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Advanced Nurse Practitioner (ANPs) experiences of the Quality and Outcomes Framework (QOF) Scheme: a UK case study

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ABSTRACT

Objectives The primary focus of pay-for-performance (P4P) schemes in the UK has traditionally been related to the public health and inclusion elements related to the activities of doctors with comparatively less attention given to nursing care as a component of the scheme. However, nursing is an integral part of healthcare delivery in the National Health Service and nurses constitute the major group of healthcare professionals in most countries. Our aim was to explore advanced nurse practitioner (ANPs) experiences of the Quality and Outcomes Framework (QOF), using the Implicit Leadership Theory (ILT) frame.

Methods We used a case study approach. Six articles on the QOF work were synthesised, focused on ANPs and their leadership potential in healthcare. Evidence showed that despite having importance in delivering the activities of QOF, nursing activities overlooked. We undertook a thematic synthesis of these papers, with a specific focus ANPs' leadership development in Long Term Conditions (LTC) care within general practice and capacity to influence the healthcare system.

Findings Six themes were identified: (1) sensitivity, patient-centred care, context and continuity of care; (2) intelligence—leaders capable of making strategic decisions in healthcare settings, (3) dedication, trust, equity and equality, (4) dynamism of nursing, (5) tyranny, guise of teamwork, collaboration and (6) nursing and healthcare leadership.

Conclusions Nurses in leadership roles created good working relationships, coped with conflicts and contributed to shared objectives and were sympathetic collaborators. Using the six ILT characteristics, we found that nurses were collaborators. Future P4P schemes should benefit from a collective lens of healthcare personnel when focusing on quality initiatives and improving the delivery of healthcare activities.

STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ Few current data sets relate to nurse leaders' perceptions of the part they play in hospital's efforts to meet the demands of pay for performance (P4P).
⇒ This research has shown there is a failure to recognise the importance of how nurses are impacted by inclusion in schemes that are not targeted at their activities, or healthcare contributions.
⇒ The sample size of papers included was much smaller than originally intended due to no further studies of Quality and Outcomes Framework and little focus on nursing measures and indicators.
⇒ Thematic analysis can be data driven or theory driven and the failure to distinguish adequately between these two approaches can result in a lack of transparency.[1]
⇒ Our results cannot be generalised to all P4P schemes.

INTRODUCTION

Pay-for-performance scheme: the Quality and Outcomes Framework

The core element of the provision of primary care in the UK is a general practice function, which provides the first point of contact, management of care and are the gatekeepers of specialist care service. There are approximately 6495 general practices in England,[1] each owned and/or led by a senior general practitioner (GP) or formed a partnership with other principal GPs in the practice as joint owners of the practice. Funding is a practice-based capitation payment, based on patient list size with some additional specific funding add-ons for staff, premises, deprivation payments, specific service contracts, since 2004a pay-for-performance (P4P) element—the Quality and Outcomes Framework (QOF) in England, Northern Ireland and Wales; a quality improvement incentive payment in Scotland. The specific activities undertaken in practices are embedded in the GP contract which is negotiated annually between the government and GPs.

In common with all P4P schemes, the QOF was a form of P4P scheme that was designed to incentivise specific outcomes. P4P is a reimbursement method devised to incentivise healthcare providers for accomplishing elevated levels of working and delivering the greatest value from healthcare investments.[2] It's introduction was a response to years of

underinvestment in general practice compared with other parts of the health service and variations in the quality of primary medical care.[3 4] It was intended to provide a mechanism to motivate GPs and to increase funding for their practices, and the vast majority of practices took up the opportunity for additional income. The UK model of general practice is predominantly one of GP partners who own the practice and the contract that provides the main proportion of practice funding is between the National Health Service (NHS) and GPs.

However, it is widely acknowledged that care is often delivered through diverse providers such as social care, mental health and primary care teams and not a single provider working in isolation. Advanced nurse practitioners (ANPs) have played a key role in UK general practice for many years and there are now approximately 20,000 practice nurses, and a part of a larger 30,000 workforce, which includes healthcare assistants and ANPs. An ANP is a registered nurse who has acquired additional knowledge, skills and competencies for expanded practice and is, therefore, working at an advanced level. ANPs work in GP surgeries, to assess, screen, treat and educate patients, supporting doctors in providing medical care. However, when the NHS employs ANPs directly, their standard working week will be around 37.5 hours if they are employed by the NHS and paid on the agenda for change (AFC) pay system, typically starting at band six. Although practices do not work with the AFC, they are private contractors, and they are employed by the practitioners.

For many aspects of QOF delivery, it is nurses rather than doctors who provide care interventions and support patients offering a large amount of both, firstly contact and continuing care, managing long-term conditions such as chronic heart disease, diabetes and asthma, treating acute illness and supporting vulnerable groups like children, the elderly and those with mental health problems, learning disabilities or dementia for the UK population.

Although the QOF was an innovative P4P scheme to enhance the value of primary care in the UK through financial rewards,[5] it was also initially a scheme designed to affect the quality and delivery of primary care in the UK. While the QOF was/is not a personal GP reward, it is negotiated by GP representatives as part of GP contract negotiations on an annual basis. Given the prominent GP partnership ownership model of practices, the rewards for other staff and their work were to be negotiated through the mechanisms for paying other staff at the discretion of GPs and practices. An important principle of the contractual negotiation over the QOF was that only those actions for which GPs were solely responsible were included in the scheme. Nurses and other healthcare professionals took on tasks formerly directed by GPs, so GPs could conduct consultant tasks hitherto limited to secondary care.[6]

In a previous paper, we highlighted that the work involved in activities incentivised by QOF was distributed throughout primary care practice, involving nurses, managerial staff and healthcare assistants but without monetary reward for these groups and this was experienced by other practice staff as an injustice in the reward system.[7] This is despite the clear evidence that reimbursement, financial rewards in return for extra work are linked to increased morale[7] and workers' morale improves the quality of care delivered by an organisation involved in provision of healthcare services and can fundamentally support its survival.[8] Over the past two decades, there has been a 70% increase in the number of hospital doctors and a 10% increase in the number of nurses and health visitors.[9 10] When compared with other EU nations, the ratio of numerous staff groups per 1000 population is still lower than average.[10] In recent literature there have been calls for a sustainable long-term workforce strategy to redress, including supporting new ways of working for professional groups (p.15), and possibly indicating a strategy that includes both nursing teams and those working in the domain as allied health professionals.[9 10]

Implicit Leadership Theory

Social cognitive approaches to leadership

There is an intrinsic acceptance that leadership is essential for organisations and individuals to deal with challenges and to make positive outcomes occur. Numerous leadership studies link leadership behaviours and leadership situations via theories arguing that a leadership style should be relevant to the situation to ensure effectiveness[11 12] and recognising that leadership is a trainable behaviour.[13] However, the literature is focused on leaders and views leadership as a motionless independent reality. Cognitive theory of leadership includes the Implicit Leadership Theory (ILT) which was developed by Robert Lord *et al*.[14] Social-cognitive approaches to leadership characterise a process of interpretation and outcome which reflects a key facilitating course between leaders and followers and situating trust approaches for the main leadership dynamics[15] that match perceived leader and follower characteristics,[16 17] affecting perceptions, descriptions and reactions to both leaders and followers behaviours.[18] The leadership role is granted, if there is a match between followers implicit leadership beliefs and the leader's qualities and behaviours. The reason we selected ILT as a conceptual lens was because patients' trust and follow nurses in a comparable manner, nurses are the most trusted profession, yet this is not reflected in their status as leaders in healthcare organisations. Hitherto, nurses are not given healthcare leadership power in the same way that medical colleagues are in the health systems, which they work for and P4P schemes have effectively all but excluded nurses during the planning and implementation phases of the QOF, by the government. Furthermore, developing excellent relationships between leaders and followers helps to create a motivational and trustful environment where nurses can be confident in their actions and decisions.[19] This rationale is important because nursing is challenged differently compared to the power of medicine, nursing challenges can influence

nurses' role and activities, impacting the quality of nursing care, 'patient' or nurse satisfaction, and the quality of healthcare services within an organisations' (P.1).

In ILT, leaders are identified by implicit expectations and assumptions about the personal characteristics, traits and qualities.[14 20] These assumptions, called leader prototypes, lead followers' perceptions and responses to leaders.[14 20] The term implicit is used because the expectations and assumptions are unspoken and the term theory is applied as it means the generalisation of previous understandings, to new events.[14] This idea is based on the notion that individuals create cognitive representations of the world, to interpret and control their behaviours.[20] There are six dimensions of the ILT and effective leaders: sensitivity, dedication, tyranny, dynamism and charisma, masculinity, intelligence and strength. We took this concept and applied the ILT as a framework to our synthesis, to elicit nurse leaders' experiences. Focusing on their capacity to develop as systems leaders and the changes that were impacted by the load of their QOF work.

METHODS

Thematic case study analysis

Case studies are in-depth exploration of a single entity or small number of entities. The entity can be an individual, family, group, institution, community or another unit. The researchers obtain descriptive information as data and examine relationships between the different phenomena and themes. The case study approach attempts to analyse and understand issues that are important to the history, development or circumstances of the entity under study. We used this method because it was suitable to understand why P4P schemes develop in a particular way rather than to develop in a collaborative inclusive method to reduce inequality. Case study methodology offers: flexibility in design and application, a means of investigating complex collective systems, frequently explores aspects of human thinking and behaviour that would be impractical to study via other methods.[21] It was not appropriate or possible to involve patients or the public in the design, or conduct, or reporting, or dissemination plans of our research as it was focused on professionals, leadership, and published data on ANPs experiences of the QOF.

The case study approach confirms the researchers' preconceived notions at the outset of the investigation, especially in problem-solving scenarios. In a case study method, the papers included in this study were taken from the 18 papers used in our previous study, as they befit an intense analysis.[7] These papers had already been screened and critically appraised in a study published elsewhere.[7] It is not unusual for secondary data to be used in this way for an alternative research question using this method.[22] We searched Medline, Embase, Healthstar, CINAHL and Web of Science to elicit the 18 papers (figure 1).

Our original search strategy included seraches that were run in:

- Ovid Medline 1946—September week 1 2018, Imported 21 references to EndNote, EndNote library holds 21 references.
- Embase Classic+Embase 1947 to 6 September 2018 excluded Medline records. Imported two references to EndNote—no duplicates, Endnote library holds 23 references.
- Ovid Healthstar 1966 to July 2018. Imported nineteen references to EndNote—19 duplicates removed; Endnote library holds 23 references.
- CINAHL 2004—present, 7 September 2018. Imported four references to EndNote—0 duplicates found, EndNote library holds 27 references,

Terms used included:

- (reimbursement adj3 incentive*).mp. [mp=title, original title, abstract, floating sub-heading word, name of substance word, subject heading word].
- ENGLAND/ or england.mp. scotland.mp. or SCOTLAND/ WALES/ or wales.mp. united kingdom.mp. or United Kingdom/
- limit 20 to english language
- (((“semi-structured” or semistructured or unstructured or informal or “in-depth” or indepth or “face-to-face” or structured or guide) adj3 (interview* or discussion* or questionnaire*)) or (focus group* or qualitative or ethnograph* or fieldwork or “field work” or “key informant” or observation or “reflective diaries”)).ti,ab. or interviews as topic/ or focus groups/ or narration/ or qualitative research/
- pay w2 performance, “OUTCOME ASSESSMENT (HEALTH CARE)"/
- "OUTCOME AND PROCESS ASSESSMENT (HEALTH CARE)"/
- (outcome adj2 assessment).mp. [mp=title, original title, abstract, floating sub-heading word, name of substance word, subject heading word]
- (quality adj1 outcome* adj1 framework*).ti,ab. or Quality Indicators, Health Care/ or quality indicators.mp. [mp=title, original title, abstract, floating sub-heading word, name of substance word, subject heading word]
- quality of health care.mp. or “Quality of Health Care”/

A subset of six papers specifically on nursing (primary care) and QOF were reviewed as a case study for analysis to explore ANPs' experiences of the QOF, to elicit the experiences for future lessons. These specific papers were selected, as we anticipated to capture the impact of formal exclusion of ANPs in this P4P scheme. We originally included studies that reported primary qualitative research (in-depth interviews, focus groups, ethnography, observation, reflective diaries, case-studies and reviews containing qualitative analysis) of the QOF published in English between 2004 (when QOF was introduced) and 2018. We excluded studies that did not specifically focus on the QOF, UK and did not involve primary qualitative research methods. See box 1 for the included papers.

We use ILT to form insights into the organisational perception of leadership for nurses at the outset of the

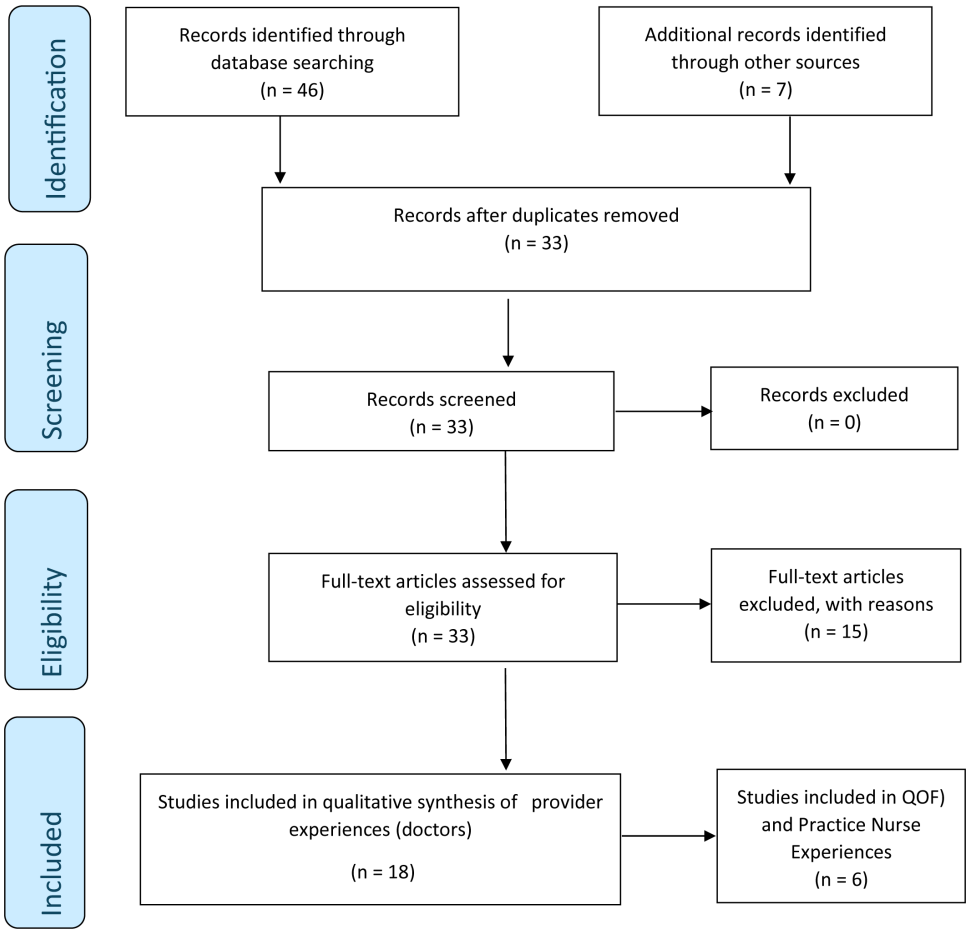

Figure 1 PRISMA flow diagram. PRISMA, Preferred Reporting Items for Systematic Reviews and Meta-Analyses; QOF, Quality and Outcomes Framework. Implicit Leadership Theory (ILT)

QOF scheme and implications for the main organisation (National Health Service, NHS) to officially include nursing leadership in the QOF reforms and implication for future P4P schemes. The coding and extraction of data was undertaken, using QDA miner by NK, and these were verified by SP. Using WORD NK and SP analysed the extracted data to generate themes. The thematic analysis undertaken, overlapped with narrative summary and content analysis,[23] the stages we followed were as follows:

1. Identification of prominent or recurrent themes in the literature.
2. Summarising the findings of different studies under thematic headings.
3. Application of the ILT as a conceptual lens, to create summary tables, with descriptions of the key themes.

Box 1 Included articles

Articles
(P1) Hackett *et al.*[41]
(P2) Alderson *et al.*[42]
(P3) McGregor *et al.*[43]
(P4) Maxwell *et al.*[44]
(P5) Maisey *et al.*[45]
(P6) Campbell *et al.*[46]

We used this method of analysis as it permits transparent recognition of important themes and allows for systematic and defined meanings of exchange with the literature according to those themes.[24]

Patient and public involvement

None.

FINDINGS

Our analysis suggests that ANPS felt that they should have been reimbursed for the QOF work they undertook. Our findings confirm the ongoing discussion around the substantial amount of work that was conducted by nurses for the success of the QOF.

> I think we feel that we do a lot of work towards the QOF, and we probably feel as though we ought to recompense, if we had a bonus that was specifically because we knew that we'd hit QOF targets. I think people feel well why should only certain parts of the team get it when everybody's worked as hard towards it? (P1N).

The QOF work was experienced as an unfair load on the nursing profession creating inequility in leadership in the healthcare context. Nursing care did not feature in

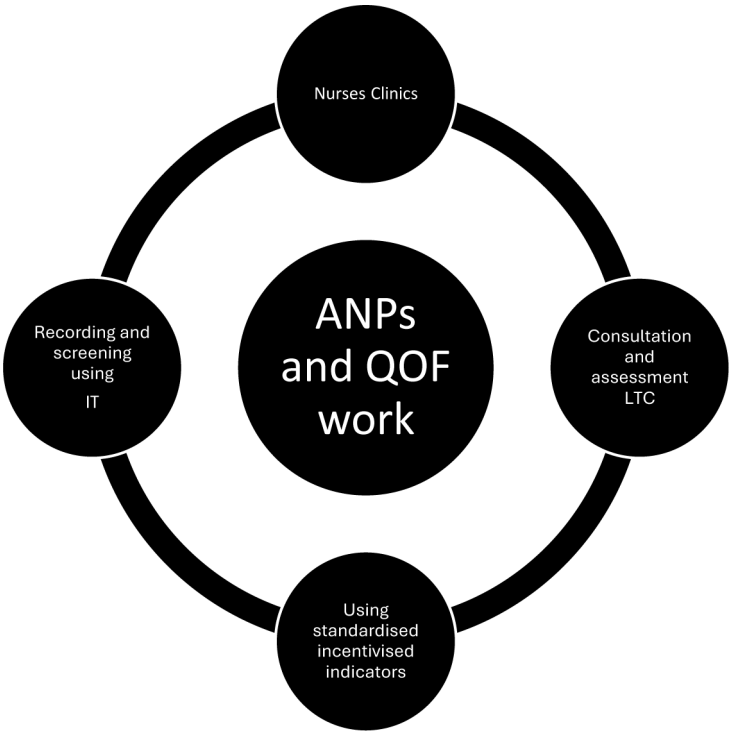

Figure 2 QOF work and the nurses' role. ANPs, advanced nurse practitioners; QOF, Quality and Outcomes Framework.

the reward, or status for formal leadership construction and planning of the QOF. Reducing equality for ANPs was related to misssed opportunity for their leadership development, so that their status as a valuable occupation in healthcare.

> The workload is heavier now than what it was before the introduction of the new GMS (P3N).

ANPS were expected to shoulder the burden of QOF work created by the scheme. For the QOF work that nurses undertook, please see figure 2.

Nursing embeds characteristics of leadership, and when we applied the ILT lens, our extracted data showed that ANPs were working accordingly with QOF targets and goals. The QOF scheme and it's organisational structures did not support training of nurses for the changes that were required, which inevitably influenced both the nurses work and their leadership (without status), that progressed as part of the new culture change that emerged. Consequently, we found that the choices for nurses and their aspirations to work in areas which they preferred were ignored and restricted by the QOF work. Furthermore, the increased responsibilities thrust upon ANPs was conducted under the pretext of teamwork and goodwill and no formal status as a leader in the activities they had to conduct.

> 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 teamwork (P3N).

We present the findings as quotations taken from the six paper to support the themes according to the ILT characteristics in online supplemental material.

Sensitivity, patient-centred care, context and continuity of care

According to ILT characteristic 'sensitivity,' nurses identified as sensitive leaders, showing concern for complex concepts such as patient-centred care, continuity of care and context. Their roles appear aligned to these constructs and all their work was encapsulated by caring, listening, empathising and advocating for the individuals in their care.

> So, I think in the half hour you get a good idea of whether someone is… this is just a bad day, or whether there's been a lot of bad days… And I think your instinct kicks in, you know? (P4N).

Nursing processes were aligned more naturally with the care processes and the QOF work seemed to oppose this, causing a duality in the delegated and perpetual conflict.

> The QOF questions are progress in tackling this issue but a lot of us don't like using PHQ9 because we're sitting speaking to the patient, you then print off this sheet, give it to them to fill in rather than engaging verbally … it's really much less professional I think most of us feel, but we have to do it, so… (P4N).

Intelligence: leaders capable of making strategic decisions in healthcare settings

Hoeve *et al* state that nursing is identified as a profession, with its own standing.[25] Professionalism has been

described as demonstrating your values and standards in practice and Zulipiye states that this is also reflected in the work attitudes and behaviours.[26] Nurses deliver care which is embedded in close contact with patients who are vulnerable, completely or partially dependent while developing enduring relationships.[27]

Analysis indicated that, as a profession, ANPs were not involved formally in the administrative process or supported to acquire knowledge of how practices worked or how partnerships in the practice were established. Mechanisms to develop such practices and domains of work were not realistically considered as an option in the QOF scheme.

> [The nurse] referred to QOF as coming from "on high" to tell her to incorporate it. She felt depression screening was problematic as they had received "no training" in mental health or in screening and they were very "stretched for time in the appointment" (P2N).

There was little evidence in our findings to suggest that the NHS organisation or practices that implemented the QOF had introduced support for the granular details of structures of the QOF, although ANPs role remained informal compared with the formal medical leadership.

Dedication, trust, equity and equality and nursing leadership

ANPs experiences in the data from the published papers, demonstrated distrust, generated through unfair distribution of incentives.

> We're paid money to do that anyway, why is it that there's extra money given when you're given a wage to do it anyway? I don't know why a carrot should be dangled to a health professional, personally I find it immoral (P1N).

We found that there was a clear hierarchy of power, for ANPs to voice and to report or express dissonance in an analogous way to their medical colleagues.

ANPs' experiences suggest that they were service-oriented and did assist the QOF work that was required of them to support and coordinate care for service users. They managed to prioritise the QOF work while maintaining patient engagement and reducing their own preferred work in areas that they initially trained in, suggesting a form of sacrifice in their chosen career.

> 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 (P3N).

ANPs behavious, attitudes and the activities undertaken as part of the QOF work indicated that they were effective, skilful and developed a department-wide service-oriented culture through the processes, they placed great value on teamwork, despite stressful, overwhelming or frustrating situations. ANPs showed accountability and loyalty under the QOF, acting as full partners to changes, with both medical colleagues and other health professionals requiring their input.

Dynamism of nursing

Findings also demonstrated that ANPs were strong communicators and were effective collaborators and could engage comfortably with support staff, doctors, and specialists, nurses, and trainees, patients, and their families and could communicate with senior executives. However, the data indicate a reverse of this in terms of the lack of communication from QOF handlers.

> If we'd been told a bit more, we might have been more engaged (P1N).

Our analysis indicates that ANPs were strong communicators and listened to patient concerns.

> I've got him coming back in six months time; he didn't want to see anybody, but I thought it was planting the seeds to… you know, if he went home and thought about it and thought 'well, actually maybe I do need to speak to somebody' then he could come back and do that either at the [nurse led] clinic or with the GP (P4N).

The data we explored also support the pliability demonstrated by ANPs as they absorbed the rapid changes required of them as part of the QOF. The QOF changes included evolving regulatory requirements, new evidence-based standards and processes, and regular updates to reimbursement policies.

Tyranny, guise of teamwork, collaboration and inequity

There was evidence that a lot of the QOF work that was undertaken in the forms of routine screening was a decentralising of Long Term Conditions (LTC). Consequently, this led to limiting ANPs preferred development, choice and training in preffered areas.

> I would just like to see more minor illnesses and to have more clinic time for that. My clinic is always 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 now we need the chronic disease management in relation to the contract requirements, but I don't know whether that will change or not (P3N).

QOF standardisation created mechanism where routine care was recorded by nurses using technology and tools such as—prepared templates, to extract the correct information from patients for the availability of doctor colleagues. ANPs participated in screening and appeared to be tech-savvy, and this led to a further increase their workload.

Analysis of the data indicate consequence of other motivating strategies, which were used by the medical colleagues, such as giving a small bonus, increased holidays or taking nursing staff out for a meal, at the end of

the year, which was in fact experienced as insufficient reimbursement for work that was carried out by ANPs.

> 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 (P3N).
>
> 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 (P3N).

Terms such as 'team player' were used to motivate ANPs and other administrative staff to meet the QOF goals and targets specific to incentivised indicators, these were required to secure money for the practice. Regardless, working from a collective lens was welcomed by the ANPs and was linked to responsibility and ownership. However, it was fundamentally not linked to income for ANPs, which was caused conflict and incongruency in their sense of satisfaction and decreased their opportunities to train and develop in roles related to their preferred areas of interest.

> Overall, nurses described their current roles in very positive terms. 'There was a cohesion developing that we were suddenly having all these meetings and having to put our heads together about how we did things as a team rather than things being a bit fragmented as they were previously. (P1, nurse)
>
> It makes a more fulfilling job … It's something I've got responsibility or ownership of and that to me is a rewarding thing (P5N).

Masculinity, can feminine discipline in healthcare lead

Literature is enshrined in historical roots of the current gender hierarchy in the healthcare professions. British sociologist, Anne Witz, has shown that the gender blindness of prevailing neo-Weberian and neo-Marxist approaches. She examined the strategies of medical men, midwives, nurses and radiographers in the emerging medical division of labour in the latter half of the nineteenth and early twentieth centuries. Witz has explored how class and gender have interacted in complex ways to produce hierarchies of power and prestige in professional work.[28]

Despite the medical profession previously being a male-dominated sector to achieve parity; many qualified GPs are now female; this trend could mean that the majority of all doctors are soon set to be women. However, a government report in 2009 claimed that female GPs continue to be deprived of contractual rights, denied maternity support and are missing out on leadership roles.[29] The British Medical Association has been accused of having an 'old boys' club network' culture, which treats women as of less importance and ability. Following these claims, an investigation into sexist behaviour revealed that many female doctors felt 'undervalued, ignored and patronised because they are women.'[30]

Nursing is a feminine discipline; more females make up the majority and are a large part of the profession everywhere. Approximately 27 million men and women make up the global nursing and midwifery workforce. This accounts for 50% of the global health workforce. The nursing and midwifery workforce is 91% female compared with 9% male in the UK.[31]

Contrastingly, the medical discipline within healthcare is masculine and more men have traditionally been allowed entry into medicine compared with females in the past. Subsequently, medicine is often seen as the natural choice to lead in the NHS changes, reforms and policy changes.

> Well, it's certainly improved my income. Probably increased my workload, not to the same degree as it increased my income. But I'm a bit worried that we've sold our soul to the devil to some degree because they can change the goal posts later (P6D).
>
> In some respects, my role hasn't changed and never will do, as far as I can see, and not in my lifetime anyway. A person comes in the door, sits down and I ask them what's wrong and you try and fix it. That hasn't changed (P6D).

Consequently, Weber's rationalisation thesis claims that social actions are ever more structured under the various forms of rationality (especially formal rationality). For example, the rationalisation of society is advancing, which shifts 'older forms' of authority and organisation.[32 33]

DISCUSSION

In Eliot Freidson's book on Perspectives in Biology and Medicine (p. 458–462) he highlighted that an ideal type of professionalism. He argues 'the third logic,'—a logic of professionalism, should be ingrained in 'a set of interconnected institutions providing the economic support and social organization that sustains the occupational control of work' (p. 2).[34] Equally with medicine, nursing care is central to preventing poor outcomes and ensuring optimal outcomes in the different sectors of the healthcare system. Empirical data recommend that patients in institutions that have investment in nursing care, for example, in staffing levels or nurse education have less adverse events.[35] However, the connection between nursing care or the resources for providing it and hard patient outcomes in healthcare facilities remains relatively weak.[36] However, Larson's rationale for the 'professionals and the monopoly of expertise', along with the rise of modern educational systems, provides a conceptual resolution to the incongruence between universalistic values and the limited privilege of expertise.[37]

Our analysis shows that institutions and schemes have focused on specific indicators, without a focal point on or with any necessarily improvement of the expansive aspects of care related to ANPs activities as the end outcome. Similarly, other literature has also found that nurses were taking on work that was commonly undertaken by medical professionals.[38] An increasing emphasis

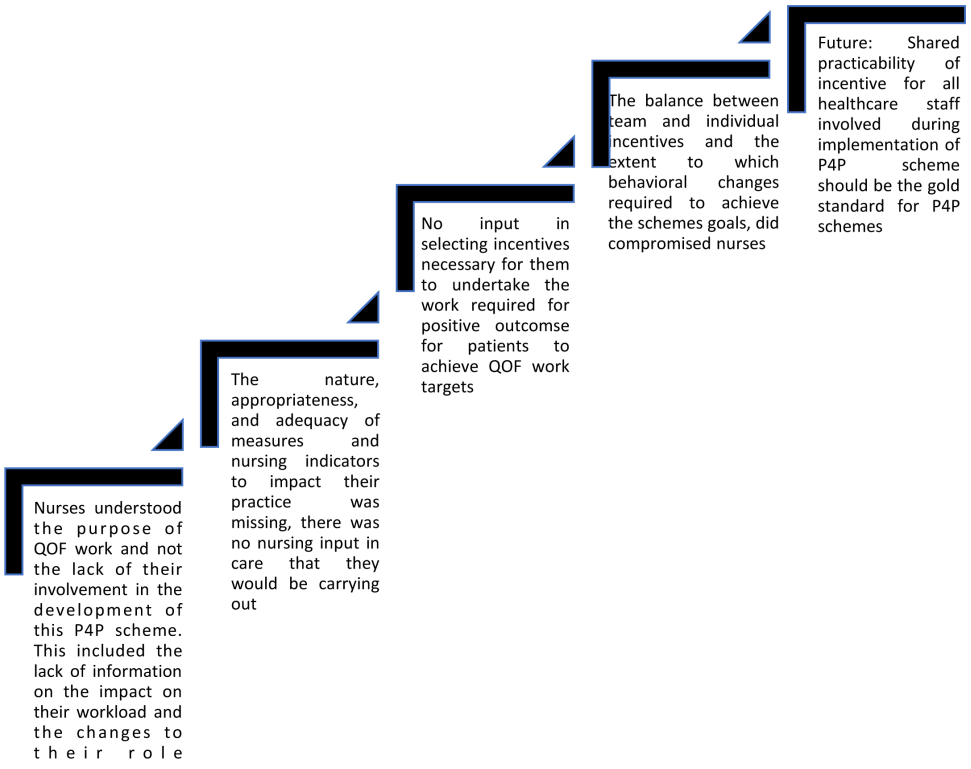

Figure 3 Nursing involvement in P4P Schemes. P4P, pay for performance; QOF, Quality and Outcomes Framework.

on nurses' accounts in technical skills and knowledge may help decouple nursing from a narrative of caring, which has been seen as detracting from professional advancement. Yet, the NHS Long Term Workforce Plan advocates increasing education and training to record levels and to deliver additional doctors and dentists, more nurses, and midwives, and more of other professional groups to care. This also includes new roles to link the shifting needs of patients to support the ongoing changes in care.[39] If nursing factors such as close contact with patients in acute care and central role in patient flow are to be linked with the process and/or outcome indicators involved in incentivised schemes—as early evidence suggest, then P4P initiatives may provide an entirely new line of arguments for investments in nursing services and structures that include their activities and the work they are expected to contribute.[36] ANPs work can target outcome measures to track, report and drive payment decisions to go beyond measures of patient satisfaction to reflect nurses' contributions to health and adaptation to illness and recovery.[36] Nurses have a social responsibility to evaluate the effect of nursing practice on patient outcomes in the areas of health promotion; injury and illness prevention and alleviation of suffering.[40] Patients typically receive care from teams of semi-autonomous providers representing multiple disciplines and specialties working interdependently and therefore, health outcomes are rarely, if ever, the result of a singular process or provider.[40] According to the six ILT characteristics, nurses are team players— in leadership roles, nurses create good working relationships, they can cope with conflicts and contribute to a shared objective with collaborators. Nurses demonstrate natural collaboration with different departments as routine providing multidisciplinary care seamlessly. The QOF overlooked the opportunity to develop, involve formally the intentional collaboration of nurses, with genuine training or development opportunities linked as guidance to the GP contract. The QOF data have shown that where nurses were collaborating in the QOF work, they encouraged a form of functional teamwork and contributed to the teams' well-being and resilience.

Respectful leadership can also be seen as pushing back on innovative ideas that are not equitable to nursing. It appears that nursing also missed the opportunity to push back on this UK P4P scheme that did not make any allowances to incentivise their activities linked to the scheme and improve the nurses working lives and their well-being. The QOF (P4P) with its sole purpose of increasing doctors pay in primary care restricted the NHS as an organisation to permit nurses to remain confident and reduced the opportunity for the NHS organisation to align any decision-making process across the organisation, so that it empowered nursing to act with greater autonomy. Such acknowledgement and incentivisation in the future could encourage ANPs to feel confident, respected and valued by their organisations to balance unlimited risk liability, in the way the medical profession does. In view of Weber's model of social closure and its relationship with the development of the professions and patriarchal capitalism, nursing remains weak in bargaining power and leadership because general practice is loathed to give up power or profit. Finally, reporting, archiving and reimbursement provisions of such schemes should at the national level encompass nursing-sensitive outcomes

data beyond medical treatments and mortality rates. Clarke *et al* indicate—the initiative to drive the creation of new sources of well-collected nursing-sensitive process data. That could yield a number of benefits because the process of care is an area where well-managed nursing services shine.[36] QOF and most P4P initiatives have not yet become wholly aligned with a broader healthcare agenda that centres predominantly on work of nursing and allied healthcare professionals. If such schemes attempt to drive quality of care by aligning desired care processes and outcomes with reimbursement, then, as a group ANPs would appear ideal leaders as they deliver and provide services that are patient centred, relationship based, which consider the broad aspects of patients' experiences in the world, and their social networks.[36] Nurses and other healthcare professionals will be the primary resource or staffing for services transfer from secondary care[6] (see figure 3).

Future schemes should shift the focus from individual medical roles to shared leadership for improvement at local level and national. Developing and emphasising collective responsibilities, which may soften strong (historically) grown emotions and create spaces in which new roles become negotiable, should include nursing teams at the inception and this could reduce the chance that nurses will suffer ethical distress, moral injury, disempowerment, and it can boost workplace fulfilment in the future of nursing careers. The government should support the NHS as an organisation to implement schemes that work within a framework that includes ethical integrity and inspires these construct throughout the schemes and all the staff that are required to make it a success.

P4P initiatives exist in the literature prior to this date; however, there are limitations in research on this topic. We have focused this research on the ANPs experiences of the QOF in the UK. Though, the literature offers studies regarding quality care efforts in various aspects of the hospital including the way that nurses deliver care—there is a failure to recognise the importance of how nurses are impacted by inclusion in schemes that are not targeted at their activities or healthcare contributions. They experience such work and schemes as working against them and find such schemes unethical without any formal benefits. One key limitation of this work was, the sample size of papers included, which was much smaller than originally intended due to no further studies of QOF and little focus on nursing measures and indicators. Few current data sets related to nurse leaders' perceptions of the part they play in hospital's efforts to meet the demands of P4P, these perceptions may help us better understand nurses' role in leadership and the way they see themselves delivering quality care within the organisation. Thematic analysis can be data driven or theory driven and the failure to distinguish adequately between these two approaches can result in a lack of transparency.[24] Our results cannot be generalised to all P4P schemes that are implemented in other contexts.

CONCLUSIONS

Conventionally, P4P scheme design has limited the power of nursing, however, it's involvement is an opportunity for such schemes to include nurses to extend P4P structures rather than delay involvement of key healthcare staff to simply act as reactionary agents to its effects.[36]The problems that arise from lack of nursing involvement in P4P schemes; the power structure in general practice places ANPs and healthcare assistants as employees of the GPs, overlayed by medical power and dominance and with little status to impact executive decisions.[36] Secondly, most treatment processes are easy to measure and treatments deemed medical can be measured are routine—for example, BP, blood sugar and so forth, excluding complex constructs that cannot be measured in the same ways, belonging to nursing care.[36]

P4P, government and institutions can benefit from nursing representation in leadership. They can support the development of complex measures linked to reimbursement in future P4P schemes, see recommendations below:

- Identify performance indicators that specifically improve the quality of nursing care for underserved and vulnerable populations.
- Accumulate evidence to support validity of nursing specific measures or treatment methods.
- Nurses should be involved in deciding the proportion of reimbursement that should be at stake to constitute adequate inducement for improvement,
- Nurses should have a voice at the table and be seen as 'best' providers to be recognised and rewarded.

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