Influences on the achievement of four indicators, categorised using the Theoretical Domains Framework.[7]

	Avoidance of risky prescribing, especially of NSAIDs	**Treatment targets in type 2 diabetes**	**Anticoagulation in atrial fibrillation**	**Blood pressure targets in treated hypertension**
Knowledge	GPs more knowledgeable compared to other staff Awareness of drug interactions and patient history	Variable awareness of recommended HbA1c levels Knowing the rationale and evidence behind recommendations Guidance generally familiar as standard practice	Indicators familiar because of QOF Importance of access to specialist knowledge Treatment often initiated in secondary care Lack of staff experience in starting treatment given relatively infrequent clinical presentation in primary care	Indicators familiar because of QOF Indicators ingrained as “bread and butter” of general practice
Skills	Communication skills for effective patient counselling Limited time to use skills, e.g. communication	Communication skills for effective patient counselling Need for technical skills such as medication initiation and titration	Communication skills for effective patient counselling	Communication skills for effective patient counselling Practice staff typically well skilled in measuring blood pressure and initiating and titrating treatment
Social professional role and identity	Prescribing perceived to be mainly the role of GPs GP autonomy to deviate from guidance Threat of litigation reinforces nurse prescribers’ adherence to guidance Key role of pharmacist in improving prescribing Prescribing practice driven by perceived patient needs than by guidance	Clarity of roles and responsibilities Can refer to practice diabetic lead if patient taking multiple medicines Tailoring care to patient needs more important than achieving strict targets	Tailored patient care can both help and hinder adherence, e.g. in elderly patients and patients with multiple conditions Role more focused on long-term rather than acute care as atrial fibrillation often initially presents to secondary care Contradictory advice from secondary care Clinicians with more cardiac expertise tend to be responsible for most patients	Clarity of roles and responsibilities Professional ethics and threat of litigation promote adherence Tailoring care to patient needs more important than achieving strict targets

			Practice nurses viewed their input as restricted to reviewing medicines if required	
Beliefs about capabilities	Clear guidance and access to specialist knowledge and training Adequacy of information technology system support	Confidence in ability to achieve targets depends on patient factors such as attendance and motivation Many clinicians confident with blood pressure and cholesterol but less so with HbA1c and any associated medication changes Organised links between primary and secondary care Confidence in diabetes lead Practice IT systems able to identify patients not achieving targets	Confidence related to availability of specialist staff, training and updates Supportive, organised links between primary and secondary care	Confidence helped by relative simplicity of guidance and decision support Confidence hindered by patient factors and limited resources for referrals Practice IT systems able to identify patients not achieving targets
Beliefs about consequences	Ensuring quality of care, patient health, and patient safety Reputation for following guidance reflects well on practice and professional Perceived threat of litigation to nurse prescribers if guidance not followed Immediate financial and time costs (prescribing budget, increased appointments, auditing) outweighed by the potential longer term NHS cost reduction	Achieving targets linked to quality of care and better patient outcomes Job satisfaction in achieving targets Perceived pressure to achieve targets undermines rapport with patients Achieving targets requires time and increases workload Costs for patients and side effects from additional prescribing to achieve targets	Ensuring quality of care, patient health, and patient safety Strict adherence to guidance inappropriate for some patients, e.g. elderly and those on multiple medications	Ensuring quality of care and patient health Perceived increased workload associated with following guidance, e.g. consultation length
Motivation and goals	Adherence ensures quality of care, patient health, and patient	Achieving targets associated with short term gains in QOF	Ensuring quality of care, patient health, and patient safety	Ensuring quality of care, better patient health and job

	safety Promoting a positive reputation for the practice Guarding against litigation Incentivisation of good prescribing	income and longer term NHS savings Achieving targets linked to quality of care, better patient outcomes and job satisfaction	Achieving targets associated with short term gains in QOF income and longer term NHS savings	satisfaction Achieving targets associated with short term gains in QOF income and longer term NHS savings
Memory, attention and decision processes	Patient history provides important information for decision making Automatic thinking processes useful in high-risk situations Patient history provides important information for decision making Decision aids and prompts for drug interactions Computerised prompts often not in line with consultation processes, e.g. triggered following clinical decision	Awareness of patient characteristics such as older age can influence decision of whether or not to aim for targets System prompts useful for embedding targets into memory	Relatively infrequent presentation of atrial fibrillation hinders commitment of guidance to memory Prompts and the ability to view guidance support decision making	High prevalence of hypertension helps embed guidance into routine practice Patient characteristics (e.g. older age) can influence tailored care to meet patient's needs Guidance considered easy to retain Prompts useful for supporting adherence to guidance
Environmental context and resources	Practice nurses can pick up medication issues during reviews but lack knowledge and suitable templates Prescribing policies, support and advice available from CCG medicines management teams and pharmacists Limited time (including for training and education) and decision support Limitations of information	External support from CCG, information technology systems and training opportunities Low staffing levels and high workloads Communication between primary and secondary care could be improved to support achievement of targets	Communication systems and established lines of responsibility within the practice needed to identify potential issues around professional adherence Inadequate communication between primary and secondary care Time and workload, especially as current information technology systems do not support easy identification of	Established lines of responsibility, clear templates and access to training and education Limited availability of home blood pressure machines, heavy workload and short duration of consultation makes it difficult to schedule a specific time to measure blood pressure which contributes to difficulties in achieving targets

	technology systems and communications with secondary care		eligible patients	
Social influences	General approach and support of practice team Patient preferences	Pressure from QOF to achieve targets, including comparison with other practices Practice managers aware that achieving targets is linked to practice QOF performance Overall team approach in practice Patient preferences	Pressure from QOF to achieve targets, including comparison with other practices General approach and support of practice team Patient preferences	Pressure from QOF to achieve targets, including comparison with other practices Team factors and support within and outside the practice (e.g. network meetings Patient preferences
Emotion	Discomfort when guidance conflicts with patient-centred care Feeling constrained by guidance Caution and worry when prescribing additional medication Workload-related fatigue restricts ability to have in-depth conversations with patients	Achieving targets lead to job satisfaction Adverse impacts of fatigue on achieving targets Frustration from missing targets and patient factors, e.g. resistance, low motivation Perceived pressure from targets which can generate tension between clinicians and patients	Frustration caused by complicated guidance making treatment difficult to explain to patients Limited time, mood and fatigue result in deferring decisions to further consultations Discomfort with pushing adherence amongst elderly patients	Achieving targets lead to job satisfaction Fatigue and workload influence whether targets were considered at every consultation Unease created by patient reactions to additional prescribing
Behavioural regulation	Computer prompts for drug interactions, templates, audit and medication reviews Problems associated with rapidly accessing and interpreting full patient records Computer prompts not always useful – can be overwhelming	Help from computer prompts, recall systems, clear protocols and templates Habitual action sequences helpful, e.g. reviewing patient medical notes and setting electronic reminders for action to self within patient record	Help from computer prompts, recall systems, clear protocols and templates Limited ability of current computer prompts to support adherence to guidance	Help from computer prompts, recall systems, clear protocols and templates Patient risk factors act as prompts Opportunistic reviews of patient records Computer prompts not always considered useful and potentially distract from main

				purpose of consultation