, from QOF) that is not shared (or reported to be shared) by partner colleagues.

6.4 Professionalisation of nursing and admin roles

QOF has changed the face of English general practice in many ways since it was first introduced. One of these changes has been its impact on the role of the nurse in the general practice team. The Nurse Practitioner role was introduced prior to QOF, and has expanded since, taking on more professional responsibilities in relation to delivering QOF, usually in the form of running long term conditions clinics. This role took on much of the routine work that had previously been conducted by a general practitioner. The nurses who took part in my fieldwork spoke about their careers and how they had changed since QOF was introduced.

Quote 18:

> ... you're looking at it from a nurse perspective. So, with the junior doctors' contract, with the reducing their working hours, there's obviously kind of this gap. And what nursing practice has been able to do is to kind of take, take that opportunity and develop. So, whereas roles were filled by GPs and trainee GPs before, you know, practices are finding – well actually, you know, we need to be looking elsewhere. That sort of advanced nursing practice role is much more common now. And that's what GP surgeries are looking to recruit because they can see that ... nurses can do some of that work with the advanced practice skills (Practice B: Nurse Practitioner).

This interviewee was cautious that this view did not chime with the position taken by the professional nursing bodies,

Quote 19:

> And when I did my masters study, it was all about advanced nursing practice substituting for GPs on home visits. ... This has been a negative in terms of less GPs and obviously there's a big recruitment of 5000 GPs which they're not going to hit that target, not any time soon.... but then I did go to an advanced clinical practitioner conference last week where they were talking about, "Oh, you know, we mustn't see ourselves as substitutes for GPs." So, they have a completely different opinion that we shouldn't see ourselves as that, but we should see ourselves as advanced clinical practitioners in our own right with our own skills, which I do. But the job that I do will definitely substitute for a GP because all of these visits that we do are the visits that GPs used to do. So, there's a little bit of a contradiction there between the two. But, you know, we're all obviously advanced nurses – we're all non-medical prescribers as well. (Practice B: Nurse Practitioner)

This respondent clearly identified the policy gap between her views and experience and those represented by her professional body. As the GP profession faces a recruitment and retention crisis, policy opportunities emerge concerning the

professionalisation of the nursing profession and how it might make gains in the context of the recruitment and retention crisis in general practice.

A further interesting theme that came from interviews with nursing participants centred on respondents reporting that QOF allowed them a space to query decisions taken by GP colleagues, in a way that (they felt) would not have been possible prior to QOF.

One respondent spoke about how the advent of templates and diagnosis pathways (issued by NICE) enabled her to query a GP colleague's diagnostic decisions. She also spoke about how, because it was 'written down in black and white' it made the challenge to their authority less personal. She was able to point to the template and ask her GP colleague if they had followed the pathway in a non-confrontational manner. She and other Nurse interviewees echoed this and said that without the NICE pathway/template this would not have been possible.

Quote 20:

> And this is what happens, you know... Doctors will diagnose from their medical feeling, but don't see the importance of actually, you know like for example in asthma, well, have we got reversibility? Is this asthma? They will just start them on an inhaler... and it's not all GPs, but this is the trend. And this is what QOF has helped us to stop. And also, with COPD. I mean you have patients who will be in hospital...a GP will, or someone, a doctor in hospital will go, "Oh it's COPD." That gets put on as the diagnosis, but actually, they may have normal lung function. It's just because their history is there but what you need, is that backed up with the actual diagnostics, which is what we do with QOF and the long-term conditions. I think it's (QOF) given us a tool and it's given us more, it's given authority, even. (Practice C: Lead Nurse)

This respondent spoke about the audit trail that QOF generates and viewed it as a positive as it enabled correct diagnosis as well as offering a source of authority that was perceived as neutral. When prompted to recall a time they had queried a GP's decision, the respondent pointed to the neutrality of QOF as helpful.

Quote 21:

> **Interviewer**: And were you in a situation where you have ever had to challenge, or say that's not asthma?
>
> Well, because it's there in black and white. I mean we've done a lot of work. We've done a lot of audits. I mean they want to achieve QOF, so they want it as well. So, I've never had anybody say, "Oh well, you know I'm the doctor and I know best." No, it's all been very much, "Well, yes, how can we try and stop this happening?" ...anybody's entitled to a right diagnosis. It needs to be right. You can't, you can't guess. And it helps to have the paper trail to say that you've done it correctly. I think that's only fair, isn't it? And, as nurses, you know, if you're going to treat patients with asthma you want to make sure they've got it. (Practice C: Lead Nurse)

The quote also demonstrates how the QOF affords a camaraderie or equality within the team which means that a clinician's decision might be challenged by a nurse or a colleague and this would be seen as working collectively towards the practice's QOF achievement score. The independence that the template affords the consulting practitioner was mentioned voluntarily by another nurse interviewee when discussing how it had helped her tackle sensitive subjects with patients.

Quote 22:

> I quite like parts of the template. So, I like the fixed questions on the exercise and things like that because it focuses in, because sometimes you know, you start with patients who say, well for breakfast I had this, this and this and you're there half the day. So, I find it quite useful because it's quite structured and they can see the screen, so they can see what you're actually asking. And it calculates, so we can say 'Oh the computer's saying you're moderately active or the computer is saying that you're inactive' and then they can start to say 'oh why is the computer saying that? And you're not saying it... because you don't want them to get upset and think 'Oh I don't like that nurse and the nurse thinks I'm lazy and I'm not going to see her again' it doesn't take much to upset people at all... (Practice B: Practice Nurse)

The above quote illustrates that as well as aiding conversations around potentially sensitive topics, the interviewee felt that the template also helped to keep the consultation 'structured' and running to time. It also illustrates how far QOF, and related NICE guidance can dominate and direct the consultation. Another Lead Nurse interviewee spoke clearly about how she felt QOF had enabled the nurses in her practice to gain influence.

Quote 23:

> ...QOF has enabled us to, and because we have to, deliver QOF the doctors have required nurses to provide annual reviews. And that has given us a basis for saying well actually this is how we're going to do it. This is how we're going to deliver it. So, for us nurses, we've allowed it to drive quality – (Practice C: Lead Nurse)

During an interview with a Practice Nurse, the interviewee reflected on how QOF had changed the role of the nurse taking an historical view.

Quote 24:

> **Interviewer**: So, practice nurse is completely different because you're in a similar position to the salaried GPs? Am I right in saying that?
>
> Yes, but we tend to take more ownership. I don't know why. We take ownership. And I went to a round table discussion about the nurses' voice. About why did we do this? And allied professionals that, that are trying to do deals over pay and conditions. And, you know? The nurses we're...quieter because we have just historically got on with it, and that's what the doctors like.

Later in the interview, the respondent talked about how the dynamics between the roles of practice nurse and GP colleagues were constantly in flux as a result of QOF. This quote demonstrates the constant power dynamics being played out between the two roles. However, it is of note that the contested dynamic is visible and discussed. While it is arguable that this power dynamic is not new, it could be argued that QOF has made it visible in a way that prior to QOF it might have been hidden.

Quote 25:

> I mean at [redacted] practice, we're trying to make sure that all clinicians take it (QOF) seriously and with every encounter make it count and you know, if they do a blood pressure, that they record it...But, what I've found is with some of the GPs there's a real change in ownership of things. And you know when they've got the acute patient in front of them the last thing, they can do is worry about QOF checks if they've got an infection or they've got chest pain. (Practice C: Lead Nurse)

6.4.1 Patient views of the nurse role

While nurses working in general practice have gained career opportunities because of QOF, there remains, among some patients, the sense that they would still rather see a GP. The increased responsibility that a role such as Nurse Practitioner affords did not appear to be understood by patient interviewees in my fieldwork.

Quote 26:

> Yes, because a GP knows more about the illness, I think, than the nurse. That's why we ask to see a doctor, isn't it? (Practice A: Patient)

The same patient interviewee recounted that sometimes when they asked to see a doctor, they were given an appointment with the nurse. When asked how this made them feel, they said they felt 'fobbed off'.

The following quote illustrates how for this patient there are limits to how happy they are to see a nurse rather than a GP.

Quote 27:

> I do not mind seeing the Nurse for routine check-ups or MOTs but if I'm not well I want a doctor – (Practice C: Patient)

6.5 QOF: The GP view

Once QOF was introduced and established, despite the many months of negotiations that preceded its introduction, it was greeted with scepticism by some in

the GP community. Despite the professional bodies' negotiating efforts, many GPs on the frontline viewed QOF with suspicion and as a symbol that the government did not trust GPs.

One GP in my study recalled that time in his career.

Quote 28:

> "I mean I can understand the government want to have an output … so they can justify what payments they make to us. But really there's no trust. I think that QOF came because they didn't trust us", (GP Partner Practice D, Staff 4).

The group that most challenged the introduction of QOF was the GP profession. Although the new Contract vote was passed by BMA members, there was still much resistance on the front line of general practice during the first few years of its implementation. For most, this resistance has abated (see later data chapters), but for some, feelings of resentment remain.

Prior to QOF becoming established, some in the profession were concerned about the effect that financial incentives might have on consultations. There was anxiety that the traditional patient-led consultation might change to reflect a more biomedical approach to the consultation. In 2008, a research study interviewed GPs about their experiences of QOF over the previous years. One of the findings to come from the research was that,

> many respondents felt a pressure to concentrate on incentivized standards in the consultation, at the expense of other aspects of care. Most participants described a continuing principle of sharing clinical decisions with patients at an individual level, but a few acknowledged pressures to emphasize issues incentivized by the contract. While better information technology was an important component of improvements in care, there was a downside to increased computer use in the consultation. Prompts on the computer screen, though seen as useful in ensuring coverage of appropriate clinical activities, were identified by most respondents as a significant distraction from the patient's concern, (Maisey et al., 2008)

This extract from Maisey et al's research contrasts with findings from my research conducted almost 10 years later. Many GPs in my fieldwork reported that QOF did

not affect their consultations. There are several possible reasons for this which are discussed in the following two chapters. Suffice to say here, that the timing of the fieldwork is probably crucial in explaining the differences in the findings. Maisey et al's research was conducted in the early days of QOF when the medical profession was still learning how to implement and integrate it into their daily working lives. Ten years later, my fieldwork demonstrates that for many GPs, QOF had now become part of the background to their daily practice.

Quote 29:

> So, you kind of, you know, it's almost second nature to do the QOF as you're seeing that patient, Practice D, Staff 1

Added to this is the fact that my fieldwork included a new cohort of GPs, many of whom received their medical training in a post QOF world, where performance measuring and accountability are now accepted as part of public, professional life.

Quote 30:

> ...so, I was training for a couple of years before that, but during my whole training time, and as a GP, the QOF has been there..., (Practice A, Staff 11).

GPs' concerns that QOF would lessen the patient-centred approach in general practice, also raised concerns over multimorbidity and how it would be treated in the new QOF world. The literature documents concerns that QOF is not suited for treating patients with multimorbidity. With its pursuance of single-issue diseases, it is not equipped to deal with patients who present with several issues in a single consultation.

> Multimorbidity is common in the population and most consultations in primary care involve people with multimorbidity. These people are less likely to receive continuity of care, although they may be more likely to gain from it, (Salisbury et al., 2011).

Much of the resistance to QOF, expressed on the frontline of general practice, centred around fears of deprofessionalisation and threats to the autonomy of the GP. Some GPs viewed it as evidence that they were not trusted by the government and

felt they should be left alone to get on with the job. This theme is supported by my fieldwork amongst general practices and GPs.

6.6 Patient Views of QOF and the GPPS

6.6.1 Patient views of GPPS

Almost 30 years after the introduction of the Patient's Charter, patients who took part in my fieldwork were invited to reflect on how they had chosen a general practice with which to register. Time after time, patient interviewees reported that they felt they did not have a choice when they registered with their practice. General practices are not allowed to turn patients away if they live within the published catchment area. However, some patients in my fieldwork had been told that they did not live within the catchment area of their preferred practice. For the patients, this translated as not being able to exercise their choice. Hence, their laughter during interviews when asked about patient choice. Consequently, patients in my study expressed deep cynicism when asked about their 'choice' of general practice:

Quote 31:

> I didn't really feel I had proper – I had a choice, but it was, you know – this one or that one, (Patient 2, Practice A).

Another patient spoke about how they found their practice:

Quote 32:

> I may be wrong, but when I went on to the website to choose, there wasn't a lot of choice. Basically, I think it was here or [redacted]. It would have been – we sort of quite fancied the one down towards [redacted] Street, but that's not within the same borough and it's not the same – well, it's in the same borough, but not the same catchment or something like that. So, we wouldn't..., (Practice A, Patient 2).

While practices are not doing anything wrong by not registering people outside their catchment areas, the effect on the patient is to make them feel they do not have a meaningful choice.

Quote 33:

> I mean I feel as if they're telling us who we can see, what – we should have a say, as patients, which doctor we can see, (Practice A, Patient1).

The GPPS remains deeply unpopular with general practice staff and for many, irrelevant. A member of the admin team responsible for handling patient surveys reported that,

Quote 34:

> To be honest, in terms of the MORI poll…. we don't really take notice of the MORI poll. I mean we are busy, a city centre, you know, in terms of the population, they all know about it. But, I mean, it feels as if it's almost not connected – Practice A, Staff 1

The GPPS was and remains unpopular with general practice staff in my study. When QOF was first introduced, GPs were able to select patients to complete (by invitation from the GP) a patient experience questionnaire. This meant that the GP had control over which patients participated and thus affected the practice's patient experience score. The introduction of the GPPS, administered by Ipsos-MORI, removed the control of which patients were surveyed from the hands of the GPs and left it to the random allocation of sampling by Ipsos-MORI. GPs lost control of this measure of patient satisfaction and became distanced from its administration. In contrast, GPs can 'control' QOF achievement. GPPS achievement is largely in the hands of patients themselves. This may go some way in explaining the almost uniform rejection of the GPPS and its results by the GPs and practice staff in my study.

My fieldwork demonstrates how patients refuse and contest this role. Time after time, they report that they do not want to choose between a good or bad practice (thereby exercising their role as an informed consumer) – instead they simply want good services.

This begs the question of, for whom the GPPS is intended? If it is for the benefit of general practitioners, then it has sadly failed to impact. If intended for the public, (in their new role as consumers demanding a continuous flow of information) then it has also failed. My fieldwork shows that most patients have never heard of the GPPS. Those that have, have done so in the context of having been asked to complete a postal questionnaire – even those that have done so were unaware that they could

log on and see the data, as a way of deciding which practice with which to register. Practice staff reported several times in interviews that they believe the only group of staff to use the GPPS data are Clinical Commissioning Group Managers and the CQC. This perception enhances staff suspicions that it is used as a tool against them, or to catch them out.

6.7 Changes to Dr/Patient relationship

All clinician interviewees spoke about how the feeling of always being watched and monitored through the lens of QOF had consequences on their relationships with patients. For some, as seen in previous sections (particularly salaried GPs and those GPs who had trained since QOF was introduced) this was not seen as a major problem. It seemed to be accepted as part of being a GP. All respondents reported that there was less time in the consultation for the patient agenda as a result of QOF. For some, this was not viewed as a negative development. They cited that it had enabled the consultation to become more efficient, as their time was spent on the area(s) they knew needed to be monitored. Others, mainly from the older generation of GPs viewed this as a negative impact of QOF. The reasons given were not that they preferred to focus on the patient's agenda, but rather they believed they gave a better consultation when they exercised their own judgement over what the consultation needed to cover.

Quote 35:

> But the big problem has been that it (QOF) interferes in many ways with the consultation. So, for instance, when I see a patient, right, I may only see that patient one time in a year. And if I don't collect that QOF data at the time she comes to see me, and I give them an appointment to come back and see me another time, they probably won't come. They don't value it. So that means we're financially – I may be, may be hindered. And subsequently, consequently I will actually endeavour to collect that data because I know that patient won't come back to me, so it interferes with the consultation itself (Practice D: GP partner)

This quote demonstrates how for some partners the financial incentive of QOF is constant and paramount. The same respondent went on to explain that he felt QOF

delivered worse consultations because he was not able to exercise his judgement during the consultation.

Quote 36:

> But, you know, but I can tell you one thing – my consultations were so much smoother when I didn't have QOF, because I did the work that I thought was appropriate for that patient, you know, rather than sit there collecting data before I see the patient for the problems that they came for ((Practice D: GP partner).

One interviewee identified the conflict between a population-based approach such as QOF and an individual based approach to the consultation.

Quote 37:

> I think it's difficult, isn't it? if you are trying to implement anything at a national... you can't be patient specific I mean, how can you be? (Practice A: GP, Clinical Lead)

For some GPs QOF delivers higher clinical standards brought about by more efficient consultations. For this interviewee, prioritising the agenda of the GP over that of the patients was a positive development and resulted in delivery of better standards of care for the patient.

Quote 38:

> So, if I perhaps start with myself, I think we all, we all tend to be sort of reasonably arrogant and think that we do the very best for our patients in every contact. And I think actually, what QOF shows us or has showed us, is that probably we didn't. So, I think it has, it has sort of pushed us to be a bit more aggressive in how we manage some of those conditions. So, it has meant that often the consultation is more about my agenda in collecting the appropriate data than necessarily the patient's agenda. (Practice C: GP partner)

One GP partner was very honest about how QOF not only shaped his consultations but how he viewed the patients. He also spoke of challenges if QOF ceased to exist.

Quote 39:

> ...the difficulty of mine would be tomorrow if QOF goes away...I will have to train myself to see a patient globally again because, at the moment, I am driven by the QOF. So, then I will have to...I'll have to retrain myself ...No, I'm not going to look at the spending on the QOF, but I'm going to concentrate on what's in front of me and what's relevant for him (the patient) in that context. (Practice B, GP partner)

This concern for how GPs would cope without QOF was voiced by another partner at a different practice who spoke of how, without QOF he "would have to wean his doctors off QOF." (Practice A: GP Clinical Lead)

Both these quotes illustrate the degree to which QOF is now embedded in the daily, working life of general practice and general practitioners when they conduct patient consultations. Nursing colleagues commented too on how QOF impacted on consultations they conduct with patients. In many practices, the Practice Nurse carries out several clinics aimed at achieving maximum QOF points. One nurse interviewee echoed some of the views heard above, one was that the prioritisation of the clinician's agenda over that of the patient's should not be seen as a negative development.

Quote 40:

> … because it (QOF) helps us maintain standards, national standards... you know I'm not saying we should not view the individual as a whole, but you know if we just keep viewing the individual as a whole and listening to patients you know, who don't want to take their medication, and don't want to do this, and don't want to do that, you know in the end it leaves them with complications... you know we've got to balance things out... (Practice A: Practice Nurse)

A Nurse Practitioner with over 15 years of practice spoke about her patients experience of attending QOF clinics and how she felt they had tired of them after many years.

Quote 41:

> **Interviewer**: So when you do QOF how do you find it?
>
> Tedious (laughs) it's absolutely tedious. It's a tick box exercise that sometimes just doesn't bring results whatsoever and the patients know it inside out, upside down and back to front. So, they'll come in for a medication review and they'll sit there, and they'll say this, this, this, this and this does that answer your question? I just want my tablets and out they'll go. Yeah. The diabetes guys definitely, the ones that have been doing it for so long.
>
> **Interviewer**: The real expert patients?
>
> Yeah absolutely, they've all gone through the expert patient programme. ...But they'll tell you. I've got this, I've got that. I'm sure I've got basal cell pneumonia; can I just have my antibiotics please? And they'll tell you! (laughs). But the patients, the long-term condition patients, the true LTC's (long term conditions), they will come in and tick your boxes for you - (Practice B: Nurse Practitioner).

The same respondent raised the topic of patients being bored by the QOF checks.

Quote 42:

> The patients are absolutely sick to the back teeth of walking through the door for blood tests here and they're fed up. They know that we're strapped for appointments but they, they're being called for them, because if we don't call them through then we don't get paid. (Practice B: Nurse Practitioner).

This last quote raises a worrying trend for general practices and their staff – if patients are consistently finding it hard to get an appointment yet are being called in repeatedly for QOF check-up QOF clinics - this might lead to a disengagement with the practice and the staff there. This is an important policy point which speaks to how well attuned a policy is to the public mood. Despite QOF's stated aim of delivering

better standards of quality care to general practice patients, if the practice population only experiences it as an inconvenience, then there is a gap between the aims of a policy and the people it is supposed to be helping. Ironically, it may end up increasing dissatisfaction among the practice population.

QOF has a financial incentive element. The consequences and impacts of this were remarked upon by most general practitioners. One respondent spoke of the strains it created among colleagues as well as the pressure of feeling that you might be letting the team down through your performance.

Quote 43:

> But with my partners I think that there are some very able, very quick-thinking able doctors who, they would love all of us to be as quick and able as them because quite frankly we would earn more. Because we'd be able to get through more patients. We'd need fewer locums and fewer salaries, and we would be richer if we were all as quick as them. And that is a constant elephant in the room.... Well, you know I've been their colleague for twenty years and I pick these things up. I know, I know. (Practice C: GP partner)

6.8 GP views on the financial aspect of QOF

Only one GP raised this point in interviews, but it chimes with a theme from the literature review, so it is included here (Roland, 2013). A salaried GP offered his view on how the QOF might work better. He acknowledged that it was useful and played a role in increasing quality standards in general practice. However, he believed that the financial incentive of it should be removed. He felt that the financial incentive meant that tasks were conducted when they did not benefit the patient but did benefit the practice. Removing the financial element of QOF would provide a solution, in his opinion. I include this here because it chimes with some of the literature findings but also because he was the only GP respondent in my study to raise this. This in itself makes it of interest.

6.9 Ethics, Consent and the QOF

As stated previously, patients in this study were recruited from the Patient Participation Groups at each practice. This meant that the patients were likely to be better informed about the workings of the practice than patients were not members of the PPG. Only two patient interview participants had heard of QOF. Of the two, they were unaware that there was a financial payment to the practice based on their QOF achievement score. Both patients were shocked upon learning this. This echoes findings in the literature among patients upon learning of the financial component of QOF (Hannon, n.d.). Kramer (2012b) writes that of course a patient can refuse a QOF intervention through exception reporting, but this requires a degree of self-education about the workings of QOF as well as some risks that the author argues might accompany exception reporting.

> Levels of exception reporting may correlate more to the characteristics of individual GPs and practices rather than demographics of their patients. Finally, there is concern that once patients have become exception reported they receive less attention. (Kramer, 2012b, p. e218)

6.10 When bureaucracy has no impact – the General Practice Patient Survey

Interviewees were asked to talk about both QOF and the GPPS at the start of each interview. In all interviews, speaking about the GPPS was not volunteered. In every interview with all participants, I had to prompt the participant to speak about the GPPS and the topic of patient satisfaction or patient experience.

Whilst the topic of the GPPS itself was never raised voluntarily by the participants, it would be wrong to conclude that patient experience was not deemed important to practice staff. It was clear that for most of the interviewees, patient experience (if not satisfaction) took up a lot of thought and space in team discussions. Several times, interviewees reported that if they received a poor satisfaction rating or report, it had a significant impact on staff morale. At one case-study practice, the practice manager would hide the report as much as possible so as not to upset the staff. At nearly all the case study sites, the practice manager designed and carried out their own patient satisfaction survey. This points to the importance that the staff team afforded the concept of patient experience. The case study practice sites chose not to accept

the GPPS results because they did not believe it to be reliable despite formal evidence of reliability (Tanday,S. 2009). This was the case even in those case study sites which had scored very highly on Q28 on the GPPS. When I queried this, the two case study practices were unaware of their high performance on Q28, GPPS. It seemed that the practice manager had not even bothered to check their score at these two case study sites. When I told them that their results were very high, staff and practice manager's both, were always very surprised. I spent many interviews with senior, experienced clinicians who were deeply concerned about their patients and their experiences at their practice. They feel, correctly or incorrectly, that there is yet to exist a way of measuring patient satisfaction or experience reliably.

When asked about if the General Practice Patient Survey featured in his mind during a patient consultation, this GP partner explained his response.

Quote 44:

> … I don't sit in the consultation thinking this patient's unhappy or dissatisfied about the consultation. I try and understand why they are, you know, why they're with me and what they want, and then try and explain to them why that's a good or bad idea. But it's not as prominent in my mind's eye as making sure we've got the QOF boxes ticked - (Practice C: GP partner)

Quote 44 shows, that while the patient's experience and reasons for coming to see him (the GP) are in his mind, priority is given to the QOF.

While it became clear from interviews that staff and patients do not take much notice of the GPPS, it could be argued that nevertheless, the GPPS has had an impact on general practice. It has raised the concept of patient experience and satisfaction as a topic that demands attention in the world of general practice. It has placed the topic of patient satisfaction on the agenda. It seems that practice staff are undecided as to the best method to measure it, but the concept of patient satisfaction and experience featured in interviews with staff, even though the GPPS did not. Since some of the GPPS indicators have started to be included in the CQC's Intelligent Monitoring package of data, the concept of patient satisfaction will likely remain near the top of the general practice agenda.

The Friends and Family Test was introduced by the Cameron government in 2010 as an alternative method of capturing patient satisfaction. It consists of one question which asks patients if they would recommend the service they had just experienced to friends and family. It is relevant here because all interviewees (patients and staff) were aware of the Friends and Families Test, much more so than the GPPS. Interviewees (staff and patients alike) referenced it unprompted and appeared to associate the immediacy of its response with reliability. While some clinician staff admitted that it was not statistically robust, it was still afforded a degree of validity by staff and patients alike. In one practice case study site, it was used in the weekly team meetings as a reporting mechanism to measure patient satisfaction. This was in preference to the GPPS, which the (non-clinician) respondent told me that they 'ignored'. The practice preferred to use the Friends and Family Test because it used data from people who had visited the practice during the previous week. They felt this was a fairer way of measuring their efforts to improve the patient experience than the GPPS which included patients who might not have visited the practice within the previous year and a half.

6.11 Summary

Fieldwork data demonstrates the extent that QOF, and to a lesser extent the GPPS, have impacted on English general practice. While QOF has changed general practice and is now firmly established in the life of a modern general practice, interview data shows how we cannot leave it there. For a fuller, deeper understanding of how metrics have impacted on general practice, we need to delve beyond the level of the practice and start to pull apart how metrics have impacted on individual staff roles.

Metrics, understood here in the form of QOF, have impacted every area of the modern general practice. However, it would be a mistake to assume that all staff experience QOF in the same way. My interview data showed that certain roles carry the heaviest burden of the QOF workload, namely the Practice Nurse role. Further, it is the administrative team who conduct much of the processing of QOF work. QOF affects clinicians in different ways. The first, most obvious way is the difference between GPs and nurses within the practice. For nurses, QOF has had many effects. Firstly, it has offered them career opportunities in the form of Nurse

Practitioner roles and Lead Nurse for QOF clinics as well as other roles. Secondly and alongside the career opportunities, it has enabled a level of authority with GP colleagues that would have been hard to achieve without QOF. It can be argued that QOF has made the work of the admin team and that of the nursing team visible and therefore accountable, in a way that was not possible prior to QOF.

For GPs, QOF has impacted their working lives on many levels. Within this chapter we have examined some of the positive effects (as reported by interviewees). These include acting as an aide-memoire for some. Almost all agreed that QOF had succeeded in raising standards nationally through its aim of standardising quality in primary care. However, this is not a homogenous picture. Within the staff team, GPs are employed on different contractual basis. Those who are partners have a different attitude to QOF than those who are salaried or locums. All three categories have different experiences of QOF, which are explored in detail in this chapter.

The GPPS did not receive any unprompted mention in interviews. When I asked interviewees to reflect on how it had affected them and their daily lives. A few patient interviewees had heard of it and had completed one of the surveys. However, the lack of (staff) interviewees speaking about the GPPS should not be interpreted to mean that staff at the case study sites in my fieldwork do not care about patient experience or satisfaction. On the contrary, almost all staff interviewees spoke at length about initiatives they had put in place to enhance patient experience and satisfaction. For many, there was clearly deep concern about their patients and their experience at their practice. While there is clearly concern and genuine passion about patients and their experience at their practices, it seems that the GPPS does not capture the staff imagination as an appropriate vehicle to either record their efforts in this area, or indeed, reflect them.

To summarise this chapter aimed to demonstrate the complexities that have arisen from the introduction of a system such as QOF and the GPPS into English general practice. Its effects have been many and are not uniform. My fieldwork shows that the effects of QOF and how staff carry out their daily work depends on their position in the labour structure of the practice, as well as factors such as past work experience.

Metrics, incentive schemes or quality initiatives all fall under the banner of bureaucracy. Bureaucracy needs to be understood in its entirety, with recognition of all its effects on those who carry it out and those who might be on the receiving end of it. We are only just beginning to understand the consequences of introducing incentive-based metrics schemes into general practice. This chapter aims to serve as a base from which to start further exploration.

This chapter sought to explore the enabling effects that metrics such as QOF and the GPPS have had on general practice. In the following chapter, we will seek to identify effects that have not been so positive.

Chapter 7 Coercive accountability and disabling bureaucracy

7.1 Introduction

Chapter 6 presented findings from the fieldwork and examined themes that spoke about positive experiences of the impacts of the QOF and the GPPS from both staff and patient perspectives. This current chapter will be the last to present empirical findings from the fieldwork and will present themes grouped broadly under the meta theme of negative experiences of both the QOF and the GPPS.

The chapter will present views and perspectives of the two tools which participants found had brought negative impacts to their lives. It is relevant to note that views included in this chapter originated from some of the same participants who also expressed positive views of the two tools. Rather than detracting from the validity of their views, a counter argument might suggest that this demonstrates the complexity of the topic and how skilled staff have become at adapting the tools to render them useful to them in their daily work, while also being able to discard/ignore or find 'workarounds' those aspects of the tools that do not contribute positively to daily tasks in the English general practice. Where names of practices, place names or anything that might be used to identify case studies sites and/or participants, they have been blanked out.

7.2 Findings from the fieldwork

7.2.1 Big Brother and Accountability

Several themes were generated from the fieldwork interviews which I have grouped together to speak about feelings of being watched/observed or checked up on and which explored some of the more negative effects of performance metrics culture, reported by respondents. I have chosen to group these findings within this chapter under the heading of 'coercive accountability,' a term coined by Strathern (2000b) which she employed to describe the feature common to all performance related management cultures in which giving accountability publicly is not a choice.

Strathern's interpretation of the concept of 'accountability' in new public management theory identifies a coercive element inherent within it. The demand for transparency in public life and organisations is accepted now as the norm. Indeed, to be seen to question its relevance and the impacts it has on those from whom accountability is demanded, raises eyebrows. In a culture that accepts (seemingly without question)

the values of accountability and transparency as essential to modern institutions and inherent to the concept of good governance, it becomes even more important to problematise these concepts and ask what the effects have been on employees and patients after more than a decade. As Strathern wrote in 2000 in the context of the introduction of performance measures into higher education,

> "What is interesting about this case is that … such an appeal to a benevolent or moral visibility is all too easily shown to have a tyrannous side – there is nothing innocent about making the invisible visible." (2000b, p. 309).

Strathern's identification of the coercive element of performance metric culture enables us to locate what might sometimes be dismissed as GPs and practice staff 'moaning' about QOF, into the richer context of new public management theory, rendering a fuller appreciation of its impacts on the whole team.

This chapter will explore the themes that emerged from the fieldwork that highlight some of the negative or tyrannous staff and patient experiences of QOF and GPPS. The majority of negative experiences of QOF were voiced by staff participants, and this is reflected in this chapter. This was as expected, because the QOF is a tool aimed at practice staff. Patient views are included where relevant, for example, when they experience a side product of the QOF such as being called in for a review when they did not request one or being asked seemingly irrelevant questions during a consultation - but there yet remains an emphasis on staff voices in this chapter.

7.2.2 Resistant and resentful - "we were not trusted"

Among research participants who were clinicians and had practised prior to the introduction of QOF and GPPS, a theme emerged with a narrative that GPs felt they were not trusted to do their jobs by central government. This narrative was referred to amongst this group of respondents as the reason given to explain why QOF was introduced. Seen from this perspective, QOF and GPPS are understood as monitoring systems with the emphasis on making the general practice profession accountable to central government. Some respondents in this group viewed both QOF and the GPPS as forms of punitive surveillance. It was viewed as evidence of a breakdown in the relationship between central government and the general practice profession. These views were expressed mainly by interviewees who were GP

partners with many years of experience prior to the introduction of QOF and the GPPS.

A GP partner interviewee stated that,

Quote 45:

> I think that QOF came because they didn't trust us... I think it's a big, big problem that – the problem, the whole thing arose because the government didn't think that GPs did anything good anyway.
>
> (Practice D: GP partner)

This interpretation of why QOF and the GPPS were introduced is at odds with the official justification given by the Dept of Health in 2004, which centred on improving national quality standards across general practice. The policy context that produced both instruments was discussed in chapter 4. The disconnect between frontline staff's interpretation of why it was introduced, and the official reason given by central government is the focus of this chapter.

A theme emerged that focussed on some GPS feeling that central government did not trust them to do their jobs as well as a feeling that the government thought they had not been pulling their weight prior to QOF. This was illustrated clearly by one respondent. He recalled a feeling of vindication when, after the first year of QOF, most general practices (his included) achieved 90% and above of their QOF targets. This was perceived by the respondent as proof that GPs were delivering (and always had been, in his view) a good service to their patients. It is also testament to the enduring nature of these views, that this respondent was still voicing them close to 20 years later. Feelings of resentment evidently remained strong,

Quote 46:

> So around when the QOF came, in the very first year, for instance, right? Now, we were given targets by the government and how to achieve them. When it was actually uploaded on to our system, on day one, we had achieved 90% of the targets already. Okay? So that's how good our practice was at that time. And so, it was nice to be vindicated. (Practice D: GP partner)

For other GP interviewees (mainly those who had not practised prior to QOF and GPPS being introduced) such feelings of distrust and resentment about the existence of QOF and the GPPS were not expressed during interviews. There were concerns, but they focussed on the way the practice was run by management. For example, this group of participants spoke about appointment times being too short and feeling pressured by the practice manager particularly towards financial year-end to maximise QOF points etc. This contrasted with the feelings of betrayal expressed by some older GPs with pre-QOF experience, that the government did not trust them, illustrated in the quote above. A salaried GP who had not practised prior to the introduction of the QOF commented that,

Quote 47:

> I just feel I don't have enough time. In reality we are all expected to just squeeze it in. Now towards the end of this month they are telling us, whatever alerts you see please try to just tick... it becomes a tick box exercise...and you have a lot of pressure to you know... oh the end of the year is coming, finances are involved can you just do this as well please? and you end up running extremely late when you don't have the time for it. (Practice A: GP, salaried)

7.2.3 Distrust of data - GPPS

Distrust as a theme featured again when participants were prompted to reflect on the existence and use of published data sets designed to measure concepts such as patient satisfaction and patient experience. From interviews with both patients and staff, a strong theme of distrust of official data sets was recorded.

Distrust of datasets was shared by all patient interviewees – this applied to both the QOF and the GPPS. Staff interviewees accepted QOF's validity as a tool, although as we have seen elsewhere, they may have questioned the relevance and appropriateness of what it measured, but this was in stark contrast to their attitudes towards the GPPS. All staff rejected the GPPS as an appropriate tool to measure patient experience and satisfaction. Reasons given centred on the validity and reliability of the GPPS data. There was no difference among staff participants regarding the GPPS, in terms of clinicians and non-clinicians. The distrust of GPPS was found uniformly amongst all practice staff. Amongst patient respondents,

reasons given for not trusting the GPPS data included a deeper distrust of formal data and cynicism about its purpose. This chapter will explore these in detail.

As discussed in chapter 5, staff suspicions about the GPPS may have worsened since indicators from the GPPS were incorporated into the Intelligent Monitoring (IM) framework used by the Clinical Quality Commission (CQC) to gather pre-visit practice data. While attitudes of staff towards the Clinical Quality Commission's (CQC) Intelligent Monitoring are beyond this thesis, comments made by staff during interviews expressed grave doubts about the fairness and reliability of the GPPS.

This chapter will explore the reasons given by respondents about why they do not trust, or pay attention to, the General Practice Patient Survey (administered by Ipsos MORI) or other formalized patient experience data, such as NHS Choices. From both sets of interviewees (staff and patients) the reasons vary but share a distrust and scepticism of formal data sets, and an expressed preference for local, immediate data, in which they purportedly place greater trust.

7.3 The General Practice Patient Survey: The staff view

The GPPS receives a negative reception amongst general practice staff, clinicians, and non-clinicians alike. The most common reason staff gave was concern over the reliability of its results. Most staff respondents pointed to its small sample sizes as a reason to query (and then reject) its validity. For example, a GP who also performed the role of Clinical Lead with over 20 years of experience, asked:

Quote 48:

> Why should we listen to 16% of our practice population? If we did that, we wouldn't be serving the rest of our practice population properly? (Practice A: GP Clinical Lead).

Despite the GPPS employing statistical methods to boost sample sizes to achieve reliability, staff interviewees remained sceptical. In a 2008 qualitative study investigating the impact of QOF on general practice, GP partners and practice managers were interviewed. The interviews included a question on patient surveys. The authors wrote,

> "There was surprisingly little discussion of the importance of patient concerns as a measure of practice performance. The use of patient surveys to improve

> practice quality, which is also incentivized in the payment scheme (QOF), was not perceived as a driving force: respondents displayed only vague recall of survey activity or impact on practice services, despite a specific question prompt. The surveys were seen as 'political correctness', without the same evidence base that underpinned the clinical standards. Participants felt that they already knew their patients' views and had attempted to meet their expectations as far as was practical, but that these expectations were often unrealistic, unachievable, and contrary to the terms of the contract." (Maisey et al., 2008).

Despite the statistical methodology which IPSOS Mori claims renders the GPPS reliable, the finding by Maisey et al above, demonstrates how the GPPS was never accepted as statistically reliable as the QOF, by GP partners and practice managers. It also demonstrates how the GPs and practice managers interviewed in the study felt that they knew their patients best and did not need an outside organization telling them about their patients. This is indicative to issues raised in the theory chapter, which examines the perceived threat of deprofessionalisation with which many professionals interpret new public management methods (Haug, 1972; Pereira Gray, 2002).

A non-clinician staff member spoke about how the GPPS was not viewed as relevant to their practice by his colleagues,

Quote 49:

> We don't, we don't really take notice of the MORI poll. I mean we are a busy city centre [practice] you know? In terms of the population, they all know about it. But, I mean, it feels as if it's almost not connected. [Practice A: Patient Liaison Manager]

Practice managers spoke about how they paid attention to the GPPS in terms of ways they could improve the practice. However, when it came to Question 28 (now 31) which asks about overall patient satisfaction, they were less keen to take note of their results.

One GP partner with 29 years' experience said,

Quote 50:

> And then we have the national GP survey [GPPS] which is quite, it's quite a frustrating thing really, because they collect data over six months and then it gets published six months later. So, it's always a little bit out of date …and an example of, we had recently a CQC visit at one of our locations which didn't go very well. And in one of the reports, they quoted the national GP survey which had, you know…some not great findings in it. But actually, the data for it was collected something like fifteen and a half months before... And we've had a very significant restructuring and changes to the appointment system and the phone system to try and address what the patients had been telling us, but actually they weren't interested in that. They just wanted the hard and fast data that had been published…And if they'd waited, if they'd waited four weeks when the next lot would have updated, and it would have been much fresher. (Practice C: GP partner)

Staff participants in my fieldwork said that they would look at the GPPS results but would not use it to instigate changes in their practice. Instead, they turned to conducting their own in-house patient experience/satisfaction surveys. These were usually drawn up and designed by the practice manager and the results were used to inform practice development. Despite not being statistically rigorous, these results were accepted by practice staff as being much more reliable (and the results were usually much more positive). This is in stark contrast to the same participants questioning the statistical reliability of the GPPS. Other practice staff spoke about encouraging patients who had a good experience to use websites such as NHS Choices to record their positive feedback. One non-clinician participant said,

Quote 51:

> …rarely do I ever see someone, you know, that would give you good feedback, unless you, you know, if you don't incentivise them – if you push in the right direction. So, if you ask them like, "So what do you think of the practice?" And if they say, "Amazing," I'm like, "So why don't you just put it up there? Why don't you tell us about it or why don't you put it on NHS Choices or, you know, or do something with that? I mean it's nice to know that you love

the practice and, you know, you love the receptionists, and you love your doctor, you know, tell us about it, it's really important. (Practice A: Patient Liaison Manager)

A clinician from the same practice spoke about how the whole practice had engaged in a challenge to get positive comments on NHS Choices.

Quote 52:

So, what we did last year was, we got our reception staff to kind of push to try and improve some of our comments on NHS Choices. So, they've got their patients that they see frequently and we kind of just set them a little challenge or a competition to see who can get the most feedback for a month..… Yes, so we try to get positive feedback, and we've got iPads in our waiting area. We've got walking groups, painting classes. After these classes, we try and get people to log on to the iPads and leave their comments. So, yes.

Interviewer: What happens to that data? Does that go on to your NHS Choices?

Yes, that goes on to our NHS Choices. (Practice A: Patient Liaison Manager)

A reception manager spoke about how the practice manager designed her own patient survey as a means of protecting staff morale from what had been a set of poor results from the most recent GPPS. This interviewee mentioned that the staff were completely unaware of the GPPS result, a possible indication that the practice manager had succeeded in her attempt to protect staff morale.

Quote 53:

We struggle really with patient satisfaction because we have obviously the NHS Choices and they forward us things, emails, which will usually be complaints. We very rarely get much that's praising us...so [redacted] does her own patient satisfaction survey. So, our results... patients are genuinely... (surprisingly to most of us in there because I obviously deal with complaints, so I hear a lot more of people with difficulties), but they are generally quite satisfied with our practice. … And I think there was 400 odd patients that filled our survey in ...So because we just had a report, I think in the Telegraph, that

> we hadn't done well in the local area on patient satisfaction…So then she's done her own patient survey for this year. I didn't even realize that until [redacted] just mentioned it to me, because she tends to not...because we've had some negative satisfaction things in the past, she tends to not really dwell on it. If something needs addressing that comes up on NHS Choices, she forwards it to me. But yeah, she tends to be a lot happier doing her own patient survey on patients that are coming into the practice. (Practice B: Reception Manager)

It is of note that the case study practices participating in my fieldwork were, by definition, not typical. As discussed in the Methods chapter, many practices were contacted, and refused to participate. The four practices that did engage might be atypical in their approach to their care and prioritization of patient experience and in this sense, their commitment to gathering patient satisfaction data may not be representative of most general practices. Regarding the four case study practices taking part in my fieldwork, it seems that conducting their own patient surveys was their way of contesting the much-disliked General Practice Patient Survey data.

7.4 Staff criticisms of the GPPS

Practice staff have many concerns about the GPPS and how it collects data on their practices and their patients. The first of their complaints about the survey is the time lag between when a patient can report on their experience at the practice and when they complete the survey. The practices argue that this results in them being judged on patient experiences that may have occurred up to 12 months previously. Furthermore, because the survey is completed anonymously, practices complain that there is no way of knowing which GP or nurse the patient saw – the clinician may have been a locum, or a member of staff who had since left the practice.

One Clinical Quality Director (also a GP partner) commented on what he viewed as the unjust system,

Quote 54:

> Well, we had – you know, we're an organisation that should be getting outstanding CQC inspections. I mean there's no reason why we shouldn't at all. We haven't because there's problems with CQC inspections and who comes on the day and how they understand your organisation. But we had one recently which was pretty much unannounced. And we got a 'needing

> improvement' based on a patient survey that was two years old that I think only a handful of people had, had completed... but, you know that's not a representative sample. And the people that have filled out that questionnaire may not have even had any contact with the surgery for 12 months. So, are they best placed to comment? (Practice C: GP Clinical Quality Director)

Respondents also expressed concern that people are more likely to remember negative experiences more, as opposed to positive ones, when completing the survey – thereby skewing the data further.

Quote 55:

> …if I was a patient, if I knew nothing about general practice, I think I'd only fill it up if I was annoyed. Or if I didn't like my practice. (Practice A: Patient Liaison Manager)

The theme of the distrust of data was also found in Asprey et al's study (2013) which reports a practice manager expressing their scepticism about the GPPS,

> "My own feeling is that in these patient surveys, people will tend to highlight negative aspects of their treatment, or their appointment system, rather than positive. So, in that way, it might be a bit skewed and, therefore, not really fair'. Asprey et al (2013)

This highlighted the problems facing the GPPS; that while it may have internal validity, it faces a barrier of perceived barriers to its credibility amongst general practice staff. These include,

> "…the representativeness of the responders, the low response rate, the length of the questionnaire, the order and framing of the questions, and the issues selected for measurement." (Asprey et al., 2013)

Reluctance to engage with the GPPS, or acceptance of its findings, should not be interpreted to mean that case study sites in my fieldwork, do not care about patient satisfaction or prioritise it. On the contrary, many interviewees spoke at length about how they try to enhance patient satisfaction and think deeply about the whole patient experience and how it can be improved at their practices. Many cared deeply about their patients but did not relate this to acting on the findings of the GPPS or any

dataset that attempts to measure patient satisfaction. One GP partner with many years' experience spoke about an initiative they had tried in their practice to increase access for patients. Every patient who called was guaranteed an appointment on the day. She spoke about its effects on the team,

Quote 56:

> And actually, that then creates an enormous problem, because, you know, it's not sustainable... once the expectation is there amongst your population, that, you can phone in the morning and see your doctor of choice in between your hair appointment and your Pilates class – this isn't a joke…no, I'm not joking! So if you raise expectations to that level, "I want to be seen by the person that I want to see, today and I've got an hour and a half to do that in," then it does create an enormous problem for us as an organisation which – and I think, obviously, the background of people out there is raised expectations, isn't it, because that's what you want from your app or whatever. From a quality of care point of view, I'm not sure how – I mean, it sounds a bit patronising, but I'm not sure how many people would recognise that their quality of care has improved in terms of chronic disease management and that sort of thing. We try and educate people as much as possible, but actually, you know, they may be more interested in just, you know, having antibiotics quickly when they have a chest infection rather than actually not having had a chest infection for several years, because we've done the right things to prevent it from happening. Practice C: Clinical Quality Lead)

Clinicians in my study, spoke about their scepticism that patient satisfaction was something that could be measured. Some spoke about how they could 'tell' from the consultation if the patient was satisfied or not. One Practice Nurse gave her response when asked about patient satisfaction.

Quote 57:

> So how do I measure my patient satisfaction? Well one that they turn around and come back and see me again. Okay. Yeah. You know they come back and see you again. Two, that they'll actually walk out and turn around and say oh thank you. You know? And there are so many genuine people in this particular surgery ...they're so needy...there's so much that we can do to offer

to help. And when you do, and when it all goes into place, they say thank you. (Practice B: Nurse Practitioner)

Non-clinician staff spoke about patient feedback at the reception desk. Most interviewees felt confident that they knew when patients were satisfied or not through their own dealings with the patient. One Health Care Assistant spoke about her role and patient satisfaction,

Quote 58:

> And you can see when patients are genuine and they can be really upset, you know, "I've come out of the house today, took time off of work to come and see you." So that's where I come into it and, you know, help, you know? You listen to what they wanted, and you can, you can work around it. I mean there are certain times where a patient needs to see a GP, or it might be something so simple that I can just quickly go and ask one of the duty doctors just to give me a bit of advice or help me with some information for the medication. I mean it's sorted. And that's me knowing that, you know, a patient has had their satisfaction covered and they've left happy, you know. There's nothing worse than a patient leaving and feel there's a service we can't provide. (Practice A: Healthcare Assistant)

One practice manager spoke about how they used the GPPS results to inform practice development but would not use it to inform practice development for patient satisfaction in terms of interactions with clinicians.

Quote 59:

> No, it's not something that I have used if I'm honest with you (referring to the GPPS). But previously, when I first started, I know we used a similar template to do internal feedback. So, we used some of the questions from the MORI poll.
>
> **Interviewer**: Okay, and why don't you use it? I mean, what are the reasons that you wouldn't go to GPPS data?
>
> I don't think we ...I mean why would we? I mean we do look at it. We look at the feedback that we get and it's around waiting times and seeing the clinician

> of choice and stuff like that. So, we do see it, but probably we could improve on it and do a bit more on that. Again, like I said, the CFEP questionnaire does cover some of the questions as well and probably ask it a slightly different way... (Practice A: Practice Manager)

At the time that fieldwork was conducted, practices were contractually obliged to conduct the Friends & Family Test, introduced under the Cameron administration in 2013. Many practices, as well as developing their own surveys (discussed above) invested staff and resources into improving their feedback rates from the Friends & Family Test. The Friends and Family Test consists of one simple question “Would you recommend this service to your friends and family?” It is preferred by many staff working in general practice because patients can answer immediately following their appointment. Practices can access the data daily. As a result, some staff report feeling that the Friends and Family Test results are more relevant to them than the GPPS. Some staff, mostly non-clinicians, were positive about the Friends and Family Test (FFT).

A receptionist spoke about their experience of the Friends and Family Test,

Quote 60:

> Well, I deal with the Friends and Family. It has gone down as the numbers being written and filled in over the last year or so. But the results that we are going through are very positive. There is only occasionally a negative. Obviously, we'll look at that and see if there's anything we can implement to avoid having that negative feeling in the future. But most of it does appear to be quite proactive. They're very happy with the service they're getting. (Practice B: Receptionist)

Other staff interviewees (mainly GPs) recognised that there might be some limitations to the reliability of the Friends and Family Test results.

A GP partner commented about the Friends and Family Test,

Quote 61:

> The thing is as well, generally people come into the surgery and then complete the Friends and Family Test which means they've been able to access the service, they've been able to come in and see a GP. Well, okay, on the whole when someone's seen a GP, more often than not, they're quite happy about what's gone on. So, most people fill that in, in a relatively positive frame of mind. If you posted it out to all my patients that are trying to get an appointment but couldn't, that would have been a different result. Yes. I mean I'm not sure how valid it really is. (Practice C: GP partner)

Despite the immediacy of the feedback loop designed into the Friends and Family Test, it still proved difficult to get patients to engage with it. One practice manager spoke about the significant amounts of time and resources spent trying to get (not just) patient feedback, but positive patient feedback.

Another GP interviewee spoke about the difficulty of engaging patients with the FFT,

Quote 62:

> So, years ago, I used to get involved… Our Friends and Family feedback, which is the main one – and obviously there's the national survey, but the main one in-house is the Friends and Family. And the patient population are not coming back to us with that. They just – they're just not engaging with it. And we are talking with our Comms lead about how we can engage with patients, because obviously you do need that feedback. So then, even Friends and Family, which is the one that's supposed to be really easy and immediate, they're not engaging with. No, they're not engaging with it at all, no. It's really, really difficult. We have quite a difficult population. Part of our population over in one of our practices, they're predominantly Polish. So, it's very difficult to engage with those patients because of the language barriers. So, although we can book interpreters for consultations, actual feedback mechanisms, it's just not there. (Practice C: Clinical Performance Lead)

This quote raises the role of the patient. If patients are not willing to participate in feedback, then it poses questions that need to be explored about the reasons why they choose not to engage. At its introduction, the Friends and Family Test was

presented as another tool in the box of the engaged patient, which they could use to select their preferred practice. If patients are not engaging with it, then it suggests that its intended audience is not interested in using it. This begs the question of who is using it (and the GPPS data) and why?

Staff interviewees in my fieldwork expressed beliefs that the only people who use the GPPS are managers at the Clinical Commissioning Group.

Quote 63:

> Interviewer: So, I'm interested in this production of data for measurement of things like patient satisfaction...I mean is it any use? is anyone using it?
>
> Interviewee: The CCG do! (Practice A: Nurse Practitioner)

This illustrates the view, amongst staff, that the datasets exist to serve the managers at the Clinical Commissioning Group, rather than general practices and their patients. This ties into the theme of distrust of the Quality and Outcomes Framework, for those who view it as a surveillance system, benefiting the bureaucratic managers. (Although this does not work so well with QOF as many GPs saw that it benefitted patients).

7.5 The Patient View: The GPPS and Patient Satisfaction

The role of patients in the field of data gathering to measure patient satisfaction has already been alluded to in the previous section. So far, we have heard from practice staff about how they view and use GPPS data as well as the FFT data. Now, our attention turns to patients. Chapter 4 examined the policy context that produced the GPPS. The justification was that it would enable patients to make decisions about their healthcare, and as such, fitted neatly into initiatives such as The Patients Charter (HMSO 1991).

Most patients who were interviewed during my fieldwork had heard of the GPPS - some of them had received it through the post and completed it. However, they had no knowledge of what their feedback was used for, and no notion of who might use or access the data. For patients who had completed a GPPS questionnaire in the past, it was viewed as a one-way relationship. They completed it but had no further action or interaction with it. When given further information (by the interviewer) about

it, including what it was trying to do and that it was intended to be used by patients to facilitate choosing a practice, many were incredulous.

The notion that the GPPS was intended to be of use to them, in their role as engaged patients, was novel. All patients noted that catchment areas meant that they did not have a choice about which practice they register with – another reason perhaps why surveys such as the GPPS bear little, if no, relevance to their lives. Once patients had a moment to consider the GPPS with this new knowledge, two themes emerged from the interviews. Firstly, almost all patients queried how they would use it. They spoke about how they had not felt they had a choice when they registered with their current practice. They talked about how they could only have registered with one practice, due to catchment areas. They reasoned that this rendered the GPPS data useless for them. One patient commented,

Quote 64:

> 'Choice' is a buzzword. It's like parents being able to choose a school for their children, yeah, right! (Practice A: Patient)

Secondly, almost all patient interviewees said that even if they had known about the GPPS when searching for a general practice for themselves and their families, they would not have used it because they would not trust it. One patient eloquently acknowledged that risk exists despite a plethora of online data and information.

Quote 65:

> How would you know? But then again, you go online – for example, there's a builder --- an old man, retired, take his pension and he wants to do an extension to his little place to make it look nice when he's retired, look online, and look at it – oh good report – and when you get the builder, the work is shabby. So, you get a good report online, but when a person comes to do the job, you can't guarantee – like I said, nothing is guaranteed. Everything is on trust. A/2 Patient 15 years

When asked how they would choose a future practice, all respondents (staff and patients) said that they would rely on word-of-mouth recommendations from friends, neighbours, or colleagues. None of them voluntarily mentioned sites such as NHS

Choices, QOF or the GPPS. When prompted about these data sources, they were all dismissed in favour of word-of-mouth recommendations.

Quote 66:

> I'd probably go with talking to people who – yes, personal recommendation, which, of course, is a bit hit and miss, because if somebody comes and asks me about [practice name] I would sing its praises. Other people aren't always happy with it. So, if you choose the wrong person, you can get a completely different image. (Practice A: Patient)

7.6 The Panopticon QOF

A theme that emerged strongly from interviews with general practitioners more than other members of staff was the pressure they reported that came from the feeling that QOF made them feel as if they were being constantly being 'watched'. This speaks to Foucault's Panopticon and its all-seeing power to effect self-regulation in those prisoners within its line of sight (Foucault, 1995). Other staff groups did not have such a strong reaction to what some described as 'always having someone looking over your shoulder'. If it was noted by other staff groups, then mostly, it was not viewed negatively. As seen in previous sections in this chapter, many staff members view QOF as a positive addition, helping to improve quality standards and structure their daily work routines.

During fieldwork many respondents talked about the effects that QOF had on their working lives. One theme that emerged particularly amongst general practitioners centred around the notion that the QOF constantly monitored the actions of GPs throughout their day. Some viewed this as an intrusion into their professional identity.

Quote 67:

> Everything that I do is watched and actually that is quite...it's quite exhausting to know that everything you do, you know is just, Big Brother is watching you. (Practice C: GP Partner)

Others spoke about the effects that always being visible to ones' peers and colleagues had on their mental health. One senior partner with over 30 years of experience spoke about how the culture of QOF forced a culture of visibility and accountability in which it was impossible to not participate. QOF forces practices and

everyone working within them to account for themselves and their actions every day. For some, as we have seen in the above section, this is not perceived as threatening. For some GPs with pre-QOF experience, this is perceived as a professional threat.

For this group of respondents, one of the most stressful triggers was the fact that colleagues and peers could check up on your performance, without your knowledge. Colleagues and managers are able (if they wish) to check on the QMAS system and see how many tasks a team member has performed, and if they are keeping up with their targets. One interviewee with many years of experience spoke in detail about the effects this had on her mental state.

Quote 68:

> Because now we're [redacted] you know, everybody can see, everybody across the whole patch will be seeing how I'm doing on my session. They'll be seeing how many tasks I'm behind in, or not, and if I've not read my letters and sorted them out within two days. It's very disciplined. Very disciplined because somebody's noticed. And I expect somebody makes a note of that ... (Practice C: GP Partner)

The interviewee explained how the stress increased when she realised that colleagues had stepped in to help her, by taking on some of her work once she had left work and was at home.

Quote 69:

> So, and then tasks kept coming and coming. Letters kept coming and coming and I worked Tuesday and Wednesday. So, I worked late on Wednesday, and I'd done everything except 24 letters. Thursday morning, my day off, I opened up my work laptop and there were only 8 letters. I thought, "Oh, what's going on? Somebody's noticed I haven't done my letters and they'd taken them off me."
>
> And then I suddenly thought - I was just having a bit of a stress-y kind of failure-y sort of day - and I thought "I bet they've then written that down that I haven't done my letters," you know? And you sort of get that feeling of urgh.

> And I didn't even know who to call to say, "Did you take my letters off me, I was just about to do them?"
>
> Because there was a sense in which - you see our exec partner will be our executive with the Board now we've voted - There's about five of them that are on the Board and you know, they'll be looking at all that data, you know? Who keeps up, who doesn't, you know, and it's called performance management. And so, you think to yourself, "Oh, you're not pulling your weight, you know." And there's that sense - and if you've got a personality like mine - you think, "Oh gawd, I'm letting the side down." And then this week, because I did this week, I went into the office and said, "Now who does the letters? Who can I speak to?" And I had a lovely chat with them, because for me it was about talking to people face-to-face." (Practice C: GP Partner)

This long passage highlights that for this interviewee, not knowing who had been looking at their activity and knowing that their 'failure' had been noted by colleagues triggered their stress. The same respondent notes that being constantly monitored is a development that came with QOF and marks a difference between being a GP in the pre-QOF era with today.

Quote 70:

> And it never used to be like that. I suppose it's the right thing. Probably in every other job that's what happens and so we just have to wake up and smell the roses because it means that at least the patients have got, a bit of, somebody watching their backs, watching our backs, I suppose. But it, it is quite it is a whole other aspect of stress, that wasn't there before. (Practice C: GP Partner)

While the Big Brother effect of QOF is noted above, there was also a recognition that having Big Brother in the consultation, may not be ideal, but has had some positive consequences, for staff and patients both.

Another long serving GP partner at the same practice commented,

Quote 71:

> But actually, I think what QOF showed us when they introduced - that the standards weren't high enough to start with. And so, we should be looking over people's shoulder. (Practice C: GP Partner)

As discussed in the previous chapter almost all staff interviewees found some aspects of QOF helpful. Staff also spoke about the consequences of QOF that have had a more negative impact on them and how they carry out their roles. Some respondents accepted that when QOF was first introduced, it revealed the variation that existed in quality standards at a national level. A GP with over 25 years' experience said,

Quote 72:

> So, ... I think we all, we all tend to be sort of reasonably arrogant and think that we do the very best for our patients in every contact. And I think actually what QOF shows us or has showed us is that probably we didn't. (Practice C: GP Partner)

While QOF was helpful in acting as an aide memoir and functioning to highlight the areas where quality standards were not met, one GP respondent noted the risk that it may have created a dependency culture whereby staff cannot imagine their role without it. These quotes illustrate the performative nature of audit and giving account of oneself raised by Strathern and Power in separate articles (Power, 1994; Strathern, 2000a). Seen from this perspective it has embedded itself into the very organisational architecture of modern-day general practice.

7.7 The embedded QOF

During fieldwork interviews with staff a theme emerged which spoke to the amount of reorganisation each case study practice had undergone to enable them to deliver the QOF. In some cases, this had entailed a complete organisational overhaul and merging with other practices in the CCG. In this case, they became a new practice with new premises and new colleagues. Organisations had to be merged and new ways of working had to be constructed or grown organically. At the other end of the scale, a small practice remained as it was, yet changes to the ways of working and

operating had occurred. At all case study sites, the culture of the organisations had changed, and ways of daily working had altered for all staff. Analysis of this theme, what I have called the 'embedded' QOF, is the focus of this section. It has appeared in this chapter already under the guise of changing working practices. In this section, it is examined in reference to how it physically impacted case study practices, in terms of taking on more staff and relocating to new premises.

7.7 QOF - Restructuring the workforce

To deliver the QOF and achieve maximum points, most practices (at a national level) have had to restructure their teams. Each practice has had to determine how they wish to deliver QOF. If they wanted to achieve the maximum points available to them, then they will have had to change (at the very least) the way the current workforce operates and assign new roles and responsibilities to existing staff. A small minority decided not to participate at all. Some practices have undergone huge transformations, while others remained small, family operations.

In my study, one senior partner, whose practice had undergone major transformation spoke about the staffing changes that had taken place at their practice to enable them to achieve maximum QOF points. This respondent spoke eloquently about how they felt the demands of meeting QOF targets increased year on year.

Quote 73:

> However, it (QOF) then grew and grew and grew and I have to say it was infuriating. So, in order to tick all these boxes and get all these points and actually gather the income, that we used to be just getting anyway, you have to then employ these nurses to ring, and extra people to ring people and send loads of letters out and then messing about sending people for urine tests - which is not going to be neither here nor there for their actual care - justifying getting the points. And it just becomes a bit ludicrous. (Practice C: GP Partner)

This quote also speaks to the theme (discussed earlier) that QOF made GPs justify themselves, or that the government had not trusted them before QOF. The quote above shows how this respondent felt that to get the same money they had been receiving previously they had to prove themselves, or render accountability, via the tool of the QOF.

Two practices in my research had relocated to new premises. One had merged with five other practices in the area and had become a small 'super practice'. It had maintained its current sites but also had a central new building in which services were delivered. The management structure had changed to reflect the new organisation.

The second case study practice in my research had maintained its identity but had moved into a brand-new, purpose-built building. As it occupied its larger site, new hires had been made and the reception and clinician team had been expanded. Moving to the larger premises meant that it had also increased its list size. A non-clinician member of the team responsible for patient liaison described how the new reception area had been designed to enhance the patient experience as they arrived at the practice. It was light and airy, where the previous waiting area had been dark and narrow with plastic chairs placed around the edges of the room. The new waiting area had beach seating throughout the space with hubs of chairs in places. There were iPads and interactive screens in the waiting area. The space was colourful with interactive toys for children and a dedicated parent/carer space for children. The respondent explained how all this was designed to improve patient satisfaction with the practice. At no point, did the respondent mention the GPPS but this is another example of how deeply practice staff care about their patients and the experiences they have at their practice – but these attempts to improve the patient experience and satisfaction at the practice are not correlated with the GPPS data at all. The concept of patient satisfaction and experience is clearly on the agenda of general practice staff, but it is not experienced for them via the vehicle of the GPPS. It may be that the GPPS has acted to shift agendas to include the concept of patient satisfaction and in that sense, one might argue that this is an impact of the GPPS, but it is impossible to say whether this is the case or not. Suffice to say, that either via the Friends and Family Test or the GPPS or the new public management policy context with its emphasis on patient choice and patient experience, that the concept is now firmly on the agenda of general practice staff teams.

7.8 Summary

This chapter has attempted to provide an examination of the many nuanced and complex impacts that QOF and GPPS have had on English general practice since their introduction. There have been unintended consequences which could not have

been foreseen, yet as shown in chapter 2, many of the impacts described by participants in my fieldwork were intended and align with the new public management aims of introducing accountability into public services, and in particular general practice. Professionals have been forced to comply with performance targets which have, at times, left some questioning their relevance to the profession. Clinicians have been forced to account for their actions in the traditionally private domain of the consultation. This has been experienced by some GPs as an intrusion into their professional domain. While chapter 6 explored the positive impacts of QOF and GPPS, chapter 7 demonstrated how it has also developed a culture of suspicion and distrust amongst general practitioners and clinicians.

Patients have not made use of the GPPS data or other sets of data aimed at arming them with data with which to make decisions about their healthcare. They report hardly any engagement with official data sets and when they are aware of them, patients in my study displayed a deep distrust of the data, refusing to use them. Patients in the study were deeply sceptical about feeling they had a choice of practices with which to register. All patients in my study reported only being able to join one general practice. From this perspective, they queried why they would ever need to use any data designed to aid their decisions about their health. Patients in my study felt they did not have any agency about their choice of general practice for themselves or their families.

My fieldwork revealed that amongst non-clinician practice staff, bureaucracy and target culture was welcomed, adopted, and positively experienced. This was seen most clearly in their experiences of QOF but was not shared in their experiences of GPPS – which they joined their clinician colleagues in disregarding.

My fieldwork shows that the implementation of performance culture in the forms of the QOF and the GPPS has been complex and nuanced. Neither tool is experienced homogenously in the practice team. Factors such as job role, previous experience, type of employment contract, clinician/non-clinician role will all impact and mediate how the QOF and the GPPS are experienced and implemented. This in turn will affect the patient experience of these tools.

The next chapter will explore what these findings mean for a policy context.

Chapter 8 – Discussion

8.1 Introduction

This chapter aims to pull together the development of the thesis beginning with the gaps identified in the literature review through to the choice of methods and eventually the data findings as they emerged from the fieldwork. This chapter will not repeat what has been covered in previous chapters. The aim of this chapter is to discuss how, when viewed together, the literature and fieldwork findings advance our understanding of the research question: How have QOF and the GPPS impacted the experiences of patients and staff in English general practice?

The purpose of this chapter is not to prove any theory as true or false. Its purpose is to use this space to discuss the findings made in chapters 6 and 7 in conjunction with the reviewed literature (empirical and theoretical) to reflect upon how they help to answer the research question and where relevant, how future research in this area might move the field forward. This reflects and continues the theory driven approach the thesis took at the beginning of the research (Burawoy, 1998).

The thesis makes three contributions. First, a theoretical one that argues that extending Shore & Wright's fifth effect of audit culture of *perverse effects* to one of *unintended consequences* allows a theoretical space to discuss and examine the positive effects of audit culture.

Second, the thesis builds on former work detailing re-stratification among practice teams in response to QOF (Heath et al, 2008) and advances this to argue that employment status of GPs in a practice can determine their approach to and delivery of QOF.

Third, the thesis highlights the finding that choice has not operated patient experiences as NPM policies predicted it would.

These three contributions are discussed in this chapter.

8.2 Background

The literature review found that many of the articles aimed at investigating the impact of the QOF on general practice tended to focus on sampling GPs and clinicians. For some studies this was appropriate, for example, those which aimed to research GP experiences. I identified the relative lack of voices and perspectives of other practice

staff (on the subject of the impacts of QOF) as a gap in the literature. This finding from the literature review influenced my choice of research methods when I moved on to the next stage of designing the study.

Chapter 5 detailed the Methods this thesis used and the reasons for selecting them. I determined to take a whole practice approach to the research and endeavoured to interview as many job roles as possible at each case study site. The findings that this method revealed are discussed in detail in chapters 6 and 7.

I have been rigorous and have sought to justify my choice of methods in this thesis. I have chosen not to replicate the sampling methods of many of the papers examined in the literature review chapter and have had to explain the decision. Using the sampling approach that I selected revealed an insight into the subtleties of professional self-identification that exists between GPs. It also highlighted differences and contrasts in experiences of the QOF and the GPPS between clinician and administrative team members.

This section will discuss fieldwork findings, reviewed literature, and theory with an aim to see how when viewed together, what light, these three sources of data might throw on the research question. Many points from the theoretical literature were confirmed by the fieldwork research, such as the nature of performance-based incentives in the workplace. However, the fieldwork also raised points that presented a challenge to the theories. Consequently, I will detail the points that 'agree' with the theoretical literature briefly and will spend more time on those findings which do not have a home in the current theoretical literature.

8.3 Findings that were confirmed by the literature

Shore & Wright (2015) identified 5 effects of audit culture. They are domaining, classificatory, individualising and totalising, governance and perverse. Evidence for all five effects was found in fieldwork research interviews at the four case-study sites in my study and are detailed in chapters (6 and 7).

Domaining effects include what Shore & Wright refer to as the 'runaway effect.' They mean that when audit culture is introduced into a new area it reshapes that organisation in its own image. They write that the 'runaway effect' happens 'as the newly created systems and modes of operating gather their own momentum' (2015, p. 425). Power identified what he called the 'audit explosion.' He argued that when

audit is introduced to a sector for which the tool of audit was not intended – in his view this excludes any sector or discipline that is not accountancy – then it will take over and replicate itself. In all four case study sites, staff interviewees spoke about how their practice complied with QOF but also several other local 'mini' QOFs, devised in partnership with other local practices. In other words, the QOF has produced other audits in its guise. It has replicated itself.

Shore & Wright argue that audits beget audits. As audits and monitoring become part of everyday life in institutions and for the staff who work in them, more and more tasks become 'auditable.' Applied to the world of English general practice Power's concept of *mushrooming* lends itself to the concept of creeping regulation that has encroached into the world of general practice and primary care. QOF which was introduced in 2004, could be viewed as the start of bringing general practice into the regulatory orbit of central government. Traditionally located slightly outside the main NHS structure of Care Trusts, general practitioners remain independent businesses and take shape in many different variations. Some single handers still exist today, while others have merged and formed 'super practices' comprising lists of several thousands of patients.

Two years after the introduction of the QOF the GPPS was introduced and provided a way to monitor patient experiences in general practice. Participation in the GPPS was not voluntary for practices. Patients are contacted independently by Ipsos MORI, and the results are sent direct to NHSE who duly notify practices of their results. Patients may choose to complete the questionnaire if they wish, it is not compulsory. The GPPS was heralded as providing patients with a way to choose a practice based on other patients' experiences. Findings from my research challenge the assumption that patients will access and use the GPPS data as a way to choose their GP practice. Chapters 6 and 7 detail how and why patients in my study did not engage with the GPPS data. One of the main reasons for the disengagement was lack of knowledge about the availability and accessibility of the GPPS data, coupled with experiences that had taught them that they did not have a choice when it came to selecting a GP practice for themselves and their families.

In 2014, practices were forced to take more notice of the GPPS data when the CQC announced that they would start using indicators from QOF and GPPS as part of the

Intelligent Monitoring system. Viewed through the lens of Shore & Wright's 'runaway' effect and Power's concept of audit's tendency to *mushrooming*, we might view the timeline of QOF and the GPPS as examples of Power's *mushrooming* concept which culminated in the CQC's appropriation of GPPS indicators for use in its Intelligent Monitoring system (Power, 1997b; Shore & Wright, 2015).

Classificatory effects acknowledge the fact that knowledge generation is never politically neutral. Merry argues that an audit produces knowledge and then labels it (classification) and in so doing they hail it into existence (Merry, 2011). Far from being a mundane, routine administrative task, Shore & Wright argue that the classificatory effect carries political significance. They argue that "audit changes the values, priorities, and practices of organizational subjects in subtle and often unnoticed ways such that their subject positions are transformed" (2015, p. 426). In the case of the QOF and general practice, one could argue that the QOF data has been put in the classificatory bracket of 'quality'. Seen in this context, it is a highly charged political tool with potential to transform relations within practice teams and between local practice clusters. Power (1997a) writes of audit,

> "we have lost the ability to be publicly sceptical about the fashion for audit and quality assurance" to the extent that they have come to appear as natural and benign solutions to the problems of performance, management, and governance."

Shore & Wright's individualising and totalising effect follows from the classificatory effect. Once the classificatory effect is established, individuals and organisations are repurposed to achieve the targets set. Many staff interviewees spoke about how they felt it was their personal responsibility to achieve as many QOF points as possible for the practice (see quote 2). Managerial staff spoke about how they had implemented changes within the staff team to deliver the QOF targets (see quote 73). In this way, practices have transformed themselves and the way their staff are managed and operate to deliver the QOF. This effect speaks particularly to Foucault's concept of 'self-regulation.' This can be seen when staff interviewees spoke about how they manage their workload to deliver the QOF as evidence that they have internalised the aims of QOF (see quote 39).

The governance effects that Shore & Wright identify speak to the Foucauldian concept that 'seemingly mundane routines often have a profound impact on the manner in which we are governed' (2015). The introduction of performance targets and measures affect how institutions are governed. They coerce institutions to become accountable to the public gaze and open them up to public scrutiny. Strathern picks up the effect of this on the people who work in these sectors. She writes about the 'tyranny of transparency' in which she notes that it is almost impossible to resist the relentless call to accountability and audit. She writes of the moral pull of audit, until it becomes impossible to resist, either as an individual or as an organisation (2000b). Once every general practice in your area is publishing their audit results or monitoring data, it becomes unimaginable to be the one that does not do so. The innocuous disguise that audit is merely an administrative detail belies its ability to transform the way institutions operate, affecting all of us in our daily lives, either as employees or as users of services. It has also transformed the individual's relationship with the modern state through its demand for accountability.

When Shore & Wright identify perverse effects, they point to examples of what they call when 'governing by numbers' goes wrong. To illustrate their point, they refer to military strategic decisions that were taken by the US military during the Vietnam war. They argue that US military commanders became so focussed on their strategy that they did not notice until too late, the stream of US service personnel returning home in body bags.

For my fieldwork, I have taken Shore & Wright's concept of 'perverse' effects and interpreted it to apply to what I have termed the *unintentional consequences* of QOF and the GPPS. I have included in this category the stress and pressure on staff when they spoke about delivering QOF targets. This pressure was experienced differently by different staff roles in the practice. For example, clinician staff members spoke about it as a negative pressure which at times kept them up at night. Other clinician staff spoke about it as relieving them of pressure and found that they were reminded by other team members when they needed to make an effort to gather QOF points. This finding speaks to and confirms McDonald et al's (2008) identification of stratification within and between GP staff and nurse staff in practices. They identified that within staff teams, there were those who 'chased' other team members to deliver QOF targets and those who were 'chased' by them. This

distinction resulted in very different experiences of QOF for staff who found themselves in either category.

In my fieldwork, findings added another dimension to this when administrative staff spoke about QOF as a positive force motivating them to 'turn their spreadsheets green' and the resulting feelings of satisfaction and increased staff morale it produced. This indicates that administrative staff may identify as *chasers* in a slightly different way to GP *chasers*. Administrative staff are *chasing* clinician colleagues to deliver QOF points, whereas GP *chasers* are chasing their own professional colleagues.

8.4 Findings that challenged the literature

Some of the findings were not confirmed by the literature or challenged the literature in terms of requiring the literature to be updated. One of these areas concerns whether the introduction of public accountability into public services delivered increased patient choice.

8.4.1 Did patients experience 'choice' in English general practice?

Chapter 4 traced the roots of the QOF and the GPPS back to the 1980s and the new public management ideals which were adopted enthusiastically by the UK government led by the Thatcher administration. The NPM ideology has remained a feature of the policy context throughout successive UK government administrations.

Chapter 4 identified three findings from the reviewed policy and grey literature published between 1980-2022. First, the chapter found that if NPM policies were to be realised then patients needed to be reconstructed as healthcare consumers and be encouraged to think of themselves as healthcare consumers, able to shop and choose which services they wanted and which ones suited their needs best. The second finding was that healthcare consumers would need service and performance data to enable them to exercise their choice in the market – or choose a general practice with which to register. In this way, patients/healthcare consumers would play a more active role in choosing their practice. To enable this, healthcare consumers would need data on each practice. Several things needed to happen for patients to view themselves as consumers with choices. One of the first steps towards this involved encouraging patients to switch from a system of interpersonal trust (I like the doctor/I've always used this practice etc) to a system of choice (Fotaki, 2014).

The third finding is central to NPM ideology. The theory holds that once institutions are forced to be accountable to the public or governmental gaze, the mechanism of accountability will deliver higher quality standards as a result. The certainty that accountability would deliver higher quality of services is based on a market rationale that places practices in competition for patients. The competitive element was supposed to deliver higher quality for patients and better choice. In this market-based scenario, poorly performing competitors would simply go out of business as healthcare consumers would choose not to go there.

There are many challenges to the three findings from chapter 4 which details how the theory of NPM envisages systems working and the supposed benefits that were to follow. Empirical data from my interviews with patients and staff pose problems for NPM theory on all three findings from chapter 4; patients in my survey did not view themselves as consumers with choices; patients still operated a system of interpersonal trust to choose a general practice. Furthermore, no patient in my fieldwork reported using the GPPS data to choose a practice.

My fieldwork established that the promised benefits of NPM in terms of patient choice have failed to materialise (see quote 64). This chapter will move on to consider some of the reasons why NPM failed to deliver its benefits in the context of English general practice, especially for patients.

8.4.2 Patients as healthcare consumers?

A basic model of NPM would argue that the market will regulate competition and increase choice for consumers. In this model, competition between service providers will punish weaker providers and patients will exercise their newfound power by choosing not to use them. Eventually, weaker providers will either go out of play or will be forced to raise their standards to continue existing. Patients will be empowered through their new exercise of choice and providers will compete for their patronage. This is the classic model of NPM theory and sits at the root of health policy reform throughout the late 1980s through to the present day.

As discussed already, my fieldwork has shown that patients have not experienced these benefits and do not view themselves as consumers. So why did NPM fail to deliver patient choice in the context of English general practice? For patients to be able to exercise choice there must be enough practices for patients to choose from.

If there is a lack of general practices, then the concept of patient choice is not possible. General practice has been facing a major recruitment problem since 1950 ("The Collings Report," 1950). Coupled with a large cohort of GPs preparing to retire as well as many leaving the profession early, general practice has a serious recruitment and retention crisis (Owen et al., 2019; M. Roland, 2020; M. Roland & Everington, 2016). The time that it takes for a GP to qualify is long, thus the market's usual response to meeting demand is hampered in the context of general practice. The market is not able to respond immediately to demand by providing extra GPs and practices in areas of high demand at short notice. Added to this is the reality that general practice's remain independent businesses. It is not within the grasp of the state to open new general practices where they are needed. General practitioners need to be encouraged and incentivised to open in areas with high deprivation and high need. The literature demonstrates the inequity of provision of general practices in areas with high deprivation scores (Bécares et al., 2012; McLean et al., 2006; Mercer et al., 2007; Teljeur et al., 2010).

This highlights the problem presented to NPM policies when attempts to import them into public services are made. Market analogy may work with goods or products that are able to meet demand in 'just in time' models but 'just in time' supply chains cannot be applied to the production of general practitioners and general practices.

The finding from my fieldwork that highlighted that patients did not feel they had a choice of general practice, confirms findings in an earlier study by Ferlie et al (2006). The authors investigated the effects of a major empirical study of choice in London and identified several reasons why choice in secondary care is hard to deliver. A main finding was that choice demands a surplus of capacity. In my study, surplus capacity at general practice level in England did not exist. This is a limiting factor and impacts on patient choice as patients in my study pointed out that they did not have a choice of practices with which to register.

The consequence of this failure to provide supply in the market of English general practice presents another challenge to a key component of NPM theory. Once patients discover that they cannot exercise choice in the market, they are not inclined to view themselves as a healthcare consumer. This was evidenced many times in my fieldwork interviews with patients (including staff in their role as patients).

Respondents were deeply cynical of official data and government rhetoric of ‘choice’ and concepts such as patient satisfaction.

Exworthy and Frosini (2008) and Hughes et al (2005) identified the impacts that policies of decentralisation had on the delivery of patient choice into local health landscapes. They argued that more attention to the horizontal dimensions in the analysis of decentralisation policies might further understanding of the limitations to introducing patient choice into different regional areas.

8.4.3 Professional Protectionism?

Freidson may be helpful here in his analysis of the sources of a profession’s power. A defining feature of professions (in his analysis) is control over admission to and training in the skills of that profession, for example, the licensing of those who are permitted to practise. By holding the keys to gatekeeping, the medical profession holds a source of power over the government. Governments may recognise that there are not enough general practitioners and general practices, however, it is the medical professional bodies who hold the key to the provision of doctors and the time it takes to train the next cohort of professionals. Supply and demand in the marketplace of English general practice is not just a matter of numbers, it represents a site of power and negotiation and is a delicately balanced relationship between the government and the medical profession. On the government’s side is the fact that they hold the keys to training the next generation of professionals via funding of the higher education institutions that provide the training.

If NPM has not delivered its promised benefits for patients, as my research suggests it has not, then it might be reasonable to ask for whom it has delivered? Alford suggested that one way to identify sources of power was to ask who benefits from current structural systems and who benefits from changes (1975).

In the case of the QOF, there is a financial incentive for GP partners of practices who achieve their targets. This is in return for an increased workload (not necessarily shared by those who benefit from the financial incentive) and an increase in regulation. It is possible to create a narrative that suggests that the real beneficiary of the QOF in English general practice has been the state – through the increase of central monitoring and regulatory powers, held and exercised by first the Department of Health and later by the CQC. One could argue that NPM policies achieved their

aim of shrinking the role of the state by allowing it to retreat until it became a regulator of services rather than a provider of services (Pollock & Price, 2012b; Strathern, 2000b). Pollock & Price argued that,

> "Under current law the secretary of state has a duty to "promote" a comprehensive health service and, for that purpose, a duty to provide specific services throughout England to meet all reasonable requirements.
>
> Although the secretary of state will continue to have a duty to "promote" a comprehensive health service, clause 12 of the bill changes the duty to provide to a duty to arrange, which it transfers from the health secretary to CCGs. This weakens the health secretary's overarching duty because primary legislation no longer specifies the measures, he or she must take to promote a comprehensive health service.
>
> Recent amendments would mean that the secretary of state "retains ministerial responsibility to Parliament for the provision of the health service in England."
>
> However, this would not restore the link between the duties to promote and to provide …"(Pollock & Price, 2012a)

If we attempt to answer Alford's question in relation to the GPPS, we will have to admit that the GPPS has not benefitted patients or practice staff. Who uses the GPPS data is beyond this thesis, yet all practice staff who were interviewed reported their view that the only people who use it are managers at the CCG, who (interviewees report) use it to 'watch' and monitor practices. This belief (true or not) was shared by all staff interviewees and was compounded when the CQC introduced IM and its use of some of the GPPS indicators. This enhances theoretical perspectives that place the introduction of 'accountability' in public services in a Foucauldian interpretation and see it as an 'extension of the reach of the state' (Strathern, 2000c).

The role of the nursing profession has also had to negotiate the landscape of QOF in English general practice. My findings report that while much of the work of QOF has fallen to the Practice Nurse role, some nurses in the study reported that QOF had

offered them a new-found authority to question the decisions of their GP colleagues. This confirms findings from Checkland et al (2008) which found similar enabling consequences of the use of QOF templates among nurses working in general practice. The nursing professional bodies have had to negotiate their professional boundaries since long before QOF, with Dingwall et al noting that attempts to carve out a professional space for themselves in the 1980s came about as their attempts to define themselves as something more "than handmaidens to doctors" (Newby, 1990).

8.5 'Messy' data

In true qualitative style, my fieldwork also offered evidence that contradicted all five of Shore & Wright's effects of audit culture. While this was frustrating at first, it can also be seen as a true reflection of the *mess* that qualitative work produces.

Some of the mess can be explained by methodological differences in the study design and methods I employed and those used by Shore & Wright. I used Shore & Wright's Analytical Framework because at the time it offered the closest fit to help explain my research question. I did this in the full knowledge that there were many differences between my research aims and theirs'. For example, they focused on macro-level effects of audit culture, using global accountancy firms as their case studies, while my study investigated individual English general practices. I began my research project in the knowledge that their analytical framework would take me to a certain point, after which I would have to strike out on my own theoretical journey.

My methods and sampling design were also different to their study. My aim of including as many staff roles as possible in interviews has added to the 'messiness' of my findings and has provided more of a headache in trying to make sense of it than if I had used a tidier sampling strategy and restricted my interviewing to one group of staff. Wanting to include the many voices that populate and staff modern day English general practice results (predictably) in a cacophony of voices and experiences which at first sight, appear messy and confusing. Through an iterative process of returning to the interviews and data the cacophony quietened and it became possible to identify themes and findings.

My fieldwork offers evidence for all five effects of audit culture identified by Shore & Wright as long as I only interviewed GPs with many years of experience and stopped

the interview before they spoke about how they found QOF useful. Once interviewees spoke about how QOF helped them to do their daily job, my findings moved beyond Shore & Wright's analytical framework.

This led me to consider repurposing one of the five effects of audit identified by Shore & Wright (2015). One of the five effects they identified resulting from audit culture was that of *perverse* effects. As described in other sections of this thesis, they use this category to discuss what happens (in their words) when 'number counting' goes wrong.

This concept worked in my research when discussing staff stress from QOF. However, when staff spoke to me about how QOF helped them to do their jobs and how they found it helpful – *perverse* effects was not an appropriate category. As described elsewhere in this thesis, all staff from every role interviewed, spoke of QOF as an enabling factor in their work as well as being a motivating factor in terms of staff morale. This finding was more pronounced among administrative staff.

This leads me to suggest that instead of *perverse* effects of QOF, a more apt concept for understanding the impacts of QOF in English general practice would be to talk about *unintended consequences*.

By using the term *unintended consequences* we are able to discuss the finding from field work that QOF has both enabling and disabling impacts on staff in English general practice. Changing the language from *perverse* to *unintended consequences* allows a theoretical space to discuss these findings that came strongly from the fieldwork. Until then, there was no place in the theoretical literature to discuss them.

My use of Freidson's work on the medical profession was similarly useful. Freidson wrote about the professions and in his 1970 work he concentrated on the medical profession. Many aspects of his theory concerning how the medical profession protected its sources of power could be found in my fieldwork. His work can only be applied to professionals – the doctors. It does not apply to other staff roles and their experiences in general practice. It is representative of the time and place (the US in the 1970s) it was written – the decade before NPM ideology became established in the thinking of approaches to government policy towards public services. Despite this, Freidson's insights into how the medical profession negotiates with the modern

central state during the introduction of NPM inspired initiatives remains relevant and useful to this thesis.

Where it failed to be relevant to my fieldwork is in understanding the experiences of medical professionals as they comprehend and reflect on decades of regulation and over 15 years of working to deliver the QOF. Using Freidson's 1970 theory, one would predict extreme protectionism from GPs at the introduction of QOF and other forms of regulation. When QOF was introduced in 2004, this was indeed the reaction from GPs working in practice. Behind the scenes (as discussed in chapter 4) the medical professional bodies had been integrally involved in the negotiation and delivery of QOF, so there had been a large element of cooperation between the professional bodies and the state – a process which frontline GPs might not have appreciated. After, 14+ years of working with QOF, Freidson's theory cannot explain how GPs in my fieldwork spoke about welcoming QOF and of a reliance on it to keep up with increasing targets that at times felt overwhelming.

It may be unfair to argue that Freidson's theory needs updating because it could not explain GPs in my research who spoke about welcoming regulation in the form of QOF. Friedson's work was aimed at the medical profession as a whole. When he wrote about their protectionist behaviours in response to the imposition of regulation from the centre, he was writing about the behaviours and actions that would be adopted by the professional bodies, rather than individuals.

8.6 An anthropological gap?

This is the point where my research challenges all the theorists used in this thesis. There is a lack of anthropological study into the world of general practice and the impact that NPM policies have had on it. An anthropological literature on this topic would have been useful because it would have provided a theoretical base from which I could have learnt, while designing my study. In the absence of this, I was forced to look elsewhere for theoretical help and arrived at Freidson, a sociologist. A sociological theory is useful at a meta level (as Friedson is, when analysing the behaviour of institutions) but once investigation turns to individuals working within institutions, any insights offered are of limited relevance, because individuals behave differently to institutions – which is the precise area of interest for an anthropologist. It is in this area that I hope to offer my contributions to the field.

8.7 Contributions

My thesis offers three main contributions to the field of understanding how the QOF and the GPPS have impacted staff and patient experiences of general practice in England.

8.7.1 Theoretical Contribution

My research confirms that Shore & Wright's (2015) five effects of audit culture can explain many of the impacts that the embedding of QOF and the GPPS have had on general practice in England. However, it cannot explain findings from the fieldwork that included positive reflections on QOF and how it had helped interviewees perform their roles. This finding featured across all staff interviewee groups. I propose that extending Shore & Wright's *perverse* effects to one of *unintended consequences* allows discussion and theoretical space to analyse the positive reports of QOF in practice team experiences.

The current theoretical literature does not offer a way to fully grasp all the ways the QOF and the GPPS have transformed the working lives of staff in general practice as a result. Neither does it offer ways to hear staff speak about experiences of the two tools as positive and helpful to their work. Borys & Adler 's work on the enabling effects of bureaucracy is helpful here, but the topic needs further and more detailed investigation. While useful, Borys & Adler did not include incentivised performance schemes in their analysis of management bureaucracy (1996).

8.7.2 Empirical Contributions

8.7.2.1 Restratification of staff relations in response to implementing QOF

A second contribution to this area is that GP staff approach QOF differently and that the differences in approach to conducting and delivering the QOF roughly aligns with GP employment contract. The basis of their employment (GP partner, salaried GP, or locum) shapes their attitude towards their workload, how much time they are willing to spend with a patient and how dedicated they might be to 'chasing' QOF points on behalf of the practice. This in turn contributed to the levels of stress and pressure they experienced at work.

As detailed in Chapter 6, GP partner's attitudes towards QOF differed to those of their salaried GP colleagues. Salaried GPs in my fieldwork, spoke about feeling the

pressure of QOF but also said that they would do QOF only *if* they had time, or felt it was the right thing to do. They would not do it if they felt it did not benefit the patient.

I did not have the opportunity to interview any locum GPs in my study which is a weakness, but it would be interesting to test if they displayed different attitudes to QOF to colleagues with a different employment status.

This finding is important because it raises interesting questions about the future GP workforce and how they wish to work in general practice. The future of the GP workforce is beyond the scope of this thesis but the findings from my fieldwork may offer insights into how GPs' employment status can impact on their job satisfaction and the ways they conduct their work. A new generation of GPs who have only known general practice with the QOF may wish to engage and shape their careers differently to the more traditional pathway of becoming a GP partner. The next cohort of general practitioners may wish to only work as salaried GPs or locums and be able to walk away from the stress and pressure at the end of each day. If this is the case, then it carries important policy issues for those tasked with resolving the recruitment and retention crisis in English general practice.

This contributes to earlier work by McDonald et al (2009) that demonstrated how internal restratification and hybrid roles among GP colleagues in the same practice emerged as a consequence of QOF. In an earlier work (Mahmood, 2001) discussed how the 'new' GP Contract might impact on staff relations within 'rank and file' GPs. Mahmood discusses the move from a model of collegiate structure to one of division between the 'traditional and entrepreneurial GP' as from the 1990s, GPs took on more managerial roles. Mahmood argued that,

> "these elites and self-regulatory organisations were being drawn into controlling their colleague practitioners in implementing policies over which they had marginal control. Tension consequently crept into the practitioner-profession relationship, which became more complicated." (2001, p.248).

The literature on the impacts of QOF on other staff within the GP practice team also highlighted the realignment of power relations between GPs and nurses as QOF was implemented. Some nursing colleagues adopted quasi-managerial roles and performed the role of 'chasers' of their colleagues (the chased) to achieve QOF points and targets (McDonald, 2009). A more informal example of changing

relationships within the practice team was given by Checkland et al (2009) who documented how nursing staff reported that QOF and its transparency around pathway templates, enabled them to approach GP colleagues and question their decisions, in a way they would not have felt able to do, prior to QOF.

8.7.2.2 NPM in the form of QOF and the GPPS has not delivered patients with choice of primary care provider.

NPM ideology promises the provision of choice for patients. I argue that NPM ideology manufactured a problem (i.e., that patients wanted to choose the provider of their services) and claimed it could provide a solution which would be delivered via the internal market. In one fell swoop NPM theory invented a problem and instantly provided its solution. Findings from my fieldwork demonstrated that patients did not want to choose between a good practice and a poor practice. When asked if they wanted a choice of which general practice to register with, patient interviewees said they only wanted to choose a practice if their current /nearest one did not have a good reputation. When prompted, they said that would rather have a good local practice than have to move to one further away. They said that the only choices they wanted to make concerned opening times and how likely they were to get an appointment etc. No patient mentioned clinical standards at the practice as a factor in their decision making. No patient interviewee mentioned the GPPS when asked which factors they would consider when choosing a general practice for themselves or their families. When asked if the quality of the clinical care was something they would consider when making their choice of general practice, patient interviewees spoke about not feeling confident to make such a decision. Patients in my study spoke about how they wanted to assume or trust that all general practices offer a good clinical service. Patients did not want to have to judge for themselves whether a general practice offered a high quality of care.

This poses a problem for the 'engaged patient' scenario of the Wanless White Papers (Wanless, 2002, 2004, 2006, 2007) the concept of which is a cornerstone feature of new public management theory. My fieldwork demonstrates that there is a mismatch between what the patients in my study report they want and what new public management policy makers *think* the patient wants. This prompts questions about how the creation of the 'problem' of lack of patient choice was constructed and whose interests it served and continues to serve. The patients who participated in

my fieldwork did not feel that they had experienced any choice in which general practice they registered with and furthermore, were undecided about whether they wanted that choice. Most reported that they did not want to have to choose between a good practice that might be further away or one nearby with a poorer reputation.

There is a body of literature in the UK that examines how patients experience choice when deciding upon their treatment with their GP (Edwards & Elwyn, 2009) and how they experience choice when selecting a secondary care provider (Greenhalgh et al 2013; Smith et al, 2018) and how their GP aids them in making that selection. Many of these articles focus on the launch of the UK-wide Choose and Book service introduced in 2004, designed to provide patients with a choice of provider, to be discussed with their GP, as they entered secondary care. The literature focuses on patient choice at the transition from primary to secondary care.

8.8 Policy implications of this research for general practice policy makers and researchers

Findings from this research might be used in several ways in relation to general practice development; implementation of policy into general practice and implications for future researchers in the field of general practice.

The finding that some staff embraced performance monitoring and welcomed the way it structured their working day might be used to inform policy makers and practice managers how workloads are managed and distributed throughout the team. All staff interviewees mentioned the pressure of targets and some job roles experienced the burden of this more than others. This finding might also be used to inform the construction of policy at the design stage so that workloads and tasks might be developed with thought for who might conduct them and how this would impact on the team.

Implementation of policy into frontline general practice can be a delicate and unpredictable process. Findings from this research might aid policy makers in understanding better the unintended consequences of policy implementation and how these might be managed and foreseen. Learning from the years that both the QOF and the GPPS have been in operation affords us the chance to refine both and render them more useful and applicable to general practice while they remain in use. If they are abandoned and replaced with alternative policies, findings from my

research shows that factors such as which roles are tasked with delivery of the policy play a key role in the balance of relationships within the team which in turn impacts on staff morale as well as how regulations or performance monitoring programmes are used by general practice staff and received by patients.

A third use of my research findings might be for those preparing research projects in the field of health research more widely, and particularly for those planning to conduct a research project in general practice. My research has shown the value of applying an anthropological inspired approach to the design and collection of data from the field. An inclusive approach to sampling and extra efforts made to ensure as many roles as possible were invited to participate certainly added time and administrative tasks to the project. Yet in the end, it was the addition of these insights provided by incumbents in the roles that have really shed light on what life is like for staff working in a modern-day general practice. The reward for taking a whole practice approach to the collection of staff experiences is a richer and more complex understanding of staff experiences of QOF and the GPPS in English general practice in the years following their introduction.

8.9 Reflections and Limitations

Like all research projects, my project had to adjust its aims as it progressed for a variety of reasons. One area of limitation concerns the huge amount of data generated during this thesis and the subsequent editing process. Decisions were made about what to include and leave by the wayside. Avenues that might have been followed, were not, due to my research aims and choices moving in a different direction.

Another limitation concerns the imbalance in numbers between the number of staff interviewed and the number of interviews conducted with patients. The process of recruiting practices to my study was difficult and time consuming. In the end the process of recruiting four case study sites and successfully applying for Ethics Approval took over one year. Practices that agreed to take part were later put off by the lengthy Ethics process that had to be passed before I could even begin work with them on site. I lost several case studies in this way.

Once the Ethics hurdles had been passed, I then faced the struggle to recruit patients and staff participants to the interviews. Recruiting staff was straightforward

as the Practice Manager introduced me to the team after which staff simply signed up to be interviewed. Recruiting patients was more problematic. Ethics restrictions meant that even once a patient had agreed to do an interview with me, we then had to wait a minimum of 24 hours between signing the consent form and carrying out the interview. This was to allow potential participants time to change their mind if they so wished. This meant that in the intervening twenty-four hours I lost many patients who had been happy to speak to me in the practice waiting room but did not have the time (or inclination) to make further arrangements to meet later. Furthermore, my only access to the patients was via the practice manager's introduction to the Patient Participation Group (PPG). Patient Participation Groups are mandatory at all practices and the practice has a responsibility to try to ensure they are representative of their patient list. Each Patient Participation Group operates differently but they all have the aim of ensuring the patient is at the centre of practice plans to improve the practice for the benefit of the patients and the practice. The Patient Participation Group is a self-selecting group of patients who volunteer their time. At some practices they fulfil a fundraising role, while at others they give feedback to the practice manager about the patient experience. I did make attempts to recruit patients from the waiting rooms of practices, via posters and leaflets, but was hampered by the ethics challenge outlined above and recruitment was close to zero.

Another limitation of the study is that I did not interview any locum GPs in my research. I was reliant on the practice manager recruiting staff to contact me. No locum GP was ever put in contact with me to participate in the study. When I enquired if it was possible to include a locum GP, I was told this was not possible. Given that one of my contributions to the field is that a GP's contract of employment shapes their approach to QOF – it would have been useful to include locums in my sample.

Another potential limitation of the research is the apparent overemphasis on QOF rather than the GPPS. This reflects the fact that staff interviewees hardly spoke about GPPS when asked about its impact on their work. They spoke eloquently about QOF (as is reflected in the thesis) but had little to say about GPPS, other than how they thought it did not portray their practice accurately. They all questioned its statistical accuracy and, on that basis, dismissed it and did not want to discuss it

further. Most patient interviewees had never heard about it and knew about it only as the 'IPSOS' poll. The patients who did know about it, did so only because they had completed a postal questionnaire at some point in the past. Their experience of it was of something to be passively completed and posted back to the return address. The suggestion that they might use the data produced by the GPPS to make health choices for their family was met with perplexed confusion.

The period of the research project encompassed the COVID pandemic and subsequent school closures and lockdowns. Like everybody, my circumstances changed as children stayed away from school. This meant that I had to apply for (and take) two interruptions during the research and writing up stages.

8.10 Future Research Agenda

This thesis has argued that there is a need for a theoretical literature that reflects the complexity and nuances of the effects of performance management measures in English general practice. It would be interesting to pursue this aim with the aid of further empirical work sampling as many roles as possible within English general practice staff teams.

The research found that employment contract shapes GP attitudes to and experiences of QOF. Future research into the differences between the experiences of GPs on different contracts would be valuable. For example, do salaried GPs experience less stress and pressure from QOF than their GP partner colleagues? Does this lead to improved job satisfaction for the salaried GPs? If salaried GPs feel more able to choose which bits of QOF to do, does this improve patient satisfaction? Do salaried GPs deliver higher patient satisfaction as they are able to focus on the patient's agenda rather than the QOF more than GP partner colleagues?

There is a large body of literature on the patient's voice in general practice and what patients want from general practice. My research confirms the findings from the literature. In the light of COVID and telephone appointments, it would be interesting to conduct further research into patient and staff satisfaction and experiences of telephone consultations. This would contribute to our knowledge of the patient body and help us to understand how different patient cohorts prefer to access their general practice care.

If Shore & Wright (2015) and Power (1997a) are correct that there is no end to the mushrooming or runaway effect of audits, this raises questions for the future of general practice and all public services. Perhaps the findings from this research go some way towards enhancing our understanding of how to manage the impacts of new public management inspired policies when introduced into our public services.

One of the contributions my research makes relates to the employment contract status of GPs. As noted above, my research was limited by the lack of access to, and inclusion of, locum GP staff. Further research on the different 'types' of GP (partner, salaried or locum) and their attitudes to QOF would be a helpful addition to our understanding of how employment status impacts on professionals' approach to delivering and embedding performance incentives in their daily work.

Chapter 9 – Conclusion

This chapter will conclude the research study by summarising the key findings and how they relate to the original research question and aims of the thesis. It will consider limitations of the study and propose further questions for research.

9.1 Research Aims

The research aimed to investigate what the impacts of the QOF and the GPPS have been on general practice staff and patients in England since their introduction (2004 and 2006, respectively).

9.2 Summary of research findings

Findings from the fieldwork demonstrated that impacts of the QOF and the GPPS on practice staff have not been experienced in the same way. Differences emerged in relation to clinician/non-clinician status; whether one qualified pre or post QOF and job role in the team. The study found that an anthropological inspired approach to sampling uncovered perspectives on the two tools was rewarding in revealing nuances in staff experiences. Theoretical findings from the study indicated that moving from Shore & Wright's concept of *perverse* effects of audit culture to one of *unintended consequences* allows for a theoretical space in which to discuss the enabling impacts of QOF. The literature on professions involved in English general practice needs updating to reflect the complex and nuanced world of modern general practice in England and the stratification that has occurred within practice teams as a consequence of QOF and new ways or working.

9.3 Do the findings answer the research question?

Findings from the study answer the research aims by adding to our knowledge of what the impacts on staff and patients have been of the Quality and Outcomes Framework and the General Practice Patient Survey. The research revealed the detailed and complex way that staff have adapted to and adopted the new ways of working the two tools impose on them. The research went beyond the original research question (which asked about impacts on staff and patients) and looked at the broader landscape of general practice and asked what the impacts of audit and performance management culture have been on the ways that practice staff work. Findings from the study revealed the pressures and strains that staff feel to 'hit' the QOF targets. This was already documented in the literature. My study has added to

this field by linking this finding with concepts in the theoretical and policy literature. These concepts include Foucault's 'self-regulation', Freidson's 'professionalisation' and the critique of 'accountability' as used in the new public management literature. The thesis also used Lipsky's concept of 'street level bureaucracy' and Bourdieu's 'low level bureaucrats' to understand how those professionals working on the frontline negotiate and deliver policy that has been crafted at the centres of power. In this way, the thesis raises topics relevant to the field of policy implementation.

9.4 How do the study findings relate to gaps in the literature?

The literature review and the policy scoping review (conducted later) identified several gaps. The literature review identified that the voices of practice staff who were not GP partners were seldom heard in studies evaluating the impacts of the Quality and Outcomes Framework and the General Practice Patient Survey. The study contributed to filling this gap by following in the paths of research conducted by Heath et al (2007) and Checkland et al (2007) by ensuring staff members from all roles within the practice team were invited to interview. The study heard their voices and added their experiences to the literature. A second gap identified in the literature review was that patients' views were rarely sought in relation to views of the impacts of the Quality and Outcomes Framework on their experience of their practice. The study sought to redress this imbalance by asking patients about the tool in interviews. The findings from patient participants about the Quality and Outcomes Framework were that they were not well informed about the QOF and were unaware of its aim to raise quality standards in English general practice. All of them were unaware that QOF carried a financial incentive for the practice.

A further gap in the literature was identified concerning a lack of knowledge about how well-informed patients were about the General Practice Patient Survey and how (and even if) patients ever used it. My study sought to gather information to respond to this gap in the literature. My research found that some patients were aware of the General Practice Patient Survey because they had been sent one through the post and had been asked to complete it. During prompting in the interviews, it became clear that knowledge about the GPPS was very low. Patients, for example, were unaware of what happened to their data after they had posted their questionnaire back to Ipsos-MORI. They were unaware that their data was collated at practice level and aggregated into publicly available data. Other patients in my study referred to it

as the ‘IPSOS’ survey but knew nothing else about it beyond that. It should be noted that all patients in my study were members of the Patient Participation Group, meaning they were likely to have been better informed than patients who were not members. Even among those patients who had completed a survey, none of the patients in my study used the results from the survey to inform their decision of which general practice with which to register. Furthermore, none of the patients in my study knew that they could access and use the General Practice Patient Survey data to aid their decision making in relation to their health care.

9.5 How do findings from the study speak to the current literature?

The study revealed several findings. Some confirmed the literature, others challenged it and others extended existing theories. This section will explore how the findings (empirical, theoretical, and methodological) relate to the literature. As stated in the earlier stages of this study, I expected the current theoretical literature to take me so far in my analysis of the data. Beyond a point, I anticipated my findings would take me beyond the literature. This is because I have had to borrow theoretical perspectives from several disciplinary fields because my research question was a new one. I brought an inter-disciplinary approach to this field (medical anthropology, policy analysis and qualitative social research) and asked a research question which did not fit neatly into any one disciplinary box. In the next section I will detail the areas where the findings from the study challenge, confirm or extend the theoretical literature in this field.

Fieldwork demonstrated that practice staff did not consider the results from the General Practice Patient Survey to be accurate or reliable. As a result, staff in my study reported that they did not use the GPPS data to inform practice or staff development. This confirms Asprey et al’s finding described in their paper (2013) outlining a distrust of the GPPS data amongst practice staff. Findings from my study confirm the Asprey et al findings but extend this to include patients who all reported the same distrust of datasets including the GPPS.

My study found that all staff reported some instances where they found the Quality and Outcomes Framework helpful in their job. This challenges the literature on staff perspectives of QOF which paints a more negative view of the imposition of QOF (Mangin & Toop, 2003). As outlined in previous chapters, this literature represents

the views of (mainly) clinicians in general practice. However, this finding confirms the Borys and Adler paper (1996) which argued that bureaucracy could bring enabling consequences to organisations. This finding from my fieldwork confirms the enabling effects of bureaucracy. My study argued that if we extend Shore & Wright's (2015) concept of *perverse outcomes* of audit culture to one of *unintended consequences* of audit culture, then it allows us to examine the positive effects of bureaucracy (in the form of QOF) that all staff interviewees spoke about during fieldwork. Extending Shore & Wright's concept of *perverse outcomes* to *unintended consequences* provides a theoretical space to have the discussion of the impacts of audit culture in full.

My study also found evidence to support the view that bureaucracy can bring negative impacts to the daily lives of staff. This view is mainly expressed by GP interviewees, and they refer to GP colleagues when they speak about who will be impacted by the negative effects of QOF. GPs in my study confirmed this view when they spoke about feeling the extra pressure of delivering QOF targets and of not having enough time in consultations to respond to the patient's agenda. GPs also spoke about QOF as being an intrusion in the consultation. This finding confirms the view of bureaucracy as an intrusion into the lives of professionals. Some clinicians in my study reported that while they found QOF intrusive in the early days, they understood that it also played a role in improving quality standards in general practice. Others felt that they did not need the additional prompting of QOF to deliver quality in the care they offered their patients.

The theoretical literature also writes about the intrusion of the state into institutions that were formerly less open to state scrutiny. Authors such as Rose & Miller write about the 'extended reach of the state' into higher education as a feature of new public management techniques. Strathern writes about the 'tyranny of transparency' in its relentless demand that institutions be accountable to the state and/or public (2000b).

Findings from my interviews with respondents confirmed the coerciveness of QOF and the GPPS. Although in theory, QOF is still voluntary, almost all general practices participate in it. Staff spoke in interviews of the pressure of comparison with other neighbouring practices or even colleagues within the same organisation. One

respondent spoke about how colleagues can check up on each other's daily activity and how this added pressure and stress to an already busy day. The link with QOF to practice earnings provided a further reason to feel guilty if one was having a ‘slow’ day. One respondent spoke about feeling that having a ‘slow day’ was ‘costing’ the practice (and therefore her GP partner colleagues) money. This confirms findings by Allen et al (2018) which identified that in the early days of QOF implementation, staff reported being motivated by financial rewards. As QOF became embedded in practice, the authors found that motivation for achieving targets came from reputational concerns rather than financial concerns (Allen, et al 2018).

While findings from my study confirm the negative effects that emanate from the coercive nature of performance monitoring on staff, it also found evidence to confirm the theoretical view that some aspects of bureaucracy can be helpful. My study extends this theoretical perspective to show which staff members find it most useful. In my study, it was the administrative staff who reported features such as the structuring of QOF most useful. These members of staff were also more likely to offer this information unprompted. Clinician respondents were less likely to mention it and had to be prompted to talk about it. Some even whispered when they spoke about how they sometimes liked QOF. An explanation of this finding may be helped by borrowing from Freidson’s theory of professionalisation (1970). It may be that administrative practice staff do not find QOF threatening to their professional self-identity because it is not aimed at their professional area of expertise. Clinicians in my study, spoke about how they disliked QOF telling them how to do their job. QOF was seen by some GPs as a threat to their autonomy. These findings confirm Freidson’s professionalisation theory of the medical profession.

My research found evidence that supports Alford’s theory of structural interests and power (1975). My study revealed which roles in the practice team carry the greatest share of the QOF burden. The study found that the burden of QOF work fell mainly to the Practice Nurse and to the Practice Manager. This supports the view that the GP professional bodies exercised their power in the negotiations that led to the QOF in 2004 and ensured the distribution of the labour of QOF was passed from GP staff to nursing colleagues, echoing Freidson’s claims of professional power (Freidson, 1970, 1985).

A finding that confirms Borys and Adler's concept of 'enabling bureaucracy' is that nurses in my study reported that the templates of QOF enabled them to challenge GP colleagues in ways which they would not have felt comfortable doing so before QOF. Armed with a care pathway or diagnostic audit, nurses reported that the anonymity of a QOF template allowed them to challenge clinician colleague's decisions. Not only does this confirm the 'enabling bureaucracy' it also speaks to and extends the professionalisation theory of Freidson. Freidson's work focused solely on doctors' professionalisation. Abbot's work on the professional jurisdictions is also relevant here, as the nursing and GP professions negotiate spheres of authority (Abbott, 1988). This finding invites further research into questions about how the nursing profession has responded to QOF and how it has impacted on attempts to professionalise. This finding supports Grant et al's research on internal stratification in general practice in response to QOF which also found that nurses reported an increase of authority resulting from QOF templates (McDonald, Checkland, Harrison, et al., 2009).

Findings from my study concerning how patients use data to make choices about their healthcare challenge the theory of 'patient empowerment' as a countervailing power in the Dr/Patient relationship (Roberts Johnson, 2001). The patient empowerment theory links to the 'engaged patient' scenarios of the Wanless Reviews in the UK (Wanless, 2002, 2004, 2006, 2007). The theory held that patients would make better decisions about their health if they had access to up to date and accurate data about healthcare providers. Applied in the context of a countervailing power argument (Light, 2014), the theory maintains that a well-informed patient can 'counter' the power of the GP or health professional in the consultation.

Findings from my study do not support the empowered patient theory. Findings from my fieldwork indicate that patient interviewees did not feel empowered to challenge the GP or health professional. When patients spoke about being angry or unsatisfied, they reported challenging the reception staff after the consultation rather than the GP or nurse in the consultation.

A further challenge to the empowered patient theory from my study arises from patients reporting that they did not feel they had a choice of GP practice when they were searching for one for themselves and their families. This finding presents

challenges to Light's 'countervailing powers' theory which argues that the market will 'counter' the dominance of the medical profession. In the context of English general practice, the market has not delivered choice for the patient. This confirms studies conducted by Exworthy and Frosini (2008) and Hughes et al (2005) which explored reasons why patient choice had not been delivered fully across England, Wales and Scotland. This might change if the study were to be conducted in secondary or acute care. It may be that patients in those settings might be more eager to educate themselves about their health care options and choices. This is a possibility which is beyond the reach of this thesis. My study found that patients in English general practice did not want a choice of GP practices with which to register. They simply wanted a good general practice local to them with good opening hours.

One field from which I borrowed heavily was social anthropology. I found Strathern's work on the culture of audit in higher education institutions especially useful to my analysis of how organisations and individuals within them respond to the introduction of performance metrics in their workplace (1997). My findings confirmed Strathern's theory that the introduction of performance metrics into workplaces brings with it an enforced accountability. This coerced accountability is almost impossible to refuse and places pressure and stress on staff. My study found evidence for Strathern's theories transposed to the world of English general practice in the early noughties.

Power wrote about the historical context of the tool of audit. He argued that when introduced to areas for which it was not meant (in his definition this is anything that is not in the field of accountancy) it will replicate itself and the institutions into which it has been introduced. My study found evidence for this replication effect, or what Shore & Wright term the 'runaway' effect(2015). Power also refers to it as the 'mushroom effect.' Staff spoke in their interviews about establishing 'mini-QOFs' and 'local QOFs' that they created bespoke to their practice. This finding confirms the ability of audit culture to embed itself in the general practice case studies that took part in my study.

A finding from the study was that GPs reported feeling as if they were being watched by Big Brother during consultations, as an impact of QOF. This finding confirms the Panopticon effect of a Foucauldian perspective of surveillance in the modern state. GPs used phrases such as someone 'looking over your shoulder' as they went about

their daily lives. This finding extended beyond management to include fellow GP colleagues in the same practice. A related finding includes staff reporting how they have become dependent on the QOF and the way it structures their days. Several staff reported how if QOF did not exist, they would simply replicate it as they could not imagine working without it. This confirms Foucault's concept of self-regulation to comply with state control - in this context it could be interpreted as complying with the QOF.

A finding that is new to the literature is a pattern that emerged between those GPs who had trained before the introduction of the QOF and those who trained after QOF was introduced. Those who trained before the introduction of QOF were much more sceptical of performance measures and in general displayed a reluctant acceptance towards the QOF. Those who trained after the introduction of QOF were more accepting of performance metrics and audit culture in general. This finding confirms Strathern's concept of audit as representing a cultural shift. This finding supports the view that there has been a cultural shift in the world of English general practice heralded by the introduction of the QOF in 2004. Performance measures are now accepted as part of working life in English general practice.

The study found that GPs differed in their approach to implementing QOF. My study argued that some of these differences might be related to the type of contract under which they were employed. Those who were salaried GPs reported an attitude towards implementing QOF that was different from those GPs who were partners in the practice. Further research into how locum GPs experience and deliver QOF would be of value. This finding supports Lipsky's (1980) concept of 'street-level bureaucrats' and Bourdieu's (1999) 'low-level bureaucrats' which identified the location of power throughout the policy implementation chain.

Evidently GPs are not in any way 'low-level bureaucrats' but Bourdieu's analysis of where power resides in the policy implementation cycle is relevant to this finding from my study. GPs are in a unique position in the medical profession in that they conduct one to one consultations with patients. How they deliver or implement QOF in the consultation is entirely up to them. This is where Lipsky's and Bourdieu's analysis of power in policy implementation is useful. A methodological finding of the study is that if applying an anthropological inspired approach to sampling and data

collection to a field which has under-sampled certain groups previously, then new perspectives will emerge. This finding confirms the benefits of taking an anthropological approach to sampling when conducting research.

9.6 Policy applications of my findings

Findings from my research might be used to develop thinking about policy implementation. For example, salaried GPs in my study reported how they would implement QOF if they had the time to do so in a consultation. This approach to QOF was not shared by GP partners and demonstrates the relevance of how staff are employed. This is something that might be considered when designing policy and thinking about it will be implemented. Of equal importance to the content of the policy is the issue of who will deliver or implement it and what will motivate staff to do so. Details such as these can often be overlooked by policy makers. An anthropological eye urges concentration on the individual and how they will negotiate the policy both as implementors and as recipients. Successful policy implementation involves designing the whole lifecycle of the policy, from the top to the frontline (GP practice staff dealing one on one with patients) and beyond to the recipient (the patient). If at any stage, there is a mismatch between the policy goals and staff tasked with delivering it, or its intended recipients, it will not be used and risks becoming irrelevant if that is possible. Alternatively, it could be reshaped by street level bureaucrats until it 'fits' as best it can, those who use it.

The study found that staff found aspects of QOF useful. This could be used to inform those designing the next round of performance incentives or metrics in general practice. Detailed knowledge of which roles and job types find audit culture most useful and knowledge of those who find it stressful might be used to tailor a more sophisticated tool that works subtly to enhance the experiences of different staff groups within the practice team.

An understanding of the mental stress created by performance measures, particularly on GP staff, could be used to design more sensitive policy tools for implementation in English general practice. If performance measuring is to remain (and all the evidence from this study suggests that this is the case) then a method of measuring that is not so damaging to those on the frontline might be more sustainable for the workforce. Such sensitivity informed policy might be a tool in

reducing workplace stress and be used to encourage GP staff to remain in post and/or enter the specialty.

9.7 Recommendations for future research

The field of general practice in England is under researched from an anthropological perspective. This study leads the investigator to further research questions worthy of study. My study suffered from a lack of locum GPs in the sample. Research which included locum GPs and their views on the QOF and how they choose to implement it, would complete the early findings from my study.

My study struggled to recruit patients and as a result my study is limited in the findings that might be applied to the field of patient experience of the Quality and Outcomes Framework and the General Practice Patient Survey. Further research that concentrates specifically on sampling a diverse range of patients and their experiences of general practice care in the time of the QOF and the GPPS would be useful. Such research would add to and increase our understanding of how patients experience QOF and the GPPS. Further research that concentrates on how patients use data; why and from what sources would also be helpful in this field. Research in this field may also confirm what patients in my study have already reported; that they do not want to have to sift through information and data to find a general practice for themselves and their loved ones. It may also confirm that patients want every general practice to be a good, high-quality practice. Patients in my study reported that the only choice they wanted to make concerning a general practice, was how convenient it was to reach and if it stayed open past normal working hours. Policies that aim at giving patient's information to make their own decisions about their general practice care, do not seem to be fulfilling a need (as reported by patients in my fieldwork). Sampling and recruiting from a wider and more diverse sampling of practice patients might reveal findings that challenge these findings.

My study investigated how general practice staff and general practices as an organisation have been impacted by the Quality and Outcomes Framework and the General Practice Patient Survey. Findings about the ways in which practice staff operate and deliver both tools were made. In the light of the COVID pandemic, all healthcare services have been under immense pressure to deliver. Further research investigating how general practice has operated during the pandemic and after,

would add a rich insight to this field. Research in this area that also sought the patient experience would also contribute to our knowledge of this area.

Further empirical work at general practice level adopting a whole practice approach together with a tough interrogation of the enabling and coercive theory of bureaucracy (Adler & Borys, 1996) would extend the field further.

9.8 Summary

My study set out to investigate how English general practice, its staff and patients have been impacted by the Quality and Outcomes Framework and the General Practice Patient Survey since their introductions in 2004 and 2006, respectively. The study found that experiences of the two tools are diverse and that there has been a cultural shift in attitudes towards performance measures and what some call audit culture in English general practice. Patients do not identify with the role of an active health care consumer choosing from a myriad of services in the market.

Practical applications of some of the findings have been suggested above and opportunities for further research are identified.

The field of English general practice is unique in many ways and is arguably understudied from a medical anthropologist perspective. It is a field worthy of further research among both its patients and staff teams. It is my hope that my research has contributed some findings towards furthering knowledge in this field and has set a path that others might follow.

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Appendix 1: Patient Recruitment Poster

Investigating Patient Satisfaction in general practice.

What is your experience of your general practice? I'd love to hear from you. I am a trained researcher trying to discover what patients want from their local surgery.

Alisi has 8 years experience of working in the NHS. She is now studying for a PhD at King's College, London investigating the causes of patient satisfaction and dissatisfaction with their general practice. Results from the study will be widely distributed and will inform health policy in order to improve patient's experiences of primary care.

All information will be treated confidentially. GP practices and respondents will not be identified in the study.

If you would like to participate in this research, contact Alisi via email on alisimekatoa@kcl.ac.uk or leave your details at reception. Alisi will call you to arrange an interview.

The research is part of an educational project leading to a PhD at King's College, London. The project has received full NHS Ethics approval.

Appendix 2: Interview Topic Guide - Patients

Themes from Lit Review that relate to Patient Satisfaction: Continuity, Access, Ethnicity, Age

Icebreakers: Consent**,** Participation Sheet**,** Length of time at practice

Themes to explore:

Access/Practice as a place to come?

- how do you find reception area/staff?
- Is it easy to make an appointment?
- Apart from feeling unwell when you come for an appointment how do you feel about coming to the practice?
- How regularly do you visit the practice? Give range per week/month

Biomedical approach? (how do you feel about your consultations?

- When you go to GP are there times you end up talking about stuff /issues that were not the reason you went?
- Can you tell me a bit more about that visit? What happened? Did it make any sense to you?
- Does that happen often?

Relationship with GP? (how easy do you find it to talk to your GP?

- If you disagree with the GP and their advice – what do you do? How do you manage it?
- Do you usually feel that you've been understood by the GP? Can you give me an example and talk me through it?
- If you don't get a chance to voice everything you wanted to during a Consultation, what do you do? i.e., would you see that GP again? Would you follow their advice? How do you explain to yourself the fact that you didn't get a voice? (Britten et al 2000)

QOF/GPPS

- Did you know about these prior to this interview?
- GPPS: would you use it to choose a practice?
- What things would attract you to a practice?
- How would you find those things out?

Rankings/Performance Measurement

- What do you think about efforts to rank/measure GPs or practices?
- Do you think there might be any benefits/disadvantages to such a system? (as well as on you as a patient)– can you say a bit more about this?
- There are lots of measurement tools at the moment, are you aware of any?
- Would you use/have you used any before to help you choose a practice?
- What information would you want if you were choosing a practice?
- What things are important to have in a GP practice from a patient's perspective?

Appendix 3: Interview Topic Guide - Staff

Themes to explore in practice staff interviews:

Experience at case study site?

- What is job role?
- How long in post?

Knowledge/awareness of QOF and/or GPPS?

- Does it affect your daily job?
- If yes, can you talk a bit more about how it does so?
- Time burden of the tools?

Quality? – does it enhance it?

- If yes, how/why?
- If not, how/why?
- Do you think patients get better service as result of the tools?

How do you feel about the tools being part of general practice?

Team spirit?

- Do the tools impact on team morale?
- How? Why?

Have the tools changed the way you do your job? Why/how?

Have they changed the way the team works?

Can you reflect on how you would do your job without QOF/GPPS?

- Better/worse?
- Easier?

Have they changed how you work with colleagues?

- How/why?

Appendix 4: Bespoke Practice Report Template

Thank you for taking part in this PhD research project. The research sought to investigate how staff and patients experience QOF and the GPPS (Ipsos Mori poll) and what (if any), are the effects of these tools of performance management on general practice?

Practice Name

60% of your patients who responded to the GPPS during 2011-14 gave your practice the highest overall satisfaction rating available, *Very Good*. The national average for this time-period is 48% placing Haven Medical Centre well above the national average.

How our statistical model works

- We use a shrinkage estimates quantitative model.
- We control for age, gender, ethnicity, deprivation by postcode and long-standing illness in the GPPS respondents. This serves to reduce variation in the respondent sample.
- We take a three-year average, controlling for the above variables, resulting in a more robust figure than a one-year average.
- The variable of interest used was the highest rating possible *Very Good.* This measure was chosen because it is more reliable than the multiple choice options offered in the GPPS (Burt et al. 2017).

Why we believe our data offers a more robust and reliable measure of overall patient satisfaction than a one-year data extraction from GPPS.

- GPPS is a reliable and robust dataset. However, research shows that statistical variation makes comparisons with other practices difficult. Some of the major sources of variation between practices are due to the demography of the practice list.

- By taking a three-year average of a practice's performance on Question 28 (about overall satisfaction), our model guards against the possibility that the practice had a one-off good, or bad year.

Qualitative Views from all case study practices (staff from individual practices not identified)

The study set out to answer the question:

How do staff and patients experience QOF and the GPPS (Ipsos Mori poll) and what (if any), are the effects of these tools of performance management on general practice?

Staff and patients were interviewed at four case-study general practice sites across England. General practice is a dynamic area of health care provision, and we wanted the sample to reflect a broad range of general practices. In order to gain as holistic a view as possible, interviews were conducted with GP Partners, locums, salaried, Nurse Practitioners, Practice Nurses, Clinical Leads and others. Those in both FT and PT roles were included. Non-clinicians were also included in the sample, including, reception managers, practice managers, deputy practice managers, amongst others. Patients were recruited through PPG groups. We were interested in understanding how audit culture affects each case study site as a whole, from the perspective of clinicians, patients and non-clinicians.

Staff Views

In contrast to much of the published literature on clinician views on QOF (which generally reports a negative perception - emphasising interference from the centre, excess admin work, a 'box-ticking' exercise) our research revealed a far more complex picture. Below, I present some of the main themes in response to some key questions from the interviews.

What would you do if QOF was abolished tomorrow?

Almost all staff noted the onerous aspect of QOF, citing hours of form filling, call and recall procedures etc. Almost all interview participants reported that they thought QOF had raised quality standards since its introduction in 2004. When asked what they would keep (if anything) from QOF if it was abolished tomorrow, most staff reported that they would retain the structure it gave to their working day and its reporting systems. This was reported more consistently by non-clinician, reception staff, but also by some clinicians.

What would you do if QOF were abolished tomorrow?

"the difficulty of mine would be, tomorrow, if QOF goes away, I will have to train myself to see a patient globally again, because at the moment I am driven by the QOF" – Interview with GP partner

"I would have to wean doctors off QOF' – Interview with GP partner

"Well, there wouldn't be ...there wouldn't be much of a purpose without it. I think. From the admin side of things, we aim for the highest percentage we can on QOF so I think it would be...it would be very weird without it...because we wouldn't really have anything to aim for. Well, we do, but I don't know about the other things.

It gives you a purpose, yeah, to my job – Interview with administrator.

Unforeseen effects of QOF

Some themes emerged which demonstrate the unforeseen effects that QOF can have. One Practice Nurse reported how QOF introduced a *third party* into the consultation, enabling the practice nurse to deliver potentially sensitive information from a neutral position.

*"So I find it quite useful because it's (*QOF templates*) quite structured and they* (the patient) *can see the screen so they can see what you're actually asking… and it calculates so we can say 'Oh the computer's saying you're moderately active or the computer is saying that you're inactive, and then they*

can start to say 'oh why is the computer saying that? and you're not saying it.. because you don't want them to get upset and think Oh, I don't like that nurse and the nurse thinks I'm lazy and I'm not going to see her again, it doesn't take much to upset people at all" – Interview with Practice Nurse

Another participant discussed the opportunities for a more equitable relationship developing between nursing and GP roles.

"It gives, yes, I think it's given us a tool and it's given us more, it's given authority, even.

And have you ever had to sort of challenge or use that authority of QOF to say actually, that's not asthma?

Well, well, because, because it's there and it's in black and white... I mean they, you know, they want to achieve QOF, so they want it as well. So, I've never had anybody say, "Oh well, you know I'm the doctor and I know best." No, it's all been very much, "Well, yes, how can we try and stop this happening?" – Interview with Nurse

Does job role affect your experience of QOF?

Amongst clinicians, differences in views were expressed between those holding partner, salaried and locum roles. Generally, GP partners expressed views that reported a more negative experience of QOF. Such views tended to emphasise the onerous work of QOF, the extra hours of form filling. Some expressed resentment about QOF interfering with the consultation. Interviewees holding salaried or locum positions, reported not feeling as pressured as other partner colleagues to complete all their QOF points during a consultation. Some reported that if the on-screen reminder was helpful and relevant to the consultation then they would pay attention to it. If that was not the case, they felt able to ignore it and continue with the consultation in the way they deemed appropriate. It should be noted that the sample is small, and the results are mixed.

"Oh, if you're a Partner you're going to be more worried about the finances and you're going to want to tick it off. If you're a salaried then you're going to ...I mean, I, and I know one other, who have the attitude that we'll try to do it,

but if it hasn't been done, …if the thing hasn't been done, then it hasn't been done" – Interview with salaried GP.

"Okay. So, what you've got, you've got new general practitioners coming into practice, and so they're on a salary. So, I'm finding that actually they're very, very… whereas like previously when you didn't have salaried GPs, you had just partners and registrars and there was a, there was a, they were much more willing to go the extra mile and do much more. Whereas there's much more moaning with the salaried GPs and actually, "Why should I do that?" And they just, you know… But I mean the thing with the locuming, you know, we train them, and they go off and be locums. So, while we've got them here, why should they work really hard, be working really late when they can go and locum? - Interview with Nurse

Amongst non-clinician staff, some were much more affected by QOF than others. In larger practices, there might be a team dedicated to call and recall. In smaller practices, this was shared amongst the team, with everyone taking their turn on the phones. Views expressed amongst this staff group were surprisingly positive about QOF. This group consistently reported positive experiences of QOF. Reasons given were that QOF gave a structure or a framework to their day. When asked what they would do if QOF were abolished tomorrow, this group particularly stressed that they would carry on with it and would keep all the systems they had in place already. Most, in this group, reported that QOF, and especially achieving QOF targets, generated a sense of team spirit and of working towards a common goal.

Yeah. Knowing that I'm making a difference. Because obviously if we achieve more on QOF then...I don't actually know what we get out of it but... We get something.

We do earn money...But it's like a sense of achievement doing it because at the start of year everything is red and then aim for it all to be green by the end and then if it is all green then you feel really good because you're like 'yay I've done it – Interview with Administrator

Views from the patients

Most of the patients who took part in the study were unaware of QOF. When it was explained to them, some remembered hearing about it from PPG meetings, but did not think it affected their care.

Patient's concerns echoed each other throughout all four case study sites. In general, concerns focused on ease of getting an appointment, seeing a preferred GP, and linked this to seeing someone who knew their history. Patients also reported wanting to feel able to trust their clinicians' professional skills.

> *"And, in fact, at one point, I'd got into the habit of taking my own photographs of the thing, each time they opened it up. And one of the nurses said, you know, that would be a good idea. And I thought, yes it would be a good idea. Why isn't it being done?"*

> *"Yes, because a GP knows more about the illness, I think, than the nurse. That's why we ask to see a doctor, isn't it?"*

Some patients discussed how they felt about being able to choose which doctor they could see:

> *"I mean I feel as if they're telling us who we can see, what – we should have a say, as patients, which doctor we can see, because when I was in __ I had a choice of doctors I could pick. But here, they're just telling you, "You're going to see so and so," you know. You're not given enough choices, yes"*

What does this mean for the future of general practice?

- Taking an inclusive sampling approach, which sought to interview as many roles within the modern general practice as possible, my research has been able to reveal a complex view of general practice after 14 years of QOF. The results show a mixed narrative in terms of how staff and patients have experienced QOF.

- Job role affects how a person experiences initiatives such as QOF. This has not been clearly researched before. A person's experience of QOF is

influenced by factors such as job role, age, and contract status which in turn affects how it is delivered, managed, and practised.

Appendix 5: IRAS Favourable Outcome Letter

See attached

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Appendix 6: Patient Consent Forms

See attached

Appendix 7: Staff Consent Form

See attached

Appendix 8: Staff Information Sheet

Participant Information Sheet

Investigating patient satisfaction and dissatisfaction in general practice in England.

Are you over 18 years of age? Speak English fluently?

We invite you to take part in a research study.

- Before you decide whether to take part, it is important for you to understand why the research is being done and what it will involve.
- Please take time to read the information carefully.
- You are free to decide whether to take part or not. If you choose not to take part, this will not affect your employment.

What is the research trying to find out?

Around 90% of patient interaction is provided within the setting of a general practice. Further improving the quality of this care is a priority for the NHS and patients. This study will produce findings that could help to support further improvements in general practice care by showing what makes patients satisfied or dissatisfied with their general practice**.** We will be working with

other practices across England to try to find out what makes a good general practice, for staff and patients.

What do I have to do?

- Take part in an interview with me, the researcher, discussing your experiences of working in general practice.
- The interview will be audio recorded.
- The interview will be confidential – any data used from it will be anonymised.
- Confidentiality would only be broken if disclosure was required under exceptional circumstances to protect other people, for example, if non-disclosure posed a serious threat to others.
- If it is necessary to break confidentiality, the researcher will inform you, where practicable to do so, in line with GMC Confidentiality Guidance.

Are there any risks to me if I take part?

- There are no clinical risks in taking part.
- There is a risk that during the interview you may become upset if discussing sensitive topics.
- The researcher is trained in dealing with sensitive topics.
- You, the participant, can at any point, stop the interview or choose to talk about something else.
- If you withdraw after, or during, the interview, the information you provided will be destroyed and will not be used in the study.

Are there any benefits if I take part?

- There is no direct benefit to the participant.

Will my information be confidential?

- We will not tell your employer that you have taken part.
- All information you give will be treated confidentially.
- Things you say in the interview may be used in reports or publications, but we will not mention your name or include anything else by which you might be identified.

What if there is a problem?

If you have a concern about any aspect of this study, you should speak to the Chief Investigator who will do his best to answer your questions (Dr Juan Baeza, juan.baeza@kcl.ac.uk). In the event that something does go wrong, and you are harmed during the research then you may have grounds for legal action for compensation against King's College London, but you may have to pay your legal costs. King's College London maintains adequate insurance to cover any liabilities arising from the study.

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How much of my time will it take?

If you choose to take part, I will contact you to arrange a meeting of approx. 30 minutes to one hour at a convenient time and location.

If you would like to take part in this study, please contact the researcher on alisi.mekatoa@kcl.ac.uk or leave your name and contact details at reception and I will contact you.

This study forms part of an educational project leading to a PhD in Health Management Studies. The study has been funded by Ipsos MORI and King's College London and has received full NHS Ethics Approval

Appendix 9: Patient Information Sheet

Participant Information Sheet (Patients)

Investigating patient satisfaction and dissatisfaction in general practice in England.

Are you over 18 years of age? Speak English fluently?

We invite you to take part in a research study.

- Before you decide whether to take part, it is important for you to understand why the research is being done and what it will involve.
- Please take time to read the information carefully.
- You are free to decide whether to take part or not. If you choose not to take part, this will not affect the care you get from your doctor.

What is the research trying to find out?

Around 90% of patient interaction is provided within the setting of a general practice. Further improving the quality of this care is a priority for the NHS and patients. This study will produce findings that could help to support further improvements in general practice care by showing what makes patients

satisfied or dissatisfied with their general practice**.** We will be working with other practices across England to try to find out what makes a good general practice, for staff and patients.

What do I have to do?

- Take part in an interview with me, the researcher, discussing your experiences of general practice.
- The interview will be audio recorded.
- The interview will be confidential – any data used from it will be anonymised.
- Confidentiality would only be broken if disclosure was required under exceptional circumstances to protect other people, for example, if non-disclosure posed a serious threat to others.
- If it is necessary to break confidentiality, the researcher will inform you, where practicable to do so, in line with GMC Confidentiality Guidance.

Are there any risks to me if I take part?

- There are no clinical risks in taking part.
- There is a risk that during the interview you may become upset if discussing sensitive topics.
- The researcher is trained in dealing with sensitive topics.
- If, during the interview, it becomes clear that you have grounds for a complaint, the researcher will direct you to the NHS Complaints Procedure.
- You, the participant, can at any point, stop the interview or choose to talk about something else.
- If you withdraw after, or during, the interview, the information you provided will be destroyed and will not be used in the study.

Are there any benefits if I take part?

- There is no direct benefit to the participant.

Will my information be confidential?

- We will not tell your GP that you have taken part.
- All information you give will be treated confidentially.
- Things you say in the interview may be used in reports or publications, but we will not mention your name or include anything else by which you might be identified.

What if there is a problem?

If you have a concern about any aspect of this study, you should speak to the Chief Investigator who will do his best to answer your questions (Dr Juan Baeza, juan.baeza@kcl.ac.uk). In the event that something does go wrong, and you are harmed during the research then you may have grounds for legal action for compensation against King's College London, but you may have to pay your legal costs. King's College London maintains adequate insurance to cover any liabilities arising from the study.

How much of my time will it take?

If you choose to take part, I will contact you to arrange a meeting of approx. one hour at a convenient time and location.

If you would like to take part in this study, please contact the researcher on alisi.mekatoa@kcl.ac.uk or leave your name and contact details at reception and I will contact you.

This study forms part of an educational project leading to a PhD in Health Management Studies. The study has been funded by Ipsos MORI and King's College London and has received full NHS Ethics Approval.

Appendix 10 **Summary of approach to creating the shrunken estimators conducted by Sarah Tipping of Ipsos MORI.**

Outline of decisions made about the QOF and GPPS variables when merging the data, and outline where this departs from Llanwarne and why. Then how the various estimates were generated, and what variables are included in the final dataset.

GPPS data

We took the last 3 years of GPPS data available (waves 1&2 of years 7-9) and extracted information about age, sex, ethnicity, long standing illness, IMD scores relating to the patient's postcode, practice size and the variable of interest. I merged these into a single file with patient ID, practice code and a variable showing year of fieldwork.

We used the raw score and two scores – one that flags patients saying very good and the other flagging patients saying very bad. So, at practice level we had the % saying very good and the % in the practice saying very bad.

The variable of interest was Q28: overall experience of GP surgery. Llanwarne et al calculated a summary score based on a number of indicators, whereas we are concentrating on a single overall question. This summary score was rescaled so that it ran from 0-100. There was little point rescaling a single 5-point question, so we did not do this.

QOF data

Sarah Tipping of Ipsos MORI had QOF scores for the last 3 years. She felt there were three ways of summarising the scores. I could then decide which to use, or use a combination:

1. Create mean clinical and overall scores for each practice based on the clinical and overall scores received for the past 3 years. So, this is the average score for the past 3 years. These averages were based on percentages, since the maximum number of points available varies across years. (NB: the 11/12 scores were proportions, rather than percentage, so these were multiplied by 100. In addition,

there was a small number where the 11/12 scores were missing, and the averages were based on the other two years only). These means were merged to the GPPS data by practice.

2. The second option was to merge each QOF score to the respondent-level GPPS data by year and practice (i.e., merge the 11/12 scores to the Y7 data, merge the 12/13 scores to the Y8 data, etc.), at patient-level this is the yearly score. We then aggregate the scores by practice to get the overall practice mean. This gives a mean score for the practice over three years that is weighted by the number of respondents in each practice.
3. The third option was to aggregate the scores giving weight to practice population size.

The three scores are pretty close, as size doesn't fluctuate much over the years. The one I choose to use will depend on what I think makes most sense.

The first approach gives each year's QOF score equal weight (this is the equivalent of matching the QOF scores to GPPS-level practice data and then aggregating the file). The second gives more weight to the QOF scores from the years with most respondents. For example, if a practice had 500 respondents in Y7, 800 in Y8 and 600 in Y9, then the most weight will be given to their QOF score in Y8. The third does the same thing but based on population size.

Note: Llanwarne attempted to standardise the QOF scores by estimating what % of the practice's population of patients were affected by the QOF scores. We have not done this – the QOF scores I received from Mark expressed the scores as the % of points scored out of all possible available. I couldn't see a benefit of changing this as the scores are effectively standardised (i.e., the actual number of points available may change each year, so the total number of points gained would not be comparable between years, however the percentages are comparable across years). This means our QOF scores are % of QOF points available, rather than the % of population for whom the measure was met.

Some practices were missing QOF scores, so there is a bit of missing info in the file. I'm not sure of the reasons for this.

Also dropped practices with <100 patients.

The matched data

So, the result is 3 years' worth of respondent-level GPPS data with various QOF clinical and overall scores (which are at practice-level) matched to it.

We then use this to generate a number of scores:

Source	Measure	Comments
GPPS	Raw mean score	
	Shrunken mean score without any case-mix adjustment	I don't recommend using this, I don't think it is very informative
	Shrunken mean score with case-mix adjustment	includes adjustment for age, sex, long term illness, ethnicity and IMD (based on patient's postcode)
	Raw proportion of patients saying, 'very good'.	
	Raw proportion of patients saying, 'very bad'.	
	Shrunken proportion saying 'very good' without any case-mix adjustment	As above – I don't think it is very informative
	Shrunken proportion saying 'very good' without any case-mix adjustment	
	Shrunken proportion saying 'very good' with case-mix adjustment	includes adjustment for age, sex, long term illness, ethnicity and IMD (based on patient's postcode)

	Shrunken proportion saying 'very good' with case-mix adjustment	
QOF (same for both clinical and overall)	Raw score – mean of the 3-year scores	See (1) above
	Shrunken mean scores	
	Raw score – respondent averaged scores	See (2) above
	Shrunken respondent averaged scores	
	Raw score – population averaged means	See (3) above
	Shrunken scores – population averaged means	

Note: we would not have been able to do case-mix adjustment for QOF scores, since they are generated at practice-level. For the GPPS case-mixing, I have based this on the age, sex, etc. of respondents. LLanwarne, etc., based this on the case-mix of the practice. Except they didn't have information about ethnicity for everyone in the practise, so they estimated this based on the respondents. I've gone with the respondent info as this is what the satisfaction score is based on – i.e., the satisfaction score is for respondents only, so I thought the case-mix should be for respondents only, since this will best correct for differences in the satisfaction scores.

Shrunken estimates – method

Shrunken estimates were generated in Stata using the 'mixed' command (http://www.stata.com/manuals13/me.pdf) and using the restricted maximum likelihood estimation (REML). This is explained in these bits copied from my previous note…

Shrinkage estimates are where the observed (raw) estimates are pulled in towards the overall average. The degree to which they are adjusted depends on both the within-practise and between-practice variability. Recommended methods include 'empirical Bayes' and 'full Bayes' techniques.

These methods are supposed to deal with regression to the mean. (Regression to the mean in is where extreme behaviour measured in one time point (i.e., one wave) tends towards the average at a second measurement. This is usually because the reasons for extremity have caused bias in some way – for example, if we take the bottom 10% achievers in a class and reassess them a month later, their average scores will be closer to the average at the second time point, since this is the only direction in which most individuals can travel).

More information about random effects models to create shrinkage factors is given below (copied from http://www.jmp.com/support/help/Estimation_of_Random_Effect_Parameters_Example.shtml)

> Random effects have a dual character. In one characterization, they represent residual error, such as the error associated with a whole-plot experimental unit. In another characterization, they are like fixed effects, associating a parameter to each level of the random effect. As parameters, you have extra information about them—they are derived from a normal distribution with mean zero and the variance estimated by the variance component. The effect of this extra information is that the estimates of the parameters are shrunken toward zero. Parameter estimates associated with random effects are called *BLUPs* (Best Linear Unbiased Predictors). BLUP parameter estimates are used to estimate random-effect least squares means, which are therefore also shrunken toward the grand mean. The degree of shrinkage depends on the variance of the effect and the number of observations per level in the effect. With large variance estimates, there is little shrinkage. If the variance component is small, then more shrinkage takes place. If the variance component is zero, the effect levels are shrunk to exactly zero. It is even possible to obtain highly negative variance

components where the shrinkage is reversed. You can consider fixed effects as a special case of random effects where the variance component is very large. The REML method balances the information about each individual level with the information about the variances across levels. If the number of observations per level is large, the estimates shrink less. If there are very few observations per level, the estimates shrink more. If there are infinitely many observations, there is no shrinkage, and the estimates are identical to fixed effects.

In summary – I model the data using the variable of interest (i.e., the GPPS satisfaction score or the QOF clinical score, etc.) as the outcome. I used a random effects model. The data are at respondent-level, but I include a practice indicator in the mode to identify which patients belong to the same practice. REML estimation is used (as above) to estimate the variance components of the model. The model is used to estimate predicted values of the outcome. These predicted values are the shrinkage estimates. For the case-mix adjusted estimators, I include the respondent's age, sex, ethnicity, long-standing illness and IMD score (I actually use quintiles) in the model. For the non-case-mix adjusted models the scores are simply based on an empty model, meaning the scores are predicted using nothing except the outcomes themselves and information about how the scores are distributed across practices (i.e., the practice mean and the variance structure).

practice code	Practice code
practice_name_original	Name of practice
practice_pop_size	Population size of practice (average over 3 years)
respprac	Number of respondents in practice (average over 3 years)
male	% respondents male
ethnic	% respondents non-white
depriv	Average deprivation score of respondents
age1824	% respondents 18-24
age2534	% respondents 25-34

age3544	% respondents 35-44
age4554	% respondents 45-54
age5564	% respondents 55-64
age6574	% respondents 65-74
age7584	% respondents 75-84
age85pl	% respondents 85+
q28	GPPS satisfaction score (raw)
q28shrunk1	Shrunken mean score without any case-mix adjustment
q28shrunk2	Shrunken mean score with case-mix adjustment
q28vg	Raw score - % patients saying very good
q28vb	Raw score - % patients saying very bad
meanqof	QOF overall - Raw score – mean of the 3-year scores
scoreqof	QOF overall - Raw score – respondent averaged means
meanyrqof	QOF overall - Raw score –population averaged scores
meanclin	QOF clinical - Raw score – mean of the 3-year scores
scoreclin	QOF clinical - Raw score –respondent averaged means
meanyrclin	QOF clinical - Raw score –population averaged scores

Appendix 11: Invitation letter to GP Practices

Dear Recipient,

I am writing to invite the _practice to take part in a doctoral study investigating patient satisfaction in general practice in England.

I am a PhD student at King's College London, based in the department of Management, supervised by Dr Juan Baeza (social scientist) and Dr Mark Ashworth (GP). The study aims to investigate, at practice level, the relationship between patient satisfaction and clinical quality in English general practice. Patient satisfaction is recognized to being central to good quality care.

The _ practice has been selected to provide a fascinating glimpse into how patient satisfaction operates in general practice in England through interviews with staff and patients.

I would be delighted to work with the practice, members of staff, the Patient Participation Group, and patients over the course of one week. However, I am interested in what works best for you and your team. Ideally, I would like to give a presentation at a lunchtime meeting and would hope to interview a few GPs during the week, if convenient.

One approach might be for me to liaise with your PPG, if they would be happy to meet with me. Together, we could arrange to present the project to their members and other interested parties. In return for their help, I will make a small donation to the PPG. I hope to recruit patients for interview at this event and through a poster that could be displayed in the waiting room and staff room two weeks prior to my visit. All participation would be voluntary and confidential.

I would be happy to provide you with a useful education document summarizing the main findings that are unique to your practice and present such a report if desired.

Please contact me directly if you have any questions or require any further information. I look forward to hearing from you.

Alisi Mekatoa