Impact of the 2004 GMS contract on practice nurses:
a qualitative study

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ABSTRACT

Background
The new GMS contract has led to practice nurses playing an important role in the delivery of the Quality and Outcomes Framework (QOF).

Aim
This study investigated how practice nurses perceive the changes in their work since the contract's inception.

Design of study
A qualitative approach, sampling practice nurses from practices in areas of high and low deprivation, with a range of QOF scores.

Setting
Glasgow, UK.

Method
Individual interviews were conducted, audiotaped, transcribed, and analysed using a thematic approach.

Results
Three themes emerged: roles and incentives, workload, and patient care. Practice nurses were positive about the development of their professional role since the introduction of the new GMS contract but had mixed views about whether their status had changed. Views on incentives (largely related to financial rewards) also varied, but most felt under-rewarded, irrespective of practice QOF achievement. All reported a substantial increase in workload, related to incentivised QOF domains with greater 'box ticking' and data entry, and less time to spend with patients. Although the structure created by the new contract was generally welcomed, many were unconvinced that it improved patient care and felt other important areas of care were neglected. Concern was also expressed about a negative effect of the QOF on holistic care, including ethical concerns and detrimental effects on the patient–nurse relationship, which were regarded as a core value.

Conclusions
The new GMS contract has given practice nurses increased responsibility. However, discontent about how financial gains are distributed and negative impacts on core values may lead to detrimental long-term effects on motivation and morale.

Keywords
GMS contract; incentives; practice nurses; primary health care.

INTRODUCTION

Over the past decade, practice nursing has been one of the fastest growing fields of nursing, both in terms of numbers and scope of work.[1] Between 1995 and 2005, the number of full time equivalent (FTE) practice nurses in England increased by 42% from 9745 to 13 793,[1] with almost 25 000 practice nurses working in the UK in 2003.[2] With the possible exception of *Liberating the Talents*,[3] practice nurses are often missing from strategic policy documents[4–7] due to their position as contracted employees of GPs. As the workforce has increased, the workload of individual nurses has also increased, with more emphasis on health promotion and chronic disease management,[8–11] particularly when these areas were incentivised under the 1990 contract.[12]

The new General Medical Services (GMS) contract, including the Quality and Outcomes Framework (QOF), was a UK-wide contract implemented in April 2004. It has been suggested that it creates the foundation for radical change within general practice in terms of new ways of working, target-based payments, and realignment of roles within the primary care team.[13] The

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How this fits in

The GMS contract was implemented in April 2004. However, to date, little is known about it's impact on practices, particularly in relation to practice nurses who were thought to be a group well placed to respond to the new challenges of the contract. This study explored the views of 18 practice nurses working in affluent and deprived practices, with a range of QOF achievement scores. In general, nurses were positive about the way in which their role has developed since the new contract but there were concerns about incentives, in particular financial reward for the amount of work they had carried out, and about the impact of QOF on the patient–nurse relationship.

practice-based nature of the contract, with patients registered with practices as opposed to individual GPs, together with the focus of the target-based incentivised payment system (QOF) on chronic disease may promote role development and autonomy for practice nurses within the primary care team.[13,14] These new possibilities contrast with the more traditional role of nurses and create opportunities for innovation and career development beyond that available under previous contractual arrangements.

There is currently little empirical evidence on practice nurses' views of the new contract or of their experiences of working under it. Quantitative analysis has found that there were already improvements in practice performance prior to the new contract in the areas of coronary heart disease, asthma, and type 2 diabetes, although this improvement did accelerate for asthma and diabetes after the contract was introduced.[15] McDonald *et al* explored the early impact of financial incentives of the new GMS contract on GPs and practice nurses in two practices and found that nurses were more concerned than GPs about changes to their clinical practice, in particular monitoring target achievement.[16] Here, we report on the views of 18 practice nurses interviewed 12–18 months after the implementation of the new GMS contract.

METHOD

Study design and setting

The findings reported here are from two parallel qualitative studies set in NHS Greater Glasgow utilising one-to-one semi-structured interviews. Both explored views and experiences of practice nurses under the new GMS contract, however each had a slightly different focus. The first focused exclusively on how practice nurses perceived changes in their role since the introduction of the new contract. The second was part of a wider study investigating the role of skill mix in primary care and explored these issues more broadly, with the impact of the contract forming only part of the focus of these interviews. As such, both employed slightly different sampling frames and the interview schedules focused on a slightly different set of questions.

Sampling and recruitment

In both studies, the sampling frame was practice nurses employed in general practices within NHS Greater Glasgow. Practice nurses were sampled on the basis of the characteristics of the practice in which they were employed. These were:

- the socioeconomic profile of the practice population;
- practice size; and
- QOF points achievement.

Socioeconomic profile and practice size were selected as important characteristics because both have been shown to influence QOF achievement.[17–20] QOF points achievement was selected as it was hypothesised that there may be different views expressed in practices that had achieved higher and lower numbers of points.

Practices were ranked by the socioeconomic status of the practice population using the modified Scottish Index of Multiple Deprivation 2004 (mSIMD), which included the domains of income, employment, and education but excluded health and access to services.[21] Practices located in the top (affluent) and bottom (deprived) quartiles were selected. Practices were ranked by either QOF point achievement (from 2004 to 2005) or practice size, using the number of FTE GPs. Where QOF achievement was used, those practices in the top and bottom quartiles of QOF achievement were identified and matched to the top and bottom quartiles of the mSIMD respectively. Where practice size was the second selection characteristic, large (five or more FTE GPs) or small (two or three FTE GPs) were identified and, again, matched to the top and bottom quartiles of the mSIMD. To facilitate comparison between the studies, the QOF achievement of practices selected on the basis of size was identified retrospectively and the practices located within the quartiles of QOF achievement.

Practice nurses in selected practices were recruited through the practice manager, who was contacted and asked to pass information about the study onto the practice nurse. The practice nurse was then contacted 7–10 days later to ask if they would participate in the study. Interviews were arranged at a time and place suitable to the interviewee; in all cases interviews took place in the surgery.

Data collection

Both studies utilised face-to-face, semi-structured interviews. Interview schedules, appropriate to the aims of each study, were constructed following a review of the literature.

For the study exploring nurse views of the new GMS contract the topics included:

- current role within the practice;
- impact of the new GMS contract on practice role;
- opportunities afforded by the new GMS with regard to status; and
- incentives or disincentives with regard to the new GMS contract.

For the study exploring wider issues of skill mix, the topics covered included:

- current role within the practice;
- changes in the organisation of workload in their practice;
- how their role had/had not developed in recent years;
- drivers for identified changes; and
- future role development.

All interviews were recorded, following informed consent being given, and transcribed verbatim. Interviews lasted between 20 and 60 minutes.

Analysis

Analysis was facilitated using the framework method, with systematic identification, charting, and sorting of the data according to key issues and themes.[22] Transcripts were extensively read to identify broad, preliminary themes, guided by the topic guide and interview schedule. These were discussed and refined leading to a coding schedule, which was applied to all transcripts. Analysis was iterative, with broad themes identified first (for example, workload), then broken down into sub-themes (for example, composition of workload and IT).[23] A constant comparative approach was used throughout, with codes and transcripts continually re-assessed and re-interpreted.[24] Themes and sub-themes from both sets of interviews were then compared to identify common and discrepant areas and agreed with the other authors.

Overall, there was a high degree of agreement between the two sets of interviews with regard to the key themes and sub-themes including, for example, role development, financial impact, incentives, workload, and impact on patient care. The themes of status since the implementation of the new GMS contract and impact on the nurse–patient relationship were apparent in the interviews. An additional theme, on working relationships within the practice, was identified only in the interviews conducted in response to questions on that topic. Quotations were chosen to illustrate particular points and are identified by an anonymised code. The type of practice the nurse was employed in was also noted.

RESULTS

All practice nurses interviewed were female and had been practice nurses for between 5 and 17 years. The distribution of practice QOF achievement by practice socioeconomic profile is shown in Table 1.

Three broad themes were identified from the data: roles and incentives, workload, and impact on patient care.

Roles and incentives

Roles and incentives were discussed in relation to two issues: professional development and professional status. Most practice nurses felt they had expanded their role and taken on new skills, particularly in chronic disease management and data recording, since the implementation of the new GMS contract. This view was consistent across practices, regardless of the level of QOF achievement or the socioeconomic profile of the practice population:

'I think the contract has enhanced the nurses' role rather than hindered it.' (PN8, QOF Q4, affluent)

However, this focus on contract areas led several nurses to voice concerns at having fewer opportunities to work and train in non-contract areas, such as minor illness:

'I think it could have a detrimental effect on the development of the practice nurse's role because you could very much be here to just do the contract work and not be able to stray from that into areas that you have trained for.' (PN9, QOF Q4, deprived)

'I would just like to see more minor illnesses and to have more clinic time for that. My clinic is always

Table 1. Practice distribution by QOF point achievement and socioeconomic profile.

QOF achievement (range of points achieved)	Affluent	Deprived
Quartile 1 (lowest): (≤972)	0	5
Quartile 2: 973–1017	1	2
Quartile 3: 1018–1036	1	2
Quartile 4 (highest): 1037–1049	4	3
Total	6	12

Affluent = top quartile of mSIMD. Deprived = bottom quartile of mSIMD. mSIMD = modified Scottish Index of Multiple Deprivation 2004. QOF = Quality and Outcomes Framework.

full and I cannot see any more patients. I hope I could have less chronic disease management clinics and more minor illness. I probably would like that, but at the moment we need the chronic disease management in relation to the contract requirements but I don't know whether that will change or not.' (PN17, QOF Q1, deprived)

There was a general opinion that the new contract had enhanced their perceived status within the practice somewhat, with more autonomy, independence in organising care, and a greater centrality of role in the practice:

'Before the contract we used to just do the mundane things and we were really just a GP's handmaiden sort of style, but now we are working a lot on our own and doing a lot of things [so] *that we get out of it more job satisfaction.'* (PN14, QOF Q3, deprived)

However, for some, this increase in autonomy and role expansion was in response to the GPs' needs for work to be conducted in the area of chronic disease management to meet QOF targets, rather than in response to nurses' clinical interests:

'Yes, they directed that there had to be more clinics for whatever they were targeting and needed to improve upon in relation to the contract but I think they had that power [to direct nursing work] *anyway.'* (PN17, QOF Q1, deprived)

For some, this focus on achieving targets meant that team working had improved within their practice to maximise QOF achievement; others perceived that they had carried out most of the work required themselves:

'I do in fact do most of the work for the contract and in many ways that's not a good thing as it is supposed to be team work.' (PN1, QOF Q4, affluent)

'Well [pause] *I think that they have basically left it to me.'* (PN8, QOF Q4, affluent)

Although most nurses felt that their professional status had improved, many felt there were few tangible benefits in terms of salary, with only one nurse reporting a salary increase as a direct result of her practice's high point achievement. A substantial minority was openly critical of the GPs in their practice, feeling that while they (the nurses) did most of the work, the GPs were the ones who benefited financially. This view was not related to the QOF achievement:

'I'm not comparing it [GP salary] *to what the papers say they were walking off with, but* [they got] *financial rewards for a lot of the work that has been done by nurses.'* (PN18, QOF Q2, deprived)

'The GP's role in the contract is picking up the points and getting the money.' (PN1, QOF Q4, affluent)

'… we do the work, the doctor gets the rewards and it is up to him whether he decides to pass it on or not because he gets a global sum now. So that is a bit of conflict with a lot of nurses at the moment. So our role and responsibility has expanded but at the same time the wages are staying much the same.' (PN12, QOF Q2, deprived)

Although salary increases, while remaining on the same grade, were unusual, approximately a third of interviewed nurses had been promoted to a higher grade since the inception of the new GMS contract — which would, of course, improve salaries. This appeared to be associated with higher-achieving QOF practices, but it was unclear if these promotions were as a direct result of QOF achievement. No nurse had been offered the possibility of becoming a partner, despite this being allowed under the new contract. However, it was unclear whether this was due to GPs not offering nurses such opportunities or to the nurses themselves feeling reluctant to grasp them:

Interviewer: *'What about the partnership idea between GPs and nurses?'*

Practice nurse: *'I don't see GPs going for that.'* (PN12, QOF Q2, deprived)

'… we discussed [partnerships] *as well, before the contract started. We discussed it recently due to a partner retiring, I am not sure if I would consider that at this time. Yes the option is there — whether I would consider to do that or not?'* (PN9, QOF Q4, deprived)

Indeed, when some nurses were explicitly asked about nurse partnerships, most did not want to take on that level of responsibility, at least at that time:

'Well if it's your business it should then become, it's your source of income and you become, well you have got to make the money, you have got to make the money to dish it out and that includes our wages. Me personally, I wouldn't want to be a partner, it may well be a thing of the future.' (PN13, QOF Q3, affluent)

Practices often offered practice nurses incentives at the end of the contract year, in the form of a monetary bonus or extra holidays. Opinion as to the appropriateness of the incentive varied, with no obvious association between QOF points and the incentives offered:

'I am happy [with the incentive offered] *but I have spoken to other practice nurses who are not, I think a lot depends on who you work for.'* (PN5, QOF Q1, deprived)

'I made the suggestion that I got a percentage of the total. I could never work out what the percentage should be and in fact it was one of the GP's who came up with a figure, which was acceptable to me, so I agreed to that.' (PN1, QOF Q4, affluent)

One practice nurse in a high-achieving practice, was aware of the business side of the practice and felt that, although she received a monetary bonus, it was diminutive in comparison to the money awarded to the practice for the QOF points attained:

'I suppose if you look at it as a percentage of the actual money that comes in … [wry facial expression and nervous laughter]*'* (PN9, QOF Q4, deprived)

Such situations contributed to a general feeling of inequity in the workload/remuneration balance between the nurses and GPs. Indeed, occasionally, the use of an inappropriate incentive was perceived to be worse:

'The practice in total were all taken out for a meal, I don't like Chinese, we were all sick. A financial incentive would have been better.' (PN2, QOF Q1, deprived)

Workload

Workload had increased for all nurses in terms of clinical commitment (particularly in contract-driven chronic disease management and preventive care), bureaucracy, and data collection:

'Well we always did the asthma but we have now to do the diabetic clinic, you know more health promotion, coronary heart disease, stroke clinic, epileptic clinic, and mental health patients. These have all increased and a lot of what the doctors did, such as the epileptics and mental health patients, you know, the practice nurse is doing them now. The workload is heavier now than what it was before the introduction of the new GMS.' (PN14, QOF Q3, deprived)

Even those nurses who felt that the type of patient they were seeing hadn't changed complained that the volume of work had increased dramatically. Most felt pressurised by this, with time being a particular constraint:

'You know you are trying to do something that realistically will take three quarters of an hour and you have just quarter of an hour to do it in. Something goes, you either run late, which I frequently do, or you take a note of what has to be entered on the computer in your head and put it in after the patient has left the room, either way your surgery runs late.' (PN2, QOF Q1, deprived)

Although workload had increased, most nurses agreed that the contract had systematised and standardised care. Those in low-achieving practices were particularly likely to mention this:

'It has become much more structured and I have recall systems in place for all the chronic disease areas, before it was a bit scrappy.' (PN5, QOF Q1, deprived)

By contrast, high-achieving practices were more inclined to report that the contract represented an extension of previous ways of working:

'It really hasn't made that much of a change to our work as a practice nurse because everything that has come up in the contract and every box that has to be ticked we have always ticked before the contract, it is made no difference to how we practice but probably we are seeing more patients coming through because more patients are being chased up to come down but it has not made any difference to their care.' (PN11, QOF Q4, affluent)

Some nurses felt that there was more of a focus on population health than on the needs of the individual. They were particularly frustrated by the rigid protocols for reviewing patients and the call and recall system:

'Some of the things that should be included in it aren't and some of the tick boxes are quite ridiculous … And also insistence on three letters to patients. We are constantly hounding them and patients should be allowed to choose whether they want to cancel themselves out.' (PN1, QOF Q4, affluent)

'I think it is a bit one-dimensional and shallow and not overly impressed with the way it has made us work.' (PN3, QOF Q1, deprived)

Impact on patient care

Although there was general agreement that the new contract had improved some aspects of patient care, there were many concerns that the target-based nature of the health care provided had negative impacts too:

> *'It is very top heavy and at the end of the day what I think the NHS should be asking is what gain to the patients does it afford. Sometimes I am standing at the door holding the door open for them while I speak to them — not good care.'* (PN2, QOF Q1, deprived)

> *'But I am not sure how collecting all this data and reaching targets is going to help patients perceive their own locus of control by way of health in its holistic sense.'* (PN3, QOF Q1, deprived)

> *'… a bit resentful, in as much that the contract seems to have taken over and it is all admin and tick boxes and taking away from the patient care side of things and no incentives. You wonder sometimes if it does improve patient care or whether you are just ticking boxes for the sake of it.'* (PN8, QOF Q4, affluent)

The requirement for systematic data collection using the computer, particularly during the consultation, was also criticised as creating a barrier between the nurse and the patient:

> *'I find I am not looking at the patient, it's almost an afterthought. I better look at the patient to see how they are. "Oh my goodness you are looking awfully pale today." That should be something that's noticed as soon as they come into the room. "Good morning Mrs So-and-so come in and sit down; my you are looking a bit peely wally,* [off-colour] *how are you feeling?" But no, you are too busy on the computer and it is an afterthought.'* (PN2, QOF Q1, deprived)

> *'Well it is quite labour intensive, very labour intensive, and there were many people coming in to see me but we are more interested in what is on the screen and it is hard to sit and listen to somebody when my computer is over here, the logistics of it cannot be carried out easily, do you know what I mean?'* (PN12, QOF Q2, deprived)

Much of this was due to a lack of time during the consultation. Some tried to complete the data collection after the consultation, but this also resulted in feeling pressurised. There was also a widely held view that time spent inputting data meant less time to provide clinics:

> *'Well, say this morning I have had a diabetic clinic, I will sit for hours this afternoon putting all the information in the computer. I would not see one patient; I will just sit and do that until 5 o'clock tonight.'* (PN15, QOF Q3, deprived)

Some nurses were concerned about the ethical dimension of collecting patient information for the specific purpose of achieving QOF targets and, hence, practice payments, with patients not fully aware or informed of the reasons behind this new way of working. There were some suggestions that this was deceptive:

> *'I feel that patients don't realise that this is going on as no one had actually told them and no one has explained to them why we are asking them so many questions and gathering so much data.'* (PN6, QOF Q4, affluent)

DISCUSSION

Summary of main findings

The new GMS contract offers developments and opportunities for individual practice nurses and the profession.[25] The views of 18 nurses working in different practices across a large urban NHS setting (NHS Greater Glasgow) have been explored. Overall, nurses reported both positive and negative aspects of the new GMS contract and the QOF. They felt their professional role had increased but perceived inequities in financial reward was an area of considerable disharmony and, at times, outright acrimony. They also felt their workload had increased substantially since the introduction of the QOF. Excessive data recording, the tick-box approach, and the stringent focus on incentivised QOF areas in order to meet target payments (to GPs) were seen as detrimental to the more holistic, patient-centred approach that nurses are trained in and hold dear as a core value. Some felt that the collection of patient data for payment purposes was unethical, reporting a sense of deception in collecting the data for the purpose of maximising practice income, rather than for the purpose of enhancing patient care. This was apparent, regardless of the practice's QOF achievement:

> *'It has certainly brought more attention into my job, made me have to work much harder at prioritising, possibly improving my skills at appearing to pay attention to what the patient is saying while subtly doing what they don't think is happening. So there is a degree of deception which I am not entirely at ease with.'* (PN3, QOF Q1, deprived)

The findings highlighted several tensions and

contradictions in the way in which practice nurses viewed the contract and, in particular, the need to meet QOF targets. For example, although they had generally been willing to take on increased roles and responsibilities, it appeared that some felt they had not been adequately rewarded for that increased effort, either financially or in terms of involvement in decision making within the practice. Nurses talked about increased autonomy, and organising chronic disease management clinics within the practice, but this autonomy appeared to be located within the consultation with patients, for example dealing with treatment or prescribing decisions, rather than in reorganising their overall workload, which remained within the control of GPs. This lack of autonomy was most apparent in the area of minor illness, with nurses often unable to develop their interest in this area because they were being asked to focus on QOF-related chronic disease management.

Another clear contradiction was nurses' responses to financial reward. Although up to a third of the nurses reported being promoted, it was clear that there was an overall perception that they were not receiving adequate financial reward for the work they were doing. This may be because they did not perceive upgrading as being clearly linked to the work they contributed to contract achievement, but is obviously an area that requires further investigation now that the contract has been in place for 4 years.

Finally, nurses viewed the QOF as a means to improve patient care, making it more systematic, but objected to the way in which it made them focus on 'ticking boxes'. Some of these inconsistencies might be attributable to the slightly different aims of the two studies, with one focused entirely on nurses' views of the contract, while the other addressed wider issues of skill mix and workload distribution. However, it may also encapsulate the current tension apparent in nursing between a more medicalised form of health care and a holistic, patient-centred approach. This would be worthy of further exploration.

Comparison with existing literature

McDonald *et al* recently reported on the impact of the contract on staff working in two practices that are high achieving in QOF terms.[16] The practice nurses interviewed were generally positive about being given responsibility for delivering targets, but expressed concerns about changes to their clinical practice; the development of surveillance within practices to ensure that targets were met; the neglect of non-incentivised conditions; and potentially damaging effects on individualised, patient-centred care. A study on a larger sample of practice nurses, located in 22 practices across England, has since reported similar findings.[26] The findings of the current study corroborate and build on these, highlighting nurses' concerns about their own position and the impact of the new GMS contract on the nurse–patient relationship.

Nurses felt that their workload had increased substantially since the 2004 contract, mirroring Crossman's 2006 survey, in which most nurses reported an increase in administrative, clinical, and managerial workloads.[27] This was also true after the 1990 contract, which was influential in the development and professionalisation of practice nursing, with role development particularly apparent in the incentivised areas of health promotion and chronic disease management.[8–12] For some of those interviewed, the contract had not changed the type of patients they were seeing substantially, but had increased the workload associated with these patients, including a greater emphasis on using the computer during the consultation and 'box-ticking'. This may then squeeze out the more holistic and patient-centred aspects of the consultation, such as providing patients with explanations about treatments.[28]

QOF indicators were developed to reflect 'best practice' according to the available clinical evidence base for the chronic conditions included.[29] However, many of the practice nurses believe that the contract detracts from good clinical care. This view appeared to be due to the decreased opportunities for practice nurses to utilise their traditional nursing skills and values, such as patient communication and a holistic approach to care,[30] because of the time constraints and bureaucracy imposed upon them by the contract targets. Many of the nurses interviewed felt that the single-disease focus, excessive data entry, and use of computers, neglect of non-incentivised areas, ethical concerns, and time constraints individually and collectively were having a damaging effect on the nurse–patient relationship, which they viewed as a core value of being a nurse. What emerged from the participants was a real concern that this most basic and core function of nursing was being eroded to the detriment of the patient, with nurses moving increasingly towards a medical, as opposed to a nursing, model of care. Howie *et al*[31] and Mercer and Howie[32] also warned of the dangers of the biomedical (and therefore easily measured) aspects of the contract overshadowing the importance of interpersonal, holistic aspects of general practice and suggested ways in which such care could also be incentivised. This study suggests that this applies as much to practice nurses as to GPs.

Strengths and limitations of the study

This work was based on two separate studies, conducted for slightly different aims but at

approximately the same time, 12–18 months after the implementation of the new GMS contract, using the same qualitative approach. The findings from each are very similar. The findings were from practices with a range of QOF achievement that serve populations that are both affluent and deprived. As such, the findings are likely to be of wide applicability to practice nurses in general.

Practices in both studies were purposively selected for socioeconomic profile of the practice population (affluent or deprived) and either QOF point achievement (from 2004 to 2005) or practice size. QOF achievement for those practices selected on the basis of size was later identified; this allowed a comparison of nurse views across 18 practices with a range of QOF achievement that serve different types of populations. Ongoing analyses of these interviews indicated that, by the time these interviews were completed, no new issues or themes were identified indicating that the major issues of concern to nurses had been captured.

The two researchers who conducted the interviews are both nurses, and one is a practice nurse; other team members were academic GPs and a non-clinical primary care researcher. This ensured a range of professional views so the potential for bias and misinterpretation was minimised. Only the views of practice nurses are reported in this study and it would have been desirable to balance this with the views of GPs and other members of the primary care team.

Implications for clinical practice and future research

The new GMS contract has changed the role of practice nurses within primary care and increased their professional role. However, discontent about how financial gains are distributed and negative impacts of the necessary data collection on core values are of concern with regard to the long-term effects of the QOF on motivation and morale. Clearly the tensions and concerns raised may naturally resolve as the new GMS becomes more embedded in everyday primary care over time. If such tensions are not resolved, however, it suggests that the development of effective team working required to deliver ongoing and new QOF targets may be difficult to achieve.[33]

Previous commentators have warned of the dangers of incoherence between external drivers of change and internal goals and values,[34] and such internal motivation is regarded as a key attribute of high-quality professional practice.[35,36] A re-emphasis on holistic, patient-centred care in primary care may be a prerequisite for future quality developments[37,38] for both nurses and GPs in tackling the complexity of health problems in the UK population. The tension between meeting incentivised targets and delivering holistic, patient-centred care, particularly in relation to complex conditions, needs to be explored further.

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Competing interests

The authors have stated that there are none

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