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Evidence review on partnership working between GPs, care home residents and care homes



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First published in Great Britain in December 2013
by the Social Care Institute for Excellence

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Written by Rebecca Goldman

This report is available online
www.scie.org.uk

Social Care Institute for Excellence

Second Floor

206 Marylebone Rd

London NW1 6AQ

tel 020 7535 0900

fax 020 7535 0901

www.scie.org.uk

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Key points

The voice of the resident and their relatives

- Research and other reports emphasise the importance of residents' and relatives' 'voice' in influencing medical and end of life care. Relatives say they want to be told about developments in residents' medical care including medication changes. However, few research studies include residents and relatives as research participants.
- Positive relationships between GPs, residents and family members are associated with positive outcomes, according to residents, GPs and care home staff. Reported outcomes include residents understanding medical issues and encouraged to take medication; GPs following residents' preferences; and reductions in hospital admissions. Residents, relatives and care staff appreciate it when GPs are respectful, understanding and kind.
- Care staff often express satisfaction with GP services in surveys and qualitative studies. However, in qualitative studies, staff and relatives also report GPs' refusals or reluctance to register and visit residents. GPs' lack of knowledge of residents is associated by research participants with inappropriate hospital admissions and prescribing errors. This especially applies to out of hours GPs.

GPs and the NHS

- Reports and studies mention high GP workloads as a result of work in care homes. The reported reasons include home visiting with travel, being called out inappropriately, and the complexity of residents' health and illnesses.
- Several studies note the importance of leadership, persistence and proactivity from both care home managers and GPs in relation to residents' medical care. This includes overseeing treatment for long-term conditions, and coordinating care from health practitioners. However, research reports a lack of advance care plans, medical reviews and medication reviews involving GPs.

Relationships between GPs and care homes

- Close working relationships between care homes and GPs are associated with a range of positive outcomes, according to care staff, GPs and other stakeholders. They say that relationships need to be trusting and supportive, and involve mutual recognition and respect, to have the most impact on partnership working and residents' medical care.

- Some care staff describe health practitioners, including GPs, as sometimes patronising. Communication and understanding may be hampered by different professional values, priorities and working cultures among health practitioners and care staff. There are reports of a power imbalance, with health practitioners perceived as higher in status than care home staff.
- GPs and care staff say that if care staff have high levels of confidence and skills, this can facilitate relationships with GPs, and increase GPs confidence in care staff's work. The literature includes examples of GPs and other health practitioners delivering quality improvement advice or training to care homes. However, the review found no evaluated examples of explicitly joint training or reflective practice between GPs and care homes.
- There is evidence from qualitative studies that end of life pathways and frameworks can facilitate leadership roles for home managers, and partnership working between GPs and care homes.

Partnership working

- Several studies and reports mention the importance of effective communication and information sharing in promoting better joint working between GPs and care homes; reducing hospital admissions; reducing medication errors; and resolving difficulties obtaining medication. Care home staff and GPs say that they value their contact out of hours, using a variety of media (email, fax, mobile phone), as well as regular meetings.
- Problems with record-keeping and sharing information include unclear, incomplete, out-of-date or inconsistent medical records and care home records; residents' records not available to GPs and out-of-hours doctors when they visit care homes; and a lack of appropriate technology in care homes.
- Several studies report inappropriate and harmful prescribing by GPs. Medication errors are associated by care staff and relatives in qualitative studies with ineffective communication and information sharing, including with secondary care. Research participants and authors suggest a leadership role for GPs, pharmacists, nurses, relatives or care staff in taking responsibility for medicines use in care homes, including regular medication reviews.

- The literature describes practice models such as extended service schemes, preferred practice arrangements, multidisciplinary healthcare teams for care homes, and regular GP 'surgeries' in care homes. The review found little robust UK evidence on outcomes from studies comparing these models to usual GP care. Residents, relatives, GPs and care staff report positive outcomes for residents and care homes, but have mixed views on implementing these models and their overall benefits.
- There are examples of nurses and nurse-led teams mediating the relationship between care homes and GPs; taking on some of GPs' work; and having a lead medical role in individual care homes or local service development. Research and practice literature discuss the need to ensure the right skill level if nurses partially replace GPs in medical care; but there was no robust evaluation found in the UK literature that gives evidence on outcomes.

Introduction

This report is a review of research and other evidence from literature accessed by the Social Care Institute for Excellence (SCIE) through systematic searches (see 'Methods and studies for the evidence review' at the end of the report). Studies were subject to systematic screening, data extraction and quality appraisal. The report provides a compendium of detailed evidence (including quotes from qualitative studies) to inform the practice guide, with summary statements. Evidence and quotes are repeated in different sections of the report where appropriate to ensure that each section is comprehensive in itself as a review of all relevant evidence.

The superscript * after a reference denotes a study or report with a 'low' quality appraisal overall, or which were given a 'low' rating for quality of study design/method or for appropriateness of the study design to the review questions. Evidence reviews with no systematic elements, non-research reports (for example, practice examples and policy/practice guidance) and research with no explicit methods were all given 'low' for quality and appropriateness of study design, as were some research studies. There are further details on the review method at the end of the report.

The voice of the resident and relatives, and relationships between GPs, residents and relatives

Relationships between residents and relatives

GPs' lack of knowledge of individual residents is associated with prescribing errors and/or risk-adverse decision-making (Wild *et al*, 2010; Barber *et al*, 2009).

'... emergency call-out doctors do not know residents, so play safe and order them to be admitted to hospital for many conditions which could perhaps be resolved differently.' (Resident, Wild *et al*, 2010, pp 21–2)

Residents, GPs and care home staff say that positive relationships between GPs, residents and family members are associated with:

- residents feeling reassured, supported and listened to
- residents understanding their medical issues
- GPs following residents' wishes for treatment and care
- GPs being called out appropriately
- residents being encouraged to take medication or cooperate with treatment
- reductions in hospital admissions (BGS, 2011a*; Briggs and Bright, 2011).

An enhanced service scheme that included regular scheduled GP visits (Briggs and Bright, 2011) and regular surgeries (Jacobs, 2003) facilitated positive relationships, including GPs' understanding of residents' preferences. However, in the SCIE practice survey (Brand 2013), it was reported that residents using their own GPs facilitated good relationships between GPs, 'their residents' and the care home staff:

'Dr Andrews is absolutely brilliant. He may not be able to solve all the problems but I am intelligent and I understand him. Only a month ago he discovered why I got paralysed and he was able to discuss it all with me and I now know what it means.' (Resident, Briggs and Bright, 2011, pp 9)

'It used to be that several different GPs were covering our home but now it is one. This is a positive move because they get to know the patients, it saves time and we can build relationships.' (Care home manager, Briggs and Bright, 2011, pp 6–7)

'It is very consistent because I get to know everyone so well whether they have problems or not. I look after people with dementia, and most know who I am but some don't but they are reassured by seeing a familiar face. I can keep people out of hospital. You know what they do and don't want in their old age, and you talk to the relatives as well and you get to know them. No one really wants to go to hospital.' (GP, Briggs and Bright, 2011, pp 7)

'Now the LES [local enhanced service] has brought the whole service together and it is quicker. It really has been amazing for us: good for relationships between GPs and next of kin or friends, and has cut down referrals to hospital. Having someone come in and refer to clients personally has made a difference.' (Care home manager, Briggs and Bright, 2011, pp 7)

'I only see him once a week when he comes to do the rounds – he is a very nice young man and he is very good. He understands you and wants the best for you and listens to what you say. I've been here a year and seen another student doctor but have had no problems with either. Sometimes he is on holiday but it doesn't matter. He always orders the prescriptions monthly or something and they are sent over automatically – he is very [conscientious].' (Resident, Briggs and Bright, 2011, pp 9)

'[The GPs are] very good, they listen to you and they will help you. I see mine for all sorts [thyroid problems and multiple sclerosis] and they give me all sorts of medication. I don't have much pain now. They had to find out about the medication so it took a little time but now it is precise. I can see him when I want to or all the time, depends on how ill I am. Last week, I was calling the night doctor and he was very nice and good to me.' (Resident, Briggs and Bright, 2011, pp 9)

Residents, relatives/carers and care home managers may notice and appreciate it when professionals generally, and GPs specifically, are respectful, sensitive, friendly, understanding and kind in relationships with residents (Briggs and Bright, 2011; The Health Foundation, 2011*; Clarence-Smith, 2009). Conversely they find it distressing when GPs are dismissive, aloof, or disrespectful (The Health Foundation, 2011*).

'[The GP] usually stood some feet away firing questions at my mother and then without giving any further explanation to her would turn to the member of staff and speak with them about what to do next. This would leave my mother asking many questions after they had left the room.... The care staff said this was quite normal practice with visiting GPs.' (Relative, The Health Foundation, 2011*, pp 22)

One relative (a Care Quality Commission [CQC]-trained 'expert by experience') in The Health Foundation study suggested that "Some GPs need further training in how to communicate with older people to give them the respect they deserve..." in the context of medication safety (The Health Foundation, 2011*, pp 22).

It is not just GPs who may be disrespectful with residents. In The Health Foundation study, relatives/carers said that they witnessed care home staff being "brusque" with residents which could put them off taking their tablets (The Health Foundation, 2011*).

Participants in SCIE's practice survey reported that relatives sometimes complained about GP services. Adult protection referrals relating to people in homes had increased, and these included complaints about GPs. Relatives had complained about GPs

prescribing over the telephone without visiting to examine residents, especially for urinary infections.

The voice of residents and relatives, and shared decision making

Studies and reports emphasise the importance of the 'voices' of residents and relatives, and their advocates, in influencing medical and end-of-life care (Thames Valley HIEC, 2013*; BGS, 2011a*; Briggs and Bright, 2011; The Health Foundation, 2011*).

Participants in the SCIE practice survey said that any arrangement between care homes and GPs should primarily aim to meet residents' healthcare needs, rather than suit the GP or the home:

'Every week she [GP] comes to the home and if they [the residents] say yes or no, they are treated the same and that is so unique; she is professional. She is working with clients and relatives because some of them are forgetful and demented and she doesn't go ahead making decisions for them, she consults them and if they say yes and she will refer.' (Care home manager, Briggs and Bright, 2011, pp 7)

One enhanced service scheme, reporting positive resident satisfaction with services, aimed to incorporate residents' wishes in care plans (Thames Valley HIEC, 2013*). The scheme asked residents and families about preferences, recorded these in care plans, made sure they were carried out, and then audited the care given to check whether this had happened. They carried out a 'gap analysis' when outcomes did not follow the plan. However, Thames Valley Health Innovation and Education Cluster (HIEC) reports that shared decision-making with residents does not suit all GPs, for example, where residents' preferences are different from medical views of 'best practice'. They suggest that GPs need confidence and effective communication skills to share decision-making.

Watson et al (2006*) report the lack of a forum for discussion and decision-making that involved nurses, carers, families and GPs in the context of end-of-life care. One care home in the SCIE practice survey suggested that relatives "need to become more involved and be encouraged to participate at whatever level they can", in relation to building multidisciplinary, multiagency care plans. However, in one study, some relatives wanted to "opt out" and "hand over all medical and social responsibility to someone else", as they were fatigued from caring for the resident before they entered the care home (Clarence-Smith, 2009, p 37).

The SCIE practice survey asked care homes to report ways in which they asked residents and relatives about experiences of GP services. Most care homes mentioned quality assurance forms, CQC surveys and residents/relatives meetings, although these often focused on the general home experience rather than specifically on GP services. One respondent said that "the older generation seldom complains". Another noted that residents had never expressed concern about GP services during meetings. Care homes that had received feedback mainly reported it as positive, although one respondent said that surveys "show that the service offered by GPs is not always the best". Two care homes reported that they did not collect residents' and relatives' perspectives on GPs. Another home noted that "residents' expectations are unrealistic so [we] would not consider presenting them", although there were regular meetings with

relatives. A few care homes carried out regular resident satisfaction surveys, and managers thought it would be straightforward to include questions about GP services.

Unfortunately, few studies in this review included residents or relatives as research participants. No evidence was found in the literature that evaluated residents' or relatives' participation in shared decision-making. Similarly, studies included in a systematic review focused on health service-defined problems and outcome measures, and did not explicitly incorporate residents' priorities (Davies et al, 2011).

Sharing information with residents and relatives

Relatives/carers in two studies reported feeling frustrated that they weren't told by care home staff or GPs about important developments in their relatives' care, such as changed medication (The Health Foundation, 2011*; Clarence-Smith, 2009). They weren't involved in shared decision-making, or invited to or updated about GP visits. They said GPs tended to visit care homes when family or carers were not there. Sometimes a pre-admission GP would be happy to share information with a relative, for example, when they took the care home resident to an appointment, treating them as an advocate. Relatives could appreciate this information sharing (Briggs and Bright, 2011). However, the care home might not view the carer's role in the same way and would not share information or take instruction from them.

'Because I was involved in my mother's care with her own GP and psychiatrist they would advise me when visiting that they would be stopping a certain medication, or changing the amount of another. The problem was I was left to speak to the care staff about this and of course they would not be able to act on what I said. Therefore until written confirmation was received from the GP or psychiatrist the medication would still be given to my mother.'
(Relative, The Health Foundation, 2011*, pp 20)

'... sometimes she [GP] will call me to inform me about changes they make to her care plan because my grandma is very fragile at the moment.' (Relative, Briggs and Bright, 2011, pp 10)

Relatives of care home residents with dementia were unclear or ill informed about the roles of primary care and other health professionals, for example, about how the care home made a decision to ask a GP to visit (Clarence-Smith, 2009).

Factors predominantly under control of GPs or the NHS

General Medical Services contract, registration of care home residents, and payment of retainer fees

Two reports suggest that standard GP agreements and NHS remuneration may not allow for GPs' additional workload as a result of care home residents' higher healthcare needs (BGS, 2011a*; Jacobs, 2003). Retainer fees paid by care homes to GPs may secure standard primary care services which residents are already entitled to on the basis of the General Medical Services (GMS) contract between GPs and the NHS,¹ including registration and visits on request (BGS, 2011a*; Patterson, 2009*).

Current practice

Visits

Care home managers, relatives/carers and authors report that some GPs may not visit care home residents on request or may be reluctant to do so (Gage et al, 2012*; The Health Foundation, 2011*; Wild et al, 2010; Patterson, 2009*; Seymour and Froggatt, 2009; National Council for Palliative Care and National End of Life Care Programme, 2007*; Jacobs, 2003; Glendinning et al, 2002; SCIE practice survey).

'GPs in this area generally do not like to visit and prefer to diagnose over the phone, which we find unacceptable. We really struggle to get them to visit their patients.' (Care home manager, Gage et al, 2012*)

The overall picture may be more promising. In a nationally representative survey of 570 care home proprietors and managers (75 per cent response rate), with data collection over 10 years ago, 82 per cent of care homes had visits during surgery hours on request by all their GPs, 93 per cent by some of their GPs, and 7 per cent by no GPs (Glendinning et al, 2002). Many care home managers or owners in the linked qualitative study said they had no problems overall with obtaining GP visits on request, which one manager attributed to not asking GPs out unnecessarily:

'We never seem to have a problem and I think this has been built up by the relationship with the surgeries. Very rarely have we called a GP out and it's not been needed. We do, particularly our permanent people, we do know them, we do recognise changes, although we're not medically trained, so we're very quick on picking up urine infections. [So we] phone up and say, "Can we send up a urine sample?" and nine times out of ten it is an infection. So we never get refused or have any problems having a

¹ See www.gov.uk/government/publications/standard-general-medical-services-contract for the contract, published on 11 April 2013.

GP out.' (Care home manager/owner/matron, Jacobs, 2003, pp 116)

Retainer fees

One national survey of 89 care homes (Gage et al, 2012*), with a 16 per cent response rate, reports that 8 per cent of homes pay retainer fees to GPs. Another national survey (Glendinning et al, 2002) (with data collection over 10 years ago) reports that 9 per cent of homes (more likely to be nursing homes and larger homes) paid one or more local GPs for medical services to residents or specifically for visits, but this may include enhanced services. The total amounts paid by each home (Glendinning et al, 2002) ranged from under £500 to over £5,000 a year (modal response was £1,000–1,999 response category). Sixty-four per cent of the care homes paying some or all of their visiting GPs said payments covered visits on request to the home during surgery hours. About the same proportion (65 per cent) said they covered visits on request out of surgery hours.

Registration and prescriptions

Care home managers and GPs (Jacobs, 2003; see also Patterson, 2009*) reported that GP practices, including those with open lists, would sometimes not register care home residents (including existing patients moving into a care home) within their catchment area. They placed restrictions on list sizes and/or the number of workload-intensive, expensive, high-need patients. GPs made decisions on the basis of their judgements of the quality of care given by a home, in particular whether the care home was known to "create a lot of workload" (Jacobs, 2003, p 115) for GPs (for example, based on past experience on working with that home); the resident's needs and associated expense; the likely duration of the arrangement; and whether the GPs had other residents registered in the same care home (Jacobs, 2003). So the real extent of residents' choice of GP could be limited.

'If they have a real preference, you know, if relatives are with that GP they usually take them. But they tend to take them in rotation. You know, we have to go round to the GPs and say well, "Yeah we'll take this one but leave it for a bit", you know. So it just depends if there's vacancies or if they're prepared to take them so it's really down to the GPs not the residents which GP they get.'
(Care home manager/owner/matron, Jacobs, 2003, pp 115)

Respondents in the SCIE practice survey said that some GPs provided prescriptions for liquid foods and dietary supplements for specific residents, particularly those with dementia, where they were felt to significantly contribute to health. Other GPs would not prescribe these, taking the view that they did not fall within the definition of medication for which the NHS was responsible, and should be funded by the home.

Performance-related GP incentive payments (Quality and Outcomes Framework) as a barrier to equity and quality care

Care home residents in a comparative large-scale analysis of GP records were more likely than older people living in the community to be identified by their GP as unsuitable or non-consenting for all Quality and Outcomes Framework (QOF) indicators for a condition (that is, disease-wide exceptions). This enabled them to be excluded from

targets which needed to be achieved for GP incentive payments, for example, 34 per cent for stroke (17 per cent in community), and 35 per cent for diabetes (9 per cent in community), meaning that GP practices could obtain higher remuneration in care homes (Shah et al, 2011). The study concludes that use of exception reporting 'may compromise care for vulnerable patient groups', such as older people in care homes (Shah et al, 2011, p 1). However, it also states that 'high attainment of some indicators [related to incentive payments] shows that pay for performance systems do not invariably disadvantage residents of care homes compared with those living in the community' (pp 1).

Retainer fees as a barrier to equity

Several studies refer to inequity created by retainer fees (Gage et al, 2012*; Patterson, 2009*; Jacobs, 2003). The English Community Care Association (ECCA) argues that registration and visits do not constitute enhanced services and should be free of charge under the terms of the General Medical Services (GMS) contract at the time of writing (Patterson, 2009*). In a national survey of residential care homes (Gage et al, 2012*), comments about retainer fees were all negative, for example:

'Personally I do not think any care homes should pay a retainer, service users have a right to basic medical care and it's not right that care homes should pay for this. They would get this care free of charge in their own homes and frankly a care home is their home.' (Care home, Gage et al, 2012*)

Jacobs (2003, p 118) discusses that, as small businesses, 'homes may be forced to recoup the costs of GP payments in fees to residents'. About a third of residents funded their own care home place at the time of writing, and the profit may subsidise state-funded residents. So, self-funding residents contribute towards the cost of general medical care, which is provided free of charge to others. The evidence base informing discussion is not stated.

Primary Care Trusts have had the potential to enforce national agreements with GPs, but may not have done so actively

Some primary care trusts (PCTs) have been aware that some GPs charge retainer fees to care homes for visiting residents, or refuse to register and visit care home residents without a retainer fee (Patterson, 2009*). Just over 60 per cent of a small sample of responding PCTs (20 per cent response rate) said that the practice of GPs charging retainer fees should be abolished. One PCT said that they will always investigate evidence that practices with open lists refuse to take residents from care homes, if alerted to it, as it is against GP contract terms to decline new registrations without reasonable grounds (Patterson, 2009*).

There are examples of PCTs investigating evidence that GPs have acted against the terms of their contract, and of actively enforcing the contract. However, this is reported as uncommon (Patterson, 2009*). Only about 10 per cent of a small sample of responding PCTs said that they have policies or issued guidance to GP practices on when it is appropriate to charge retainer fees (Patterson, 2009*, with a 20 per cent response rate).

The CQC asked PCTs about enforcing the GMS contract as part of 'special review' inspections (CQC, 2012*; BGS, 2011b). Twenty-eight per cent of PCTs said they took action, but only eight PCTs talked to care homes or relatives. This was a small random sample of care homes in a purposively selected sample of PCTs, including homes for adults with learning disabilities.

This research was carried out before the recent changes to arrangements for local healthcare commissioning.

GPs altering or responding to indicators for Quality and Outcomes Framework

One enhanced service provider accepted that it is clinically appropriate for some care home residents to score lower on certain Framework targets but highly on dementia and palliative care registers (Thames Valley HIEC, 2013*). Donald et al (2008) mention modification of the QOF locally, for example, with a changed set of indicators, but it is not known whether this practice is more widespread.

GPs' decisions about residents who move outside practice boundaries

Older people may move out of their GP's catchment area when they enter a care home, especially in rural areas (Jacobs, 2003). GPs can decide whether to keep such residents, so maintaining continuity in medical care. Some GPs have strict practice boundaries (Jacobs, 2003; SCIE practice survey). Others are flexible and go 'out of their way to ensure continuity', for example, for terminally ill residents (Jacobs, 2003, p 114). When making decisions, GPs considered the likely duration of the arrangement, whether they had other patients in the care home, and judgements of the likely impact of the quality of care in the care home on workload:

'This problem came up last week. Chap who has a terminal illness, he's admitted to hospital, diagnosed as being terminal, been sent from a rest home to a full-time sort of nursing home outside of the area. Would we like to keep him? We sat down and discussed that, what the prognosis was, what the home is like, in terms of have we had any problems with them before? Do we know that they're competently run? And we got back to them and said that we would be happy to take him on, but if he's going to, if it looks as if he's going to be going for more than a month or two, we're probably not happy to.... We understand that he's got a terminal illness, but if it's not within the foreseeable, next couple of months, it's probably wisest if a local doctor took it, and got to know him.'
(GP, Jacobs, 2003, pp 115)

A: 'I've had one recently came. Now her GP in fact doesn't want to change. He said he'll come and see her, he's the only one and he's out of the area.' Q: 'But he's prepared to travel over?' A: 'Yes, because she's over 90 and he's, she's always been under him and he said, "There's no way, I'll come to keep an eye on her, I would like to come".' (Care home manager/owner/matron, Jacobs, 2003, pp 114)

It can be a problem for older people having short-stay or respite care in a care home, as re-registering a patient can be problematic (Jacobs, 2003; SCIE practice survey).

'I mean I've got one gentleman from X [name of town], and I, I've had awful problems with that surgery ... but he, he came here and the surgery's only in X, and this end of X, so it's only three miles away. I went in there, "Oh we can't keep prescribing to this man because he's out of our area". "No the doctor won't come and see him you need to re-register", because at the time he was only here for respite care. I tried to explain, I said, "Well he may only be here for three or four months, it's just a, a trial period, so rather than change GPs could you just keep him on?" "No", it was quite adamant, "And we won't be doing the GP prescriptions any more".'
(Care home manager/owner/matron, Jacobs, 2003, pp 114)

Recommendations in the literature

ECCA's *Can we afford the doctor?* cited by Patterson(2009) recommended that PCTs, the British Medical Association (BMA) and the Department of Health (DH) should agree, first, what primary care services constitute enhanced services, and so should be paid for by the care home, and second, what services should be provided free of charge to the care home under the GMS contract (Patterson, 2009*). According to Patterson (2009), ECCA believes that (i) GP practices should only expect to receive retainer fees if they have negotiated with a care home for a specified range of services outside the scope of contracted medical primary services; (ii) PCTs must be made aware of the existence of GP retainers to care homes; (iii) PCTs should play a major role in ensuring that GP practices adhere to the regulations and terms of their contracts; and (iv) PCTs should develop nationally agreed guidelines on what services constitute enhanced rather than basic services. They also argue that if retainer fees are to be paid by a home, a fair tendering process should take place to prevent inflated charges by GPs.

Similarly, SCIE practice survey participants said that a clear, simple protocol or agreed definition, at national or county level, was needed to describe what services should be on offer from every GP.

Jacobs (2003, p 118) argues for 'a revised weighted capitation system of GP funding by the NHS that takes into account, not only the age of patients, but also the additional workload involved for GPs visiting care homes'. Shah et al conclude that 'the Quality and Outcomes Framework and other pay for performance systems should monitor attainment and exception reporting in ... residents of care homes' for disease areas that are incentivised by the Framework (Shah et al, 2011, pp 1).

GP capacity and workload

Two reports and two studies mention high GP workloads as a result of work in care homes. The reasons are home visiting with travel time, being called out inappropriately, inexperience of care home staff and poor quality of care homes, and the complexity of residents' health and illnesses (Riley and Simon, 2012*; BGS, 2011a*; Briggs and Bright, 2011; Jacobs, 2003). In a survey of GPs, 68 per cent of GPs said that care home work was a major source of stress (BGS, 2011a*).

Other studies mention GPs' limited capacity to work with care homes and their residents (Gladman, 2010; Seymour and Froggatt, 2009; Winstanley and Brennan, 2007*). Examples are in weekly monitoring of the impact of reducing or changing complex

medications following medication review (Winstanley and Brennan, 2007*), and in end-of-life care (Gladman, 2010). In case studies, GPs said that they wished to work effectively with nursing homes but were concerned about “repeated calls on their time” (Seymour and Froggatt, 2009).

High workloads and limited capacity can affect GPs’ willingness to register care home residents, and provide preferred practice care and extended services (BGS, 2011a*; Jacobs, 2003) as well as all aspects of medical care (Gladman, 2010; Seymour and Froggatt, 2009). However, some GPs think that extended service contracts can recognise additional workloads (Jacobs, 2003).

This issue is not specific to GPs. In a survey of 584 Royal College of Nursing (RCN) members working in care homes (7 per cent response rate), some survey respondents mentioned that staff shortages of professionals in other sectors could cause difficulties when initiating partnership working (RCN, 2012*).

GP workloads can be decreased or increased by scheduled visits and weekly surgeries (see ‘Regularly scheduled GP visits and surgeries in care homes’ later in this report), care homes developing a wider supportive network through multidisciplinary PCT meetings (Seymour and Froggatt, 2009), shared management with secondary care (BGS, 2011a*), and nurses and pharmacists ‘substituting’ for GP roles (Winstanley and Brennan, 2007*; Jacobs, 2003). However, in a study of upskilling care home staff, only one home reported that this practice had decreased GP workload (Wild et al, 2010).

GP interest, leadership and persistence

Lack of interest

In qualitative studies, surveys and case studies, care home staff, relatives/carers and study authors report:

- individual GPs’ refusals or reluctance to visit on request (Gage et al, 2012*; The Health Foundation, 2011*; Wild et al, 2010; Patterson et al, 2009*; Seymour and Froggatt, 2009; National Council for Palliative Care and National End of Life Care Programme, 2007*; Jacobs, 2003; Glendinning et al, 2002; SCIE practice survey)
- GPs’ lack of interest in the medical care of care home residents (Wild et al, 2010; Clarence-Smith, 2009)
- GPs’ lack of interest in end-of-life planning and regular reviews and/or lack of interest in providing anticipatory care and medication, medical equipment (for example, syringe drivers and venepuncture kits), and other services to care homes, or working in partnership with care homes (RCN, 2012*; Seymour and Froggatt, 2009; Turner et al, 2009; National Council for Palliative Care and National End of Life Care Programme, 2007*; Watson et al, 2006*; SCIE practice survey).

Donald et al (2008) comment that most doctors interested in older people are likely to train as geriatricians rather than GPs, although they do not cite specific evidence to support this. Participants in the SCIE practice survey raised the issue of ageism in the

NHS. They thought that some professionals could be reluctant to give adequate support to an older person, either because they lacked expertise with older people, or because they believed there was little benefit because of their age.

GPs in the same local area vary in interest and helpfulness. One care home worker responding to the SCIE practice survey said in relation to residents using their own GP that "Sometimes it is outstanding and sometimes it is difficult." Another care home worker reported that two local GP practices were better to work with, more proactive and more supportive of active end-of-life planning than others in the area.

This perceived lack of interest by some GPs is reported to be a barrier to consistent provision of services and high-quality medical care for residents, and can contribute to inappropriate hospital admissions. Lack of interest also contributes to care home staff being reluctant to involve GPs or ask them to visit (reported by relatives/carers in The Health Foundation, 2011*), and difficulties in implementing initiatives, for example, end-of-life pathways (Turner et al, 2009; Watson et al, 2006*; SCIE practice survey). One report states that lack of interest contributes to GPs' reluctance to take on preferred practice arrangements, although gives no specific evidence for this (BGS, 2011a*).

'GPs in this area generally do not like to visit and prefer to diagnose over the phone, which we find unacceptable. We really struggle to get them to visit their patients. It takes months for medication changes to be reflected on repeat prescriptions. Medication reviews only happen at our request apart from one surgery which is very proactive.' (Care home manager, Gage et al, 2012*)

'Getting GPs on board has been very difficult in some practices. They give the impression they are interested but when it comes to it they don't actually ... they haven't wanted to participate in the information and things that are organised. We find that they don't even know themselves what they are doing ... some practices are very good and others haven't been very supportive at all.' (Key champion, Watson et al, 2006*, pp 238)

However, despite these negative comments, care home staff also express satisfaction in surveys and qualitative studies with services and support provided by GPs, or their relationships with GPs, or report that GPs do visit when asked to (Gage et al, 2012*; Ong et al, 2011; Gladman, 2010; Wild et al, 2010; Seymour and Froggatt, 2009; Jacobs, 2003; Glendinning et al, 2002; SCIE practice survey). In one small-scale survey with a 46 per cent response rate, 97 per cent of responding care home managers reported that they received 'some' or 'a lot of' support from GPs, which was higher than reported for other professionals and agencies (Seymour and Froggatt, 2009).

Leadership from GPs

Several studies note the importance of leadership, persistence and proactivity from GPs in relation to the care of individual residents (Briggs and Bright, 2011; The Health Foundation, 2011*; Gladman, 2010; Barber et al, 2009; Evans, 2009*; Jacobs, 2003; SCIE practice survey). Examples include persistent monitoring and chasing up referrals and applications for equipment (Briggs and Bright, 2011); providing oversight of chronic

long-term conditions (Gladman, 2010); coordinating care from other health professionals (Evans, 2009*); and maintaining continuity of care for a resident who had moved out of his practice area (Jacobs, 2003).

'Excellent, we are lucky to have somebody who is aggressive in the good sense of the word. She [GP] covers the bases and tells us what we need to do if we need direction, there are rarely gaps.'
(Care home manager, Briggs and Bright, 2011, pp 8)

GPs may also show leadership in relation to the care home as a whole, or locally across care homes. One GP describes local innovative practice (in relation to older people in care homes) that the GP is involved in or helped to initiate (Evans, 2009). One care home suggested that GPs could advertise their services better, for example, with leaflets sent to care homes (SCIE practice survey). An evidence-informed report (Riley and Simon, 2012*) makes the case for enhanced GP training providing GPs with, first, better organisational skills to ensure that medication review and chronic disease management occur for people living in residential care; and second, the 'flexibility to explore and assist with commissioning new working practices that could improve medical services to care homes' (Riley and Simon, 2012*, pp 79).

Another study concludes that a lead GP needs to take a leadership role in making sure that medications are reviewed, for example, by liaising with other GPs, and possibly commissioning services, and that this role would need protected time and funding (Barber et al, 2009). A relative in another study makes a similar point (The Health Foundation, 2011*). Evans (2009), a GP, describes in his paper the development of a GP Practice to Care Home Alignment preferred practice model in their area (Peterborough) in which named GPs coordinate care and take responsibility for residents' long-term medical needs, rather than different GPs in the practice visiting the home each time (Evans, 2009*). At the time of writing, work was in progress on a draft Service Level Agreement, with funding attached, for a key practice for each care home in Peterborough.

GP administration and reception arrangements

Care homes in one study could perceive GP practices as inflexible, for example, with the times of day during which they allowed homes to request visits:

'We do have problems. Especially if you don't ring up, you know, if you have somebody like for example whose conditions deteriorated in the afternoon, or after the ten o'clock deadline where they want you to ring for that day.' (Care home manager/owner/matron, Jacobs, 2003, pp 116)

Other homes had experienced arguments with GP receptionists, who they perceived as a major barrier to access to GPs (Jacobs, 2003). A care home participating in the SCIE practice survey described "over-enthusiastic gatekeeping", for example, lengthy discussions with receptionists, making it hard to maintain communication with GPs:

'I don't have any problems with the two GPs that come regular, I phone, they come out. I can phone other GPs and I've got a process of probably half the morning arguing with receptionists'

before I actually get the GP and then arguing with the GP. I've had a GP in this morning who I requested on Monday, we're now Friday, who I had quite strong words with on the phone with on Monday.' (Care home manager/owner/matron, Jacobs, 2003, pp 116)

Care homes find it useful to develop good working relationships with GP practice staff other than GPs themselves, such as receptionists, as these links can facilitate quick and effective handling of their calls about residents (Turner et al, 2009; SCIE practice survey).

Training and skills enhancement for GPs

Care home staff, relatives and trainee GPs report variable or inadequate GP skills in some areas (BGS, 2011a*; The Health Foundation, 2011*; Seymour and Froggatt, 2009). Studies found, for example, that some GPs lack skills to communicate respectfully with older people (The Health Foundation, 2011*) or recognise the dying process (Watson et al, 2006*). Others lack confidence about their knowledge of residents and of medication used in end-of-life pathways (Seymour and Froggatt, 2009). One evidence-based report states that some GPs will not accept responsibility for care home residents because they lack interest or expertise (BGS, 2011a*).

In 2000, the London Royal College of Physicians, the RCN and the British Geriatrics Society (BGS) considered interdisciplinary working in care homes and recommended specialist GP services for older people in homes (Szczepura et al, 2008*). According to Donald et al (2008), dedicated primary care services, for example, enhanced service schemes, need doctors who are expert 'care home specialists' to deliver high-quality medical care. However, a barrier to care home medicine as a specialism for GPs may be that most doctors interested in older people are likely to train as geriatricians (Donald et al, 2008).

A relative/carer talked about a care home which paid for a regular weekly visit from a GP specialist in dementia who could advise on issues across the home, even where residents had stayed registered with their family GP (The Health Foundation, 2011*). One PCT-created enhanced service scheme included a GP specialist in geriatrics (Donald et al, 2008; see also Thames Valley HIEC, 2013*).

Riley and Simon (2012*) make the case (informed by an evidence-informed analysis of challenges in the health service) that 'enhanced GP training' will improve GPs' skills for working with care homes and residents, by:

- better clinical knowledge to better manage healthcare problems
- improved communication skills to facilitate teamworking with nursing home staff and to reduce medication errors
- organisational skills to make sure that medication review and chronic disease management occur
- 'flexibility to explore and assist with commissioning new working practices that could improve medical services to care homes' (Riley and Simon, 2012*, pp 79).

In one study, trainee GPs reported “no specific education or training in care home medicine or practice” (Gladman, 2010, pp 13). Yet one participant in the SCIE practice survey reported that a GP practice arranged for every GP trainee to spend time in a care home learning about residents’ care.

Out-of-hours and locum GP services

In a nationally representative survey of 570 care home proprietors and managers (Glendinning et al, 2002), with data collection over 10 years ago, 78 per cent of care homes had visits out of hours on request by all their GPs, 93 per cent by at least some of their GPs, and 7 per cent by no GPs.

However, more recently, research participants report difficulties with GP out-of-hours services for care homes (RCN, 2012*; BGS, 2011a*; Ong et al, 2011; The Health Foundation, 2011*; Wild et al, 2010; Seymour and Froggatt, 2009; SCIE practice survey), including:

- lack of communication (SCIE practice survey)
- lack of out-of-hours visits to the care home (SCIE practice survey and other studies)
- lack of knowledge of residents (SCIE practice survey; The Health Foundation, 2011*; Wild et al, 2010)
- difficulties in obtaining medication (Seymour and Froggatt, 2009), linked to a lack of anticipatory prescribing by GPs (Seymour and Froggatt, 2009)
- having no access to adequate medical records (see ‘Record keeping, information sharing and use of technology’ later).

One care home in the SCIE practice survey highlighted the lack of an out-of-hours service or crisis team for residents with dementia. The respondent reported health services’ perception that these residents were already in a safe place, but was concerned that this assessment didn’t take into account the needs and safety of other residents.

Qualitative studies report inappropriate hospital admissions, and harm caused by prescribing errors, as a result of the actions of out-of-hours services and other doctors who do not know residents’ medical histories (Briggs and Bright, 2011; Ong et al, 2011; The Health Foundation, 2011*; Gladman, 2010; Wild et al, 2010; Barber et al, 2009; Seymour and Froggatt, 2009).

‘... emergency call-out doctors do not know residents, so play safe and order them to be admitted to hospital for many conditions which could perhaps be resolved differently.’ (Resident, Wild et al, 2010, pp 21–2)

‘Although my mother’s medical records were clearly marked “No codeine” both at the surgery and the care home, GPs still kept prescribing them and the care home would either not see this in her records or chose to ignore it and give her the tablet. Several times over the years we had to make it clear ... [but] it happened

again and again. When my mother was given this she became extremely ill which on one occasion resulted in her having to go to hospital. This would happen more when out of hours GPs visited who were unaware of her medical history. (Relative, The Health Foundation, 2011*, pp 5–6)

Enhanced service schemes (see 'Local enhanced service [LES] schemes' later) commonly specify out-of-hours GP support, either providing their own service, or linking to local services. In one scheme, at night and over weekends, a GP was available on the telephone to advise care homes on care plans (Thames Valley HIEC, 2013*). Usual out-of-hours GP services were available if a resident needed a GP visit. GPs may use the telephone, fax and email out of hours to maintain contact.

Care home staff value out-of-hours support from their own GP, and GPs also value the support they provide (Briggs and Bright, 2011). In one study, the GP saw it as her responsibility to prevent difficulties with out-of-hours support (Seymour and Froggatt, 2009). This GP tried to pre-emptively prescribe medication before weekends, but this "did not always provide the solution to unexpected problems among residents" (Seymour and Froggatt, 2009, pp 22). In another study, the GP updated out-of-hours services during days leading up to a resident's death (Turner et al, 2009). An evaluation of an enhanced service scheme found that positive working relationships between GPs and care homes enhanced GPs' willingness to go the 'extra mile', stay late, provide out-of-hours advice, and sometimes make their own out-of-hours visits (Briggs and Bright, 2011).

'We are lucky in the sense we have Dr Simmons, and we cannot complain one dot on her, she is excellent. Whenever we phone her out of hours, she advises us.' (Care home manager, Briggs and Bright, 2011, pp 7)

'We have brilliant communication. Although we are just around the corner, they [care home staff] have access to my out-of-hours number, my direct line, and fax number. They tend to fax requests across outside regular visits but also they fax for medication and dressing. It all works very well.' (GP, Briggs and Bright, 2011, pp 8)

To reduce use of locum GPs, relatives/carers suggested that two GPs could work on a rota to cover for illness and holidays. Where use of locums was unavoidable, the regular GP could follow up with a visit the next day to give continuity of care (The Health Foundation, 2011*).

Commissioning bodies' leadership and support

Participants at a seminar of independent sector care homes and wider NHS and social care discussed that local NHS bodies and commissioners (not specifically GPs) need to understand the potential added value offered by closer relationships with care homes, and provide support for these relationships (Owen et al, 2008*). In one study, care home staff attended multidisciplinary end-of-life strategy meetings in the PCT taking place in local GP surgeries (Seymour and Froggatt, 2009). As a result, they developed support from a wider network, which reduced reliance on GPs. However, another care home in the same study reported that staff were not invited to multidisciplinary PCT

meetings even though the care home manager had asked for this several times. The staff felt isolated from wider end-of-life care practice.

A study of end-of-life care concludes that ‘SHAs and PCTs need to examine how care homes in their area receive GP support, and to develop a strategic approach to ensuring that care home residents who are approaching the end of life receive consistent and coordinated medical care within their place of residence from a doctor who is familiar with them and their needs’ (Seymour and Froggatt, 2009, p 40). Similarly, Barber et al (2009) conclude that primary care services should be provided where patients live, rather than patients accessing care at local centres. This would not disadvantage care home residents and people who could not travel.

More specifically, BGS (2011a*, pp 4) argues, on the basis of evidence review, surveys and qualitative research, that a healthcare service specification for care homes should ‘guarantee a holistic review for any individual within a set period from their move into a care home, leading to healthcare plans with clear goals. This will guide medication reviews and modifications, and clinical interventions both in and “out of hours”’. The report says that health commissioners need to plan for older people in care ‘to reduce unplanned admission to hospital care services and inappropriate interventions at the end of life’ (p 30), using partnership with care homes and social care professionals. Shared information, assessments, policies, training and learning would support quality improvement and clinical governance.

There is also evidence in the literature (see ‘General Medical Services contract, registration of care home residents, and payment of retainer fees’, ‘Local enhanced service [LES] schemes’ and ‘Preferred practice arrangements’) relating to:

- PCTs’ role in enforcing the GP contract for basic services to care home residents (especially in the context of retainer fees), and providing policies and information relating to the GP contract
- PCTs providing or facilitating enhanced service schemes and preferred practice arrangements (for example, dedicated GP practices for care homes).

This research was carried out before recent changes to arrangements for local healthcare commissioning by GPs. One study proposes that a lead GP for each care home would liaise with other GPs and ensure, possibly by commissioning services, that patients on riskier medicines are appropriately monitored and that a pharmacist regularly reviews all patients’ medication (Barber et al, 2009). A report argues that enhanced GP training would provide GPs with the ‘flexibility to explore and assist with commissioning new working practices that could improve medical services to care homes’ (Riley and Simon, 2012*, pp 79).

Interventions and models

Local enhanced service (LES) schemes

Enhanced services are primary medical care purchased in addition to the standard GP service provided under the GMS contract between GPs and the NHS. This happens either because ‘the activity concerned is not part of standard services, like scheduled (rather than request) visits, or because it increases the frequency of an existing activity like medication reviews’ (BGS, 2011b*), or to buy in specialist GP input. The research described below was carried out before the recent changes to arrangements for local healthcare commissioning.

Current practice

In some areas, PCTs have paid fees for enhanced services by contracting with GP practices (BGS, 2011a* and b*; Patterson, 2009*). Just over half (51 per cent) of PCTs in a national census of PCTs reported that they provided an enhanced service for one or more activities (specifically health assessments, regular visits, support with end-of-life planning, general support, liaison with healthcare professionals, additional medication reviews), with 5 per cent covering all seven activities, and 19 per cent covering just one activity (BGS, 2011b*). Thirty-five of these PCTs also used the contract enforcement option for at least one of these activities, that is, they considered the activity fell within the standard GP contract rather than constituting an enhanced service. While about a quarter of enhanced services covered all homes and funding arrangements, most did not. Enhanced service agreements can involve specified standards and formal monitoring (BGS, 2011a*; Patterson et al, 2009*).

Care homes may also pay GPs directly for enhanced services such as regular scheduled visits, surgeries and reviews; specialist advice; and the occupational health of care home staff (The Health Foundation, 2011*; Jacobs, 2003). In a nationally representative survey of 570 care home proprietors and managers, with data collection over 10 years ago, 9 per cent of homes (more likely to be nursing homes and larger homes) paid one or more local GPs for medical services to residents, but this included retainer fees for standard services, not just enhanced services (Glendinning et al, 2002). Homes paid total amounts ranging from under £500 to over £5,000 a year (modal response £1,000–1,999). Three-quarters of homes paying GPs had a formal contract with the GP or practice. Homes paying local GPs were more likely to receive additional services over and above GPs’ core contractual obligations than those not paying GPs, ‘although there was no relationship between the amount paid and the number of additional services received’ (Glendinning et al, 2002, p547). Regular medical and medication reviews, and regular home-based surgery consultations, were significantly more likely to be provided to homes that paid GPs than homes that did not. After controlling for whether a home paid a GP, home type and size were non-significant predictors of services received.

Practice examples

Descriptions of enhanced service schemes can be found in Briggs and Bright (2011), NHS West Midlands (2011*), Patterson et al (2009*), BGS (2011a*), Thames Valley HIEC (2013*) and Donald et al (2008). GPs and/or other GP practice staff may deliver

enhanced services on their own, or GPs and GP practice staff may work with other health and social care practitioners in a multidisciplinary team. Elements of enhanced service schemes reported in this literature include:

- anticipatory/proactive care, care plans, reviews and assessments, active case management and developing and/or signing off care plans, end-of-life pathways and Do Not Attempt Resuscitation (DNAR) forms: these may include assessments on admission and/or routine reviews at regular intervals and/or assessments to identify residents at highest risk, or residents with highest potential benefit if referred to other services
- medicines management, including regular medication reviews
- scheduled regular (for example, weekly) GP visits or clinics
- out-of-hours services (for example, bank holidays) such as GP telephone support
- specialist input in chronic disease management, end-of-life care/palliative care and dementia care
- arranging input from and team networking with secondary health services
- developing policies and procedures; general support and training for care homes in, for example, medicines management and record keeping; the occupational health of care home staff; and medical record keeping.

SCIE practice survey participants reported different ways of making contact with enhanced service scheme GPs, including through a Single Point of Access team (a central triaging system).

One enhanced service scheme had responding to service users' preferences as a core principle. Staff asked residents and their families how they want to be treated, recorded preferences in care plans, ensured they were carried out, and audited care to confirm that actions had been taken (Thames Valley HIEC, 2013*).

Care homes can procure enhanced services themselves. In one example, as reported by a relative/carer, a home paid to contract a GP specialist in dementia to visit each week. The GP advised on issues across the home, although some individual residents stayed registered with their own GP (The Health Foundation, 2011*).

PCTs or care homes may commission GPs and nurses (sometimes also pharmacists, other primary and secondary care services) to work solely in enhanced service schemes for care home residents (Thames Valley HIEC, 2013*; BGS, 2011a*; Patterson et al, 2009*; Donald et al, 2008). Patterson (2009*) describes a dedicated GP practice in a large care home. It is funded directly by the PCT, and the GP practice pays rent to the care home. These GP practices may incorporate dedicated administrative staff, as well as implementing prescribing technology and clinical records in care homes. Residents may choose to opt out of the dedicated service and use their own GP (Thames Valley HIEC, 2013*; NHS West Midlands, 2011*; Donald et al, 2008).

Costs

Donald et al (2008) comment that dedicated medical practices for care homes are expensive, and their cost-effectiveness is not known. The cost of providing doctors, nurses, administration and IT support in one dedicated enhanced service practice was calculated as £650 per resident. It was suggested that per resident costs could reduce with economies of scale if the urgent intervention team were to provide care to more residents with the same number of staff (Thames Valley HIEC, 2013*).

Barriers to providing enhanced services

Approximately one-quarter (26 per cent) of PCTs in a national census reported that they did not provide enhanced services and regarded the standard GP contract as sufficient for at least one of the specified activities (health assessments, regular visits, support with end-of-life planning, general support, liaison with healthcare professionals, additional medication reviews) (BGS, 2011b*). About two-thirds of PCTs did not think that care home residents needed additional medication reviews or had not considered the matter. The equivalent figure for specialist assessments was 68 per cent of PCTs, assessments on admission 57 per cent, regular visits 41 per cent, end-of-life planning 51 per cent, general support 41 per cent and liaison with other healthcare professionals 42 per cent.

Measured outcomes of enhanced service schemes, and cost savings

Studies and evaluations report beneficial outcomes of extended service schemes:

- reduction in emergency hospital admissions or fewer deaths in hospital (Thames Valley HIEC, 2013*; BGS, 2011a*; Briggs and Bright, 2011; NHS West Midlands, 2011*; Donald et al, 2008)
- reduction in A&E attendances (BGS, 2011a*)
- reduced use of emergency care practitioners (BGS, 2011a*) and district nurses (Donald et al, 2008)
- reductions in prescribing costs and decreased dosages of antipsychotic drugs (Thames Valley HIEC, 2013*).

Evaluations report that reductions in hospital admissions or deaths in hospital can result in cost savings, ranging from £145,000 (gross saving) per annum for 500 care home beds taking part in a small-scale pilot scheme (BGS, 2011a*) to £18,000 (gross saving) per annum for one care home (net saving £3,000, taking into account cost of extended services) (Briggs and Bright, 2011). One site reports that reductions in prescribing costs result in cost savings, with over £200 per resident (£85,000 per annum overall) projected for the scheme annually (Thames Valley HIEC, 2013*).

The evaluation designs and methodologies underlying these claims of measured outcomes and cost savings are not always clear. None of these evaluations are controlled studies, although the NHS West Midlands evaluation used an unmatched comparison group of care homes that did not have extended services or proactive community health support. Most of these evaluations appear to comprise before/after comparisons over time. This means that attribution of outcomes to the enhanced service schemes can only be tentative.

Perceived/reported outcomes of extended service schemes

It may be difficult for respondents in qualitative research studies to disaggregate the impacts of enhanced service payments or retainer fees from commonly associated variables such as preferred practice arrangements, medication reviews and regular scheduled visits/surgeries. In the nationally representative survey of 570 care home proprietors and managers, with data collection over 10 years ago, a fifth of homes that paid a GP explicitly encouraged new residents to register with that GP, compared with only a tenth of homes that did not pay GPs. Paying for GP services was a significant predictor of residents registering with a 'home GP' (that is, constituting a preferred practice arrangement; $p=0.032$), but was not statistically significant after controlling for home size. Care homes that encouraged residents to register with the 'home' GP were significantly more likely to receive all five services (53 per cent; base 129) than those that did not (29 per cent; base 1,099) (Glendinning et al, 2002).

Residents and relatives in qualitative studies report positive outcomes from enhanced service schemes. For example, in an evaluation of a pilot Sheffield PCT scheme, 94 per cent of care home residents said that the GP service gave them the help they wanted and needed, 84 per cent of residents said that they felt they received better care with the new GP service, and 97 per cent of family members said that the resident received better care (BGS, 2011a*). In another evaluation of a scheme, while most residents could not accurately remember the frequency of GP visits, they liked that they could talk to the same person, understand their medical issues and feel that their concerns were heard (Briggs and Bright, 2011).

In a third evaluation of an extended service scheme, residents and families reported (sometimes high) satisfaction with the GP service, although it isn't clear what their level of satisfaction would be with standard GP services (Thames Valley HIEC, 2013*). When they have a choice, it is reported that a high proportion of residents choose to use extended service schemes (Thames Valley HIEC, 2013*; NHS West Midlands, 2011*; Donald et al, 2008), for example 95 per cent (Thames Valley HIEC, 2013*) or 85 per cent (Donald et al, 2008).

[The GPs are] very good, they listen to you and they will help you. I see mine for all sorts [thyroid problems and multiple sclerosis] and they give me all sorts of medication. I don't have much pain now. They had to find out about the medication so it took a little time but now it is precise. I can see him when I want to or all the time, depends on how ill I am. Last week, I was calling the night doctor and he was very nice and good to me.' (Resident, Briggs and Bright, 2011, pp 9)

Some care homes and/or GPs report:

- satisfaction with the scheme (Thames Valley HIEC, 2013*; Briggs and Bright, 2011; SCIE practice survey)
- streamlined or more efficient service delivery and better access to services (Briggs and Bright, 2011; Jacobs, 2003)
- better quality care (Briggs and Bright, 2011; Jacobs, 2003)

- an improved relationship between care homes and GPs (BGS, 2011a*; Briggs and Bright, 2011; Donald et al, 2008)
- an improved relationship between primary and secondary services and improved referrals (Briggs and Bright, 2011; Donald et al, 2008)
- reduced hospital admissions or crisis care (Briggs and Bright, 2011; Donald et al, 2008; SCIE practice survey)
- better continuity of care in GP practices for residents (Briggs and Bright, 2011)
- improved or greater availability of palliative care (Briggs and Bright, 2011; Donald et al, 2008)
- improved judgements of care home managers in identifying a need for a GP and in ordering repeat prescriptions (NHS West Midlands, 2011*)
- streamlined medication and prescribing procedures (Briggs and Bright, 2011)
- increased use of preventative measures through regular monitoring and check-ups (Briggs and Bright, 2011)
- better knowledge of care home staff and GPs about residents' health (BGS, 2011a*; Briggs and Bright, 2011).

As reported in qualitative studies, these impacts can be mediated by the benefits of a preferred practice arrangement, regular scheduled visits or medication reviews.

Despite reporting a range of positive outcomes, care homes and GPs also report weaknesses in enhanced service schemes. Making payments does not guarantee that enhanced services are received, and in the SCIE practice survey, care home respondents did not universally support enhanced services schemes. Sometimes it meant better access, but sometimes it did not. In one home Jacobs (2003), although £4,000 per year was paid to one practice for weekly scheduled visits, these did not always take place: "They will if there's enough people. If there's one or two we have to take, send them to the practice, which can be very difficult and expensive and incur staff travelling time, hiring vehicles, etc" (care home manager/owner/matron, Jacobs, 2003, p 116). Two care homes in the Jacobs (2003) study said they had made payments to GPs but received only visits on request and other standard services. It may be that these care homes are referring to retainer fees for standard GP services rather than enhanced service payments.

Care homes and GPs report a loss of continuity of care and knowledge of long-term medical histories when extended service arrangements are used in place of residents' pre-admission GPs. In the SCIE practice survey, one respondent commented that some residents stay with their past GP because of familiarity and continuity, especially in the context of change when moving into the care home.

GPs report potential negative outcomes such as extra workload, and changes to the doctor–patient relationship, "because really the contract's between you and the patient, not you and the home" (Jacobs, 2003, pp 116). However, some GPs believe that payments can recognise extra workload in looking after care home residents (Jacobs,

2003). Donald et al (2008) note that GPs may not gain expertise in care home medicine and deliver high standards of care.

There can also be a lack of real patient choice if care homes strongly encourage residents to register with extended service GPs (Jacobs, 2003). Extended service schemes can result in inequity, for example, geographical differences in GP services to care homes (Donald et al, 2008). Patterson (2009) recommends that PCTs should work with the BMA to produce guidelines on appropriate, transparent costings for enhanced services. If care homes are to pay fees to GPs, a fair tendering process should be followed to avoid inflated fees by GP practices.

'If they were scattered about the place they'd have to be making home visits, here at least they've got all our facilities, and a trained nurse to go round with them to carry out, to follow up their decisions, so we can't, I don't think that it's, it's extra work, but we're over a barrel, we have no alternative.' (Jacobs, 2003, pp 116)

Preferred practice arrangements

Current practice

Preferred practice arrangements are referred to in the literature as 'dedicated GPs', 'allocated GPs', 'nominated GPs', 'lead GPs' and/or 'the home GP'. In a preferred practice model, GPs or GP practices are either allocated to a home (for example, by the PCT, or by mutual agreement between GPs in an area), or are asked by an individual care home to be their lead or sole GP provider and register all residents on admission. This may be delivered through formal agreements or enhanced service contracts. Residents may have to register with the allocated GP, or they may keep patient choice and opt out to their own GP if they wish.

Preferred practice arrangements are not widespread. In a nationally representative survey of 570 care home proprietors and managers, with data collection over 10 years ago, most homes (53 per cent of all homes surveyed, those with and without preferred practice arrangements) reported that they encouraged new residents to retain their pre-admission GP, and just under one-third (29 per cent) left residents to make their own decisions (Glendinning et al, 2002). These findings are reflected in smaller-scale studies (see, for example, Gladman, 2010; Jacobs, 2003). In the Glendinning survey, 10 per cent of homes encouraged residents to register with the 'home GP' (that is, a preferred practice arrangement). This was more likely in larger homes (statistically significant relationship, $p=0.009$) although home type had no effect. The same proportion (10 per cent) said that all their residents were registered with just one GP practice. Similarly, 79 per cent of homes in a national survey of 89 residential care homes (16 per cent response rate) reported that they worked with more than one GP practice (Gage et al, 2012*).

'We don't actually have a retained GP here as such, so they would, I mean, there are a couple of surgeries that are quite local so they're sort of like the surgeries probably of choice. But you know what I mean, at the end of the day it would be down to the resident to choose, wherever they wanted to have a GP, wherever

they wanted to register.' (Care home manager/owner/matron, Jacobs, 2003, pp 115)

Estimates from national or county-wide surveys of homes are between 1 and 17 GP practices per home (Froggatt and Payne, 2006*; 33 per cent response rate), and between 1 and 50 individual GPs per care home (Froggatt and Payne, 2006*; Glendinning et al, 2002), with a median of seven GPs per home and four GP practices per home (Glendinning et al, 2002). Glendinning et al (2002) did not find a strong relationship between the number of beds and the number of GPs/practices covering each home, and there was no such relationship in nursing homes. This may be because larger homes and nursing homes are more likely to have preferred practice arrangements.

Practice examples

See above for examples of enhanced service schemes that are also preferred practice arrangements. One GP (Evans, 2009*) describes a GP Practice to Care Home Alignment model in Peterborough in which a named GP coordinates care and takes responsibility for care home residents' long-term medical needs, rather than different GPs in the practice visiting the home each time. At the time of writing, work was in progress on a draft Service Level Agreement, with funding attached, to allocate a GP practice to each care home in Peterborough.

Patient choice of GP, too many GPs per care home, or too few residents per GP, as barriers to working together or to high-quality medical care

When residents choose to keep the GP they have been registered with over a number of years before entering the care home, this provides continuity of care. However, studies and reports discuss that too many GPs per care home, or too few residents per GP in any one care home, are barriers to:

- GPs retaining older people when they move into care homes (Jacobs, 2003)
- regular visits (Evans et al, 2012; The Health Foundation, 2011*)
- GP knowledge of individual residents (BGS, 2011a*; no research evidence stated)
- a good relationship between the GP and the care home (The Health Foundation, 2011*; Jacobs, 2003)
- working together (BGS, 2011a*; Jacobs, 2003)
- care homes contacting GPs (Watson et al, 2006*)
- quality of GP care (Jacobs, 2003).

'I certainly think the care could be improved, now whether it's with some, probably a contract to look after them all, is a better idea than just going in when they call. I don't feel that we give the optimum care to the patient. It's like emergency cover we provide really. So probably if somebody regular looked after them then it would improve.' (GP, Jacobs, 2003, pp 116)

Care home managers/proprietors in one study most commonly said that dealing with a large number of GPs and practices didn't create any problems overall (Jacobs, 2003). However, they also reported that when dealing with multiple GP practices, it could be challenging to coordinate different practice systems for ordering repeat prescriptions and requesting home visits (Jacobs, 2003). Treatment could be delayed due to the time taken to contact several practices (SCIE practice survey).

Conversely, having fewer GPs or GP practices per care home (not necessarily a preferred practice arrangement), or more residents per GP practice, are perceived by relatives, care homes and GPs as a facilitator to:

- building better working relationships between GPs and residents, and between care homes and GPs (The Health Foundation, 2011*; Gladman, 2010; Jacobs, 2003; SCIE practice survey)
- more efficient medical care (Jacobs, 2003)
- an opportunity to improve GP services, for example, regular visits (Jacobs, 2003)
- greater continuity of care.

In analysis of small-scale survey data reported by both GPs and care homes, GP practices visiting care homes regularly had significantly more registered patients in care homes than practices that did not ($p < 0.001$) (Evans et al, 2012). This statistically significant relationship was 'most marked' for nursing homes (Evans et al, 2012, p 271).

'I suppose if you've only got one resident registered with a GP then you don't have as much contact with them, whereas if you've got half a dozen, you know, if they're round the corner, say, so you do tend to build up relationships with local GPs that you use regularly. Whereas if it's a GP you only called out once in a year then there's no real relationship.' (Care home manager/owner/matron, Jacobs, 2003, pp 115)

Relatives/carers, mainly referring to homes with multiple GPs, said they would like a nominated GP, with a designated day for weekly visits. Where residents choose to stay with a pre-admission GP despite a preferred practice arrangement with the care home, relatives said that there should be regular communication between the pre-admission and preferred practice GPs (The Health Foundation, 2011*).

Barriers to preferred practice arrangements

Two studies found that some care home managers do not secure preferred practice arrangements because they (Gladman, 2010; Jacobs, 2003):

- value and prioritise the resident's choice of and attachment to a GP
- value the continuity of care and knowledge of long-term medical histories from the resident's pre-admission GP
- prefer to have input from more than one GP or practice and/or

- want to avoid a GP who they do not want to work with or whom they perceive to give poorer quality care.

'Well, I think if they've known the resident for 20, 30 years, they should continue that. I don't see any point in changing, because they know them best. They've dealt with all their illnesses for the last X number of years. So, we wouldn't, you know, we wouldn't change, unless we were forced to for some reason.' (Care home manager/owner/matron, Jacobs, 2003, pp 114)

Gladman (2010) and Jacobs (2003) also found that care managers might respect their residents' right to choose their own GP, even if these GPs did not visit regularly or made it inconvenient for managers or were disliked by the care home. One care manager assumed that "it was part of her job to be able to negotiate the system on behalf of her residents" (Gladman, 2010, p 9).

'Well very often it can be, they can register with a GP that the home or if you like, myself or one of my trained nurses is not particularly popular, it's not a popular choice. It's somebody that we'd rather not work alongside but there again that is the patient's choice.' (Care home manager/owner/matron, Jacobs, 2003, pp 115)

One report discusses that some GPs will not take on responsibility for the residents of a specific care home because of the workload (and lack of recognition), and/or lack of interest or expertise (BGS, 2011a*). The evidence basis for this is not stated.

Measured outcomes of preferred practice arrangements

Jacobs (2003) concludes that research is needed to find out whether the benefits of continuity from a pre-existing GP outweigh the benefits of dedicated GPs for older people in care homes. BGS (2011a*) states that there is little evidence on whether the preferred practice model leads to better partnership working.

Perceived/reported outcomes of preferred practice arrangements

Residents, relatives, GPs and care home staff in qualitative research studies report a range of positive outcomes for residents and care homes. These include higher quality GP care for older people (Briggs and Bright, 2011; Jacobs, 2003). This reported relationship might be mediated by preferred practices being linked to payments for enhanced services (Jacobs, 2003; Glendinning et al, 2002); weekly visits to the care home (Gladman, 2010); and greater GP interest (Jacobs, 2003). However, Gladman concludes on the basis of case studies that preferred practice arrangements are not a necessary condition for high-quality care.

As stated in the section of this review on 'Local enhanced service (LES) schemes', it is difficult to disaggregate the impacts of preferred practice arrangements from commonly associated variables such as enhanced service payments, retainer fees, medication reviews and regular scheduled visits/surgeries.

Other positive outcomes reported by GPs and/or care homes are:

- continuity of care across the GP practice (Briggs and Bright, 2011; SCIE practice survey)
- better relationships between GPs, residents and families, reassuring residents and better GP knowledge of residents (Briggs and Bright, 2011)
- better medical care and less pain, according to residents (Briggs and Bright, 2011)
- improved referral processes (Briggs and Bright, 2011)
- reductions in referrals to hospital (Briggs and Bright, 2011)
- streamlined medication and prescribing procedures (Briggs and Bright, 2011)
- better working relationships and more flexible contact (for example, out of hours) between GPs and care homes (Briggs and Bright, 2011; Jacobs, 2003)
- more efficiency for care homes, for example, not taking residents to a GP or hospital as a result of regular visits (Briggs and Bright, 2011)
- a more manageable GP workload (Jacobs, 2003)
- reducing administrative difficulties (Jacobs, 2003).

'Obviously she [the GP] knows all the residents and with the elderly, continuity is very important. She comes twice a week, Monday and Thursday so three to four hours a week and with any queries she will know straight away, will know a lot of the families and it is more personal care.' (Care home manager, Briggs and Bright, 2011, pp 10)

In Briggs and Bright (2011), residents liked the fact that they could talk to the same person, understand their medical issues and appreciate that concerns were heard:

'[The GPs are] very good, they listen to you and they will help you. I see mine for all sorts [thyroid problems and multiple sclerosis] and they give me all sorts of medication. I don't have much pain now. They had to find out about the medication so it took a little time but now it is precise. I can see him when I want to or all the time, depends on how ill I am. Last week, I was calling the night doctor and he was very nice and good to me.' (Resident, Briggs and Bright, 2011, pp 9)

However, GPs and care homes can perceive preferred practice arrangements (and the associated enhanced service contracts in some cases) to take away patient choice and reduce continuity of care with the pre-admission GP (BGS, 2011a*; Donald et al, 2008; Jacobs, 2003; SCIE practice survey). Care homes in the SCIE practice survey said that pre-admission GPs had a long-term knowledge of residents and their families, which could lead to good relationships between the GPs, 'their residents' and the staff. One care home in the SCIE practice survey noted that problems such as 'patchy' cover could arise if a designated GP was not on duty.

Recommendations in the literature

Restructuring existing arrangements for GP services to care home residents into preferred practice models will need additional resources (Gladman, 2010; Barber et al, 2009), protected time (Barber et al, 2009), a top-down approach from leadership (Gladman, 2010), and use of enhanced service contracts. A preferred practice arrangement might involve a practice computer in the home (Alldred et al, 2010). In addition to caring for patients, the lead GP should liaise with other GPs and have the responsibility of ensuring, possibly by commissioning services, that patients on riskier medicines are appropriately monitored and that all patients' medication is regularly reviewed by a pharmacist (Barber et al, 2009).

Having just one GP per home can lead to greater use of locums. Relatives, mainly in homes with multiple GPs (The Health Foundation, 2011*), suggested that two doctors could work on a rota to cover for illness and holidays. Where use of locums is unavoidable, the regular GP could follow up with a visit the next day to give continuity of care (The Health Foundation, 2011*).

Regularly scheduled GP visits and surgeries in care homes

Current practice

In small-scale surveys of care homes, care home managers report that 23 per cent (Evans, 2012; 64 per cent response rate) or 38 per cent visit regularly (Froggatt and Payne, 2006*; 33 per cent response rate). Likewise, a third (33 per cent) of GPs in a small-scale survey reported that they made regular visits to care homes in care homes (Evans, 2012; 31 per cent response rate). Similarly in a nationally representative survey of 570 care home managers and proprietors, with data collection over 10 years ago, 21 per cent of care homes had regular surgeries by all GPs, 38 per cent by at least some GPs, but 62 per cent by no GPs (Glendinning et al, 2002). Regular visits (often weekly) are also reported in other studies (CQC, 2012*; Gage et al, 2012*; BGS, 2011a*; Briggs and Bright, 2011; Gladman, 2010; Seymour and Froggatt, 2009; Jacobs, 2003; SCIE practice survey). However, some GPs had discontinued regular surgeries (Gladman, 2010; Jacobs, 2003) or refused requests by care homes to hold them (Jacobs, 2003).

Facilitators and barriers

GPs may provide regular visits or surgeries/clinics as part of enhanced service payments (see 'Local enhanced service [LES] schemes') and/or preferred practice arrangements (see 'Preferred practice arrangements'), and/or multidisciplinary teams (Owen et al, 2008*) or at the request of the care home (The Health Foundation, 2011*; Seymour and Froggatt, 2009). They are more likely with more GP patients per care home and/or fewer GPs per care home (Evans, 2012; Gladman, 2010), and in nursing homes (Evans, 2012). A nationally representative survey of care home managers and proprietors (Glendinning et al, 2002) found that homes that paid GPs were more likely (statistically significant) to receive regular home-based surgery consultations.

One GP practice made weekly visits to three care homes, in which about half of their registered care home patients lived. When asked if they would consider this for other care homes with fewer residents on their practice list, the GPs said "this would be too time consuming ... given their other commitments" (Gladman, 2010, p 6). In a care

home interviewed in another study, weekly visits had been agreed with the GP practice but did not take place if not enough residents needed medical consultation on that day (Jacobs, 2003). In a small-scale survey, the likelihood of regular visits was not related to the number of GP partners in the practice, the number of salaried doctors in the practice, or the total GP numbers in the practice (Evans, 2012).

Reported outcomes

GPs have mixed views on regularly scheduled visits or 'surgeries'. Some GPs have found that they do not decrease workload or reduce or stop requests for urgent visits on other days (Gladman, 2010; Seymour and Froggatt, 2009; Jacobs, 2003). One GP practice had tried regular visits but reported that it had not reduced the number of calls on other days of the week, and, rather than being efficient, seemed to encourage care homes to ask for GP attention for minor requests (Gladman, 2010).

'There were a couple of homes that I used to visit every week without fail but I have to admit, I've stopped doing that now, 'cos they still ring up in between, so there's no advantage.' (GP, Jacobs, 2003, pp 117)

This is mirrored in studies in which care homes report regular visits as an opportunity to consult GPs over minor health problems that would not necessarily merit a call-out, or for overall guidance across the home on medical matters (Briggs and Bright, 2011; The Health Foundation, 2011*; Jacobs, 2003).

'Sometimes, if there's something little and niggling it's not always worth calling a GP for, and you feel it isn't, you feel you are being finicky and things like that, whereas if they are coming anyway it can be discussed and, just their general state of health as well, and especially elderly if anything happens like a sudden death, it's very important that they've been seen.' (Care home manager/owner/matron, Jacobs, 2003, pp 117)

In contrast, GPs in four studies report that weekly scheduled visits enable care home staff to ask GPs about non-urgent issues, and that this leads to more efficient use of GP time (for example, by dealing with several home visits at once, using the telephone between regular visits, and reducing travel time) (BGS, 2011a*; Gladman, 2010; Seymour and Froggatt, 2009; Jacobs, 2003). GPs in three studies also say that, as a result of regular visits, care home staff become more proactive, such as identifying clinical problems earlier or monitoring ongoing problems (Briggs and Bright, 2011; Seymour and Froggatt, 2009; Jacobs, 2003). In another study, GPs did not see regular visits as a means to provide proactive or anticipatory care but thought that "this is what GPs need to do in fulfilling their duties as GPs" (Gladman, 2010, p 6).

'Before LES, patients with chronic illnesses were seen more regularly and some missed out because they didn't have discernable problems but now [because of LES implementation] we are reviewing them regularly. As a result, we can better pick up and can monitor patients.... Now patients with chronic diseases have a higher standard of living, they are covered better so we can get round to everyone on a regular basis to check, for example, to

see they are not losing weight, and ensuring they don't get depressed.' (GP, Briggs and Bright, 2011, pp 7)

'It's the continuity of care that really counts for the patient. The home knows me and I know them. I can tell if they're not feeling well. And so if I get called by the home it will be something that's relevant. They know I'm coming on a weekly basis so little things that can cause a lot of work for the practice now don't happen because they can talk to me over the telephone. And they know I'm coming so it saves us and them time, and the resident gets a better service.' (GP, BGS, 2011a*, p 27)

GPs and care home staff also report that regular visits enable positive working relationships between GPs, residents, relatives and care home staff (Briggs and Bright, 2011; Seymour and Froggatt, 2009). In one study, care home staff viewed regular surgeries as beneficial to residents' wellbeing. For example, residents knew they would regularly be able to speak to a GP (Jacobs, 2003). In another study, care home staff said that weekly surgeries reduced the number of times that they had to take residents to the GP surgery or hospital (Briggs and Bright, 2011).

While most residents in an evaluation of an enhanced service scheme could not remember accurately the frequency of GP visits, they liked that they could talk to the same person and that their concerns were heard (Briggs and Bright, 2011).

'[The GPs are] very good, they listen to you and they will help you. I see mine for all sorts [thyroid problems and multiple sclerosis] and they give me all sorts of medication. I don't have much pain now. They had to find out about the medication so it took a little time but now it is precise. I can see him when I want to or all the time, depends on how ill I am. Last week, I was calling the night doctor and he was very nice and good to me.' (Resident, Briggs and Bright, 2011, pp 9)

'I only see him once a week when he comes to do the rounds – he is a very nice young man and he is very good. He understands you and wants the best for you and listens to what you say. I've been here a year and seen another student doctor but have had no problems with either. Sometimes he is on holiday but it doesn't matter. He always orders the prescriptions monthly or something and they are sent over automatically – he is very [conscientious].' (Resident, Briggs and Bright, 2011, pp 9)

'It was something that they suggested, and we weren't quite sure at first how it would work out because we don't do it with other nursing homes and whatever but I feel it works very well ... if they know that, you know, they can contact us any time but they're going to have a regular thing then they get to know us and we get to know them better which, you know, helps the patient care in the end.... The staff are very good and wouldn't ask us to see things that were just completely not requiring somebody being seen. They're very good at sorting things out.... It makes it more efficient

if you've got a regular slot each week but, of course, you can't put everything in that slot; other things that come up at different times will be seen, you know, as and when.' (GP, referring to a regular arrangement for a GP to visit a care home every Thursday morning, Seymour and Froggatt, 2009, pp 23)

'It is very consistent because I get to know everyone so well whether they have problems or not. I look after people with dementia, and most know who I am but some don't but they are reassured by seeing a familiar face. I can keep people out of hospital. You know what they do and don't want in their old age, and you talk to the relatives as well and you get to know them. No one really wants to go to hospital. When I am away, they [care home staff] have knee-jerk reactions and it is a bit of a mess but the consistency is still great – it saves money.' (GP, Briggs and Bright, 2011, pp 7)

'Obviously she [the GP] knows all the residents and with the elderly, continuity is very important. She comes twice a week, Monday and Thursday so three to four hours a week and with any queries she will know straight away, will know a lot of the families and it is more personal care.' (Care home manager, Briggs and Bright, 2011, pp 10)

One study (Jacobs, 2003, p 118) concludes that 'the practice of holding GP surgeries in homes may be compared with that of specialist outreach clinics in primary care'. Jacobs states that outreach clinics 'have been shown to improve access to services for patients and also to improve the quality of health care received' but cost more for relatively little health gain (p 118). Jacobs suggests that research is needed on the costs and benefits of regular visits in terms of residents' health and GPs' workloads.

Multidisciplinary working involving care homes, GPs and secondary care/other health service practitioners

Referrals

GPs are one referral route to other health services including palliative care, district nursing and secondary care. One report (BGS, 2011a*), based on an evidence review, qualitative research and surveys, discusses the need for close links between care homes and community mental health teams, community rehabilitation services, specialist community nursing, allied health professionals and geriatric medicine:

This means a structured and pro-active approach to care, with coordinated teams working together built on primary care and supported by a range of specialists. (BGS, 2011a, pp 3)

A systematic review found that the professional isolation of care homes was a barrier to integrated working between care homes and health services (not specific to GPs) (Davies et al, 2011).

Care homes access geriatricians mainly through GPs. In a nationally representative survey of 570 care home proprietors and managers, 83 per cent of homes could contact a geriatrician and 92 per cent a psycho-geriatrician when needed, in both instances usually via the resident's GP (Glendinning et al, 2002). Only a minority of homes had direct contact with a geriatrician (5 per cent) or psycho-geriatrician (12 per cent). In a 2011 BGS membership survey, 80 per cent of the geriatricians said that they give telephone advice to local GPs on request, but less than 20 per cent make care home visits (BGS, 2011a*). One care home in the SCIE practice survey reported that they made direct referrals to secondary services and then informed the GP.

An evaluation of an enhanced service scheme reports a GP who proactively followed up referrals (Briggs and Bright, 2011). Care home managers in this study attributed improved referral processes to the enhanced service scheme. Referrals to palliative nurses had enabled residents to stay in the care home rather than go to hospital.

'[Referral processes are] quite good. We can always fax them, phone anytime, and can get prescriptions quickly. She always gets back to [us] if she can't get here then the practice nurse will call. Both of them [the GP and practice nurse] can refer to district nurses because we are not allowed to do nursing or dressing.'
(Care home manager, Briggs and Bright, 2011, pp 9)

However, care homes in the SCIE practice survey said that there were delays in obtaining the GP's initial involvement, and in booking appointments following referral, especially for mental health and dementia.

Communication and information sharing

There can be problems in communication and information sharing between care homes, primary care and secondary services in relation to care home residents.

Relatives/carers report conflicting prescribing between hospital consultants and local GPs (The Health Foundation, 2011*). When prescriptions had been altered in hospital, GPs rarely made follow-up visits on residents' return to see if medications needed reviewing or changing. In some cases, this resulted in residents continuing to take unnecessary or conflicting medication once they were back in the care home (The Health Foundation, 2011*). Additionally, relatives found that full information about care needs and medication did not accompany residents when they were admitted to hospital. Likewise, hospitals did not always provide care homes with medication details when residents were discharged (The Health Foundation, 2011*).

A further study reported that 'hospital out-patient and discharge letters were sometimes unclear, delayed, missed or not adequately incorporated' in patient records (Barber et al, 2009, pp 344). One GP recommends in his paper that hospitals involve GPs and care home staff in decision making, in conjunction with use of Advance Care Plans (Evans, 2009*). One care home in the SCIE practice survey reported that they sent hospital discharge letters on to GPs to ensure up-to-date information, especially if new medication had been prescribed in hospital.

Reducing hospital admissions

In many studies (see, for example, Wild et al, 2010), hospital admissions (especially in emergencies or where the resident dies in hospital) or the number of referrals to

secondary services are classified as negative outcomes that can be reduced by better working relationships between care homes and GPs, and/or by better quality GP care. Yet some residents appreciate the medical care they receive in hospital when needed, and some care home managers say that some hospital admissions are unavoidable:

'I have been to casualty a few times. Been here just over a year because had a fall and had to go to hospital as well. The doctors saved my life.' (Resident, Briggs and Bright, 2011, pp 9)

Some enhanced service schemes and multidisciplinary interventions have reduced inappropriate hospital admissions or reduced deaths in hospital as targets (see, for example, Thames Valley HIEC, 2013*; BGS, 2011a*; Briggs and Bright, 2011; Davies et al, 2011; NHS West Midlands, 2011*; Donald et al, 2008; Winstanley and Brennan, 2007*; National Council for Palliative Care and National End of Life Care Programme, 2007*; Saysell and Routley, 2004*). In one study, a care home manager reported that extended services had reduced the number of referrals to hospital, mediated by greater use of palliative care (Briggs and Bright, 2011).

'I don't have the figures but we have a regular register and the last person to be admitted was March 2009. That lady was in [for] heart failure. Since, the numbers have reduced significantly, and this is because of the GP. For example, we can now have palliative care nurses referred by the GP and we can liaise with them so our clients can stay in homes rather than be transported to hospital. We have these things in place to now make them [patients] comfortable.' (Care home manager, Briggs and Bright, 2011, pp 6)

'They then got another GP out the next day who decided to send the lady to hospital where she died a few weeks later. The resident in question had dementia and had little contact with family. The lady died in an alien environment much to the dismay of the staff.' (Care home staff, in action learning set, Watson et al, 2006*, pp 238)

'We have a plan for each of our residents to identify what would potentially cause this person to go into hospital so look at what can be done to prevent this happening. I don't want them in casualty and coming out with drugs which I am going to stop again.' (GP, BGS, 2011a*, pp 27)

There is a high mortality rate among residents admitted to hospital (Ong et al, 2011). This study found that nearly 40 per cent of deaths after acute hospital admission took place within 24 hours, suggesting that many admissions were inappropriate.

A number of studies found that the actions of GPs in out-of-hours services (which may themselves be inadequate) contributed to inappropriate hospital admission or to deaths in hospital (Ong et al, 2011; Wild et al, 2010; Evans, 2009*; Seymour and Froggatt, 2009). Such actions included being risk-averse as a result of not knowing residents (Briggs and Bright, 2011; Wild et al, 2010), and arranging hospital admissions by telephone without visiting residents in the care home (Ong et al, 2011). In one study, a

care home manager reported that the actions of a GP trainee, “attending ... on behalf of the GP partner who would normally visit”, contributed towards hospital admission (Gladman, 2010, p 14). According to one study, care home staff did not receive advice about when to call out-of-hours GPs, or when care home residents who had experienced recurrent falls or were confused should be admitted to hospital. Care homes did not have regularly updated medical records (as distinct from care records) on site which staff and out-of-hours GPs thought could help with emergency care (Ong et al, 2011).

Other reasons mentioned by care home staff for (inappropriate) hospital admissions were a lack of advance care plans and regular medical reviews, limited access to palliative care and specialist nurses, limited end-of-life planning, and inadequate communication between residents, relatives, GPs, hospitals and care home staff (Ong et al, 2011; Watson et al, 2006*; SCIE practice survey). In one study, short-stay residents in care homes were reported by care home managers as especially likely to be admitted to hospital, partly because less was known about these residents and their medical histories (Briggs and Bright, 2011).

GPs updating out-of-hours services, close working between GPs and care homes, and increased confidence of care home staff in challenging GPs if a resident doesn't wish to be admitted to hospital can decrease inappropriate hospital admissions (Turner et al, 2009; Watson et al, 2006*).

Joint working and integrated multidisciplinary healthcare services

Authors, seminar participants and studies refer to the importance of better integration of services and collaborative multidisciplinary working in the context of overall health service provision (not specifically GPs) for care homes or older people (BGS, 2011a*; Davies et al, 2011; Clarence-Smith, 2009; Owen et al, 2008*; Szczepura et al, 2008*). A systematic review of international studies of partnership working between health services (not specifically GPs) and care homes reports interventions in which care homes were supported by dedicated health service teams and health service-funded beds or managed care (role of primary care not clear), integrated at the macro or meso level. These were associated with positive outcomes such as (appropriate) avoidance of hospitalisation (Davies et al, 2011). This suggests that formal arrangements may need to be in place if integrated working is to be successful.

However, in a BGS membership survey, over half of geriatricians said they were not aware of care pathways or protocols used by GP and geriatrician teams to support collaborative work in care homes (BGS, 2011a*).

The literature includes examples of joint working between primary and secondary services, and examples of integrated/dedicated primary/secondary health service teams. These involve co-working with geriatricians/other hospital consultants/community mental health teams/community matrons/complex care nurses/pharmacists/care home liaison nurses, such as buying in regular visits, assessments, out-of-hours cover or written advice or telephone support from specialists (BGS, 2011a*; Donald et al, 2008; Owen et al, 2008*). They may provide similar types of extended services to those in extended service GP schemes. It is not always reported whether or not arrangements involve payments and/or extended service GP agreements. Extended service schemes may involve multidisciplinary working, either

within the extended service practice (for example, GPs and nurses) or between the extended service practice and other agencies.

Integrated multidisciplinary health service teams involving GPs are reported as being associated with positive outcomes. These include closer working relationships between primary and secondary care (Donald et al, 2008), a reduction in emergency admissions to hospital (BGS, 2011a*; Donald et al, 2008), a reduction in out-of-hours consultations (BGS, 2011a*), a reduction in requests for visits (BGS, 2011a*), a reduction in the length of hospital stay (Donald et al, 2008) and improved clinical information following recent hospital admissions.

One pilot trialled shared management of residential home residents between GP practices and community geriatricians. GP practices had access to comprehensive geriatric assessments, care planning, rapid written feedback and a telephone advisory service. It is reported that, after the first six months, out-of-hours consultations fell by 16 per cent, requests for visits by 37 per cent, and hospital admissions fell by more than 50 per cent. The total cost of hospital admissions fell by 60 per cent (BGS, 2011a*).

Participants in the SCIE practice survey described the 'virtual ward' model of healthcare in the community, in which patients received the equivalent of hospital treatment and care in their own homes. They suggested that this could extend to care homes, to avoid hospital admissions or enable earlier hospital discharge.

In a 2006 survey, 14 per cent of geriatric medicine departments in England reported a regular forum where GPs, geriatricians and nurses could discuss challenging or complex patients (BGS, 2011a*). GPs and secondary care professionals may meet on local service development groups (Evans, 2009*; Seymour and Froggatt, 2009).

Later sections of this review ('Roles of nurses...' and 'Medicines management') cover joint working between care homes, GPs, nurses and pharmacists.

Partnership working between care homes and GPs/other health professionals

An integrated strategic approach at an organisational level including end-of-life tools

Common aims, objectives, performance indicators, policies, guidelines, protocols, frameworks and care pathways

Health and social care participants in a seminar about care homes and the NHS discussed the importance of working towards common aims, goals and objectives (although the discussion was not limited to GP services). This was in the context of an integrated strategic approach to joining up local organisational processes, including standardised practices and shared performance targets and monitoring (Owen et al, 2008*). The authors of a study of relatives suggest a need for new 'collaborative, multidisciplinary working approaches to the management and support of people with dementia and their families'. This includes identifying clear outcome measures that are reviewed regularly (Clarence-Smith, 2009).

In a national survey of 89 residential care homes, 60 per cent of home managers considered they worked with the NHS (not GPs specifically) in an integrated way at an organisational level. Similar proportions reported sharing documents, engaging in integrated care planning, and joint learning and training (Gage et al, 2012*; 16 per cent response rate). Care homes in the SCIE practice survey noted that it could be difficult to achieve consistent clinical practice, as "different doctors and nurse practitioners may have different ideas", and because of poor communication between agencies.

A systematic review of international studies of partnership working between health services (not specifically GPs) and care homes reports that a few interventions involved care homes supported by dedicated health service teams and health service-funded beds or managed care (role of primary care not clear). These were integrated at the macro or meso level, and showed positive outcomes such as avoidance of hospitalisation (Davies et al, 2011). This suggests that formal arrangements may need to be in place if integrated working is to be successful. However, the majority of studies included in the systematic review only achieved integrated working at the patient level of care.

A high proportion of managers in a national survey of 89 residential care homes saw benefits of integrated working with the NHS in terms of improving access to services, continuity of care, opportunities to discuss residents' care and speed of response from the NHS (Gage et al, 2012*; 16 per cent response rate).

Tools that have the potential to facilitate an integrated strategic approach in joint working and partnership working include shared policies, guidelines, procedures, support tools, care frameworks, care pathways and protocols. A systematic review of international literature concludes that shared assessment and care frameworks facilitate continuity in the context of high staff turnover and shift working (which applies generally to health professionals and care homes, not specific to GPs) (Davies et al, 2011).

However, with the exception of end-of-life tools and pathways, the literature rarely refers to policies, guidelines and protocols that are shared specifically between GPs and care homes (BGS, 2011a*; Davies et al, 2011; SCIE practice survey). Over half of surveyed geriatricians in a membership survey said they were not aware of care pathways or protocols used by GPs and geriatrician teams to support collaborative work in care homes (BGS, 2011a*).

Evans (2009*) describes how a GP was involved in initiating a local Palliative Care in Dementia group of health professionals from primary and secondary care, including GPs and care home managers, which (among other initiatives) has created protocols for use by care homes. One national report (BGS, 2011a*) recommends that multiagency and multiprofessional national leadership and shared policies should be promoted to support development and dissemination of good healthcare practice in care homes, supported by clinical guidance and quality standards.

A national survey of 89 care homes did not find statistical associations between care home characteristics (including the quality rating at the last inspection) and the level of integration with health services (measured through six integration indicators and an overall integration score; not specifically relating to GPs). However, the sample was small (89 homes). The care home characteristics entered into the regression were the number of beds, residents per bed, number of care homes in an organisation, proportion of residents who are self-funding, whether the home has dementia beds, whether located in London and the South East (versus the rest of England), proportion of staff who are full time, total full time equivalent staff per bed and per resident and whether rural/urban/suburban (Gage et al, 2012*; 16 per cent response rate).

Most of the evidence above relates to integrated working between care homes and broader health services, and is not specific to GPs. No detailed descriptions or evaluations of integrated working between GPs and care homes, or of the use of specific tools to facilitate this such as protocols and policies, were found in the accessed UK research literature.

End-of-life tools, frameworks and pathways

Care home managers in a number of qualitative studies report that end-of-life care tools, frameworks and pathways (whether joint or not between GPs and care homes), and other innovative end-of-life practices can facilitate partnership working and positive relationships between GPs and care homes. They also report that end-of-life frameworks can raise the quality of end-of-life care given to residents. The tools include the Liverpool Care Pathway (LCP),² the Gold Standards Framework (GSF), other integrated care pathways for end of life, a coding system to identify residents nearing the end of life and an end-of-life register. Reported outcomes specific to GPs include:

- improved relationships, rapport, working together and links between care homes and GPs (Seymour and Froggatt, 2009; Turner et al, 2009; National Council for Palliative Care and National End of Life Care Programme, 2007*)

² Use of the LCP has been discontinued in the NHS in light of the Neuberger report, *More care, less pathway* (DH, 2013) The Department of Health is giving end-of-life issues careful consideration before it publishes revised guidance.

- enhanced communication between care homes and GPs (Turner et al, 2009)
- GPs listening more to care home staff (Turner et al, 2009)
- increased confidence of care home staff, for example, as advocates for residents with GPs (Seymour and Froggatt, 2009; Turner et al, 2009)
- improved GP support for end-of-life care in care homes (Seymour and Froggatt, 2009)
- increased GPs' trust and confidence in care home staff's skills and judgements (Seymour and Froggatt, 2009)
- regular GP visits (Seymour and Froggatt, 2009)
- medical staffing problems resolved (Seymour and Froggatt, 2009)
- out-of-hours problems resolved (Seymour and Froggatt, 2009)
- emergency hospital admissions reduced through care home being more confident to discuss residents' preferences with GPs (Turner et al, 2009)
- prescribing issues addressed, including more anticipatory prescribing by GPs (Seymour and Froggatt, 2009; Turner et al, 2009; National Council for Palliative Care and National End of Life Care Programme, 2007*).

'We have found the GSF programme has definitely improved end-of-life care.... We are more confident in speaking to GPs, especially if the resident does not wish to be admitted to hospital. We are actually planning care and anticipating need, therefore our crisis admissions have reduced. I am so interested in it that I am assisting my manager to plan an end-of-life strategy across our group of care homes.' (Care home manager, Turner et al, 2009, pp 19)

'We had a couple of GPs that would just, not fob us off, but were a bit, what can I say, they wouldn't listen to our opinion. Now since we wrote the letter to say we are doing the GSF, when they have come in to see various residents, they have listened to what we have said. And ok, they have not always taken it on board but at least we feel we have been listened to. The staff feel that has been a general improvement overall.' (Care home manager, Turner et al, 2009, pp 15)

'Very often the question of end-of-life pathway drugs has been brought to us by the nursing staff [here] and always appropriately, as far as I'm concerned.... I mean we're probably more familiar to them here than any other practices because we spend so much time here. So I think that helps really because the more you know people the more you come to trust them, or you could put it the other way, I suppose.' (GP's view of care home, Seymour and Froggatt, 2009, pp 14)

The authors of a systematic review about partnership working between health services and care homes (not specifically GPs) note that, in three studies using integrated care pathways to improve the quality of end-of-life care, care pathways may increase integrated working for individual residents (Davies et al, 2011). However, integrated working will not necessarily extend to all care home residents.

End-of-life tools are associated with positive outcomes for relationships between care homes and GPs, but it is the relationships themselves that may be most important for quality end-of-life care. In one study, staff in the care home which did not use end-of-life tools could not remember any times when end-of-life care “had not been as good as they would have liked” (p 17). The GP would visit regularly when a resident was approaching the end of life, and update the out-of-hours service. In a care home in the same study which did use all three end-of-life tools, staff said that the establishment of good working relationships (trusting and supportive) between the care home, GPs and district nurses was very important in providing high-quality end-of-life care, not just using the tools (Turner et al, 2009).

Role of GPs in implementation of end-of-life tools and pathways

The literature includes examples of GPs being involved early on when care homes are planning for and first implementing end-of-life tools; jointly implementing end-of-life tool with care homes; and implementing a tool at the same time as care homes (see, for example, National Council for Palliative Care and National End of Life Care Programme, 2007*). There are also examples of enhanced service schemes and integrated primary and secondary healthcare teams (including GPs) providing medical care to care homes using end-of-life tools (Thames Valley HIEC, 2013*; Patterson, 2009*; Donald et al, 2008). Evans (2009*) gives descriptions of local innovative end-of-life practices in which the GP is involved or helped to initiate in one care home, with the GP taking a leadership role. Care homes in the SCIE practice survey said that GPs could be involved with organising DNAR forms. Care homes sometimes chose to work with specific GPs who were most helpful with end-of-life planning.

In contrast, one study of GPs and care homes describes GPs not involved in end-of-life planning. Care homes asked GPs to sign end-of-life documentation to authorise it for other healthcare professionals when they had not been involved in preceding discussions. A specialist PCT nurse or care home staff had written the documents, and GPs were reluctant to sign them (Gladman, 2010).

Care home staff report that GPs and primary care professionals more generally may act as barriers to the implementation of end-of-life pathways, or as barriers to quality end-of-life care in care homes, when care homes have implemented such tools (Turner et al, 2009; National Council for Palliative Care and National End of Life Care Programme, 2007*; Watson et al, 2006*; SCIE practice survey). Problems and challenges include:

- difficulties in or absence of communication, teamwork, shared decision-making, partnership working and relationships
- persuading GPs to prescribe appropriate/advance medication for end-of-life care, sometimes due to concern about costs (Seymour and Froggatt, 2009;

National Council for Palliative Care and National End of Life Care Programme, 2007)

- lack of interest among GPs (Seymour and Froggatt, 2009; Watson et al, 2006*; SCIE practice survey)
- lack of time for GPs to get involved (Gladman, 2010)
- lack of knowledge among GPs of medications used in end-of-life pathways (Seymour and Froggatt, 2009)
- lack of trust among GPs in the skills and judgements of care home staff, and a lack of adequate out-of-hours support (Seymour and Froggatt, 2009)
- nurses who know the residents well not feeling confident to influence a GP's decision (Watson et al, 2006*).

'Getting GPs on board has been very difficult in some practices. They give the impression they are interested but when it comes to it they don't actually ... they haven't wanted to participate in the information and things that are organised. We find that they don't even know themselves what they are doing ... some practices are very good and others haven't been very supportive at all.' (Key champion, final group interview, Watson et al, 2006*, pp 238)

Sometimes, GPs and local health professionals may implement end-of-life tools without adequately involving care home staff. One study describes a situation in which care home staff were not invited to local multidisciplinary PCT meetings even though the care home manager had asked for this on a number of occasions. Therefore the care home was excluded from a partnership approach with GPs and other health professionals in planning end-of-life care (Seymour and Froggatt, 2009). The Macmillan nurse said that "the GPs preferred to designate a member of the multidisciplinary team meeting to liaise with the care home directly" (Seymour and Froggatt, 2009, p 25). Conversely, in the survey of nursing homes in the same study, when asked about their top three priorities for improving end-of-life care, care managers' reported responses did not mention GPs (Seymour and Froggatt, 2009).

Using collaborative learning groups and action learning sets, nursing home staff considered ways they could overcome a lack of partnership working by GPs to implement an end-of-life pathway. They thought about how they worded requests to GPs, what assumptions they were making about the GPs, and ways in which they could communicate explicit options in decisions about end-of-life care. They found that this approach worked well in building up trust and facilitating the collaboration of some GPs in using the end-of-life documentation (Watson et al, 2006*).

Understanding, taking on board and agreeing roles, rights and responsibilities

Enhanced service and preferred practice agreements (see, for example, Thames Valley HIEC, 2013*; NHS West Midlands, 2011*; Evans, 2009*; Donald et al, 2008) can specify roles and responsibilities, but outside of these, agreeing roles and

responsibilities between GPs, care homes and residents and their families may not take place. One study concludes that GPs should understand the responsibility of care home managers and staff for residents, and take on board their own responsibilities to residents as NHS patients (Wild et al, 2010). Two studies give examples of GPs who felt it their responsibility to prevent difficulties with out-of-hours support (for example, availability of medication on weekends) (Seymour and Froggatt, 2009) or to undertake weekly visits (Gladman, 2010).

Specifically in the context of medication errors, research shows the need for GPs, care home staff and other health professionals to clarify responsibilities for communication and medication (The Health Foundation, 2011*; Barber et al, 2009). One of these studies found that a lack of ownership or leadership of the whole system and a lack of responsibility and coordination (not specific to GPs) contributes to medication errors (Barber et al, 2009). The authors conclude that a lead GP for each home (also mentioned by relatives/carers; The Health Foundation, 2011*), with protected time and funding, could liaise with other GPs and have the responsibility of ensuring that medication is regularly reviewed by pharmacists. Pharmacists could have overall responsibility for medicine use in one or more care homes (The Health Foundation, 2011*; Barber et al, 2009) as key 'medication liaison officers' (The Health Foundation, 2011*). Relatives/carers suggest that care home staff should take the role of 'medication champions' for their home (The Health Foundation, 2011*).

Relatives/carers in one study strongly felt they needed to play a lead role in understanding and monitoring medication as their family member was not able to. It was relatives who often noticed a change in the resident's health and would raise this with staff, who would call the GP. The care home did not always respect the role of relatives, and might not share information with them (for example, the outcome of GP visits) or take instructions from them. In contrast, a family GP could be happy to share information with a relative who took the resident to an appointment, treating them as an advocate (The Health Foundation, 2011*). The authors of another study involving interviews with relatives of people with dementia in residential homes suggest that a key worker or advocate should be appointed at diagnosis to coordinate care, and that this might be a family carer (Clarence-Smith, 2009). Care homes in the SCIE practice survey thought that relatives could make sure that residents benefit from the full range of GP services by "keeping informed about all services on offer" and "knowing what is available to them" and how to access it.

'Because I was involved in my mother's care with her own GP and psychiatrist they would advise me when visiting that they would be stopping a certain medication, or changing the amount of another. The problem was I was left to speak to the care staff about this and of course they would not be able to act on what I said. Therefore until written confirmation was received from the GP or psychiatrist the medication would still be given to my mother.' (The Health Foundation, 2011*, pp 20)

However, in one of these studies, by the time their relative with dementia moved into a care home, fatigued carers wanted to "opt out" and "hand over all medical and social responsibility to someone else" (Clarence-Smith, 2009, pp 37). This created a feeling of

relief, acceptance and trust that the home could manage medical problems. However, relatives could be confused about who was responsible for ensuring medical care, and the roles of healthcare professionals such as district nurses, audiologists, dentists and mental health practitioners. Relatives were also unclear about who makes end-of-life care decisions when a resident lacks capacity.

Later sections of this review ('GP interest, leadership and persistence' and 'Leadership roles for care home managers and other staff') cover the leadership roles of GPs and care home managers/other staff.

Personal contacts and working relationships between GPs and care home staff

Care home staff and GPs in some studies report overall positive relationships despite raising specific problems. They say that the strength and positivity of relationships vary with individual GPs and care homes (see, for example, Ong et al, 2011; Gage et al, 2010*; Gladman, 2010; Wild et al, 2010; Seymour and Froggatt, 2009; Turner et al, 2009; Jacobs, 2003; SCIE practice survey).

Reported outcomes

Positive, close working relationships between care homes and GPs are reported by care home staff, GPs, relatives/carers, other stakeholders and evaluators to be associated with positive outcomes. These include:

- better end-of-life care (Turner et al, 2009) (reported to be more important than the use of end-of-life tools)
- higher quality and effectiveness of GP care (Briggs and Bright, 2011; Gladman, 2010)
- better access to services such as regular visits, prescriptions and out-of-hours contact, and service efficiency (Briggs and Bright, 2011; Owen et al, 2008*; Jacobs, 2003)
- greater continuity of care (BGS, 2011a*; The Health Foundation, 2011*)
- improvements in care homes' working practices (NHS West Midlands, 2011*)
- better partnership working between GPs and care homes (see, for example, Owen et al, 2008*; SCIE practice survey)
- better information sharing (Owen et al, 2008*)
- helping care homes feel less isolated or overwhelmed by the responsibility of caring (Owen et al, 2008*)
- care home staff and GPs feeling more confident about the judgement of care home staff to appropriately refer residents to the GP and other health services (BGS, 2011a*; NHS West Midlands, 2011*)
- professional advice from GPs to care homes (Briggs and Bright, 2011)
- overseeing medication safety (The Health Foundation, 2011*)

- the success of implementing new services (Winstanley and Brennan, 2007*)
- the likelihood of a care home recommending a GP to a resident for registration on entering the care home (Jacobs, 2003).

In research about partnership working between care homes and the NHS (not specific to GPs), integration was mainly at the level of individual working relationships rather than at an organisational level with integration of systems (Gage et al, 2012*; also see Davies et al, 2012). The authors of the Gage et al study say that individual relationships are 'person-specific', vulnerable to change, and limited by operational factors.

Barriers and facilitators

Collaborative working relationships may be less likely to develop where a GP has only one or a few patients in a care home, or where a care home is served by multiple GPs (see, for example, BGS, 2011a*; The Health Foundation, 2011*; Gladman, 2010; Watson et al, 2006*; Jacobs, 2003; SCIE practice survey). Conversely, residents, relatives, care home staff and GPs report that enhanced service agreements, preferred practice arrangements, having just a few GP practices per home, regular visits, collaboration in using end-of-life tools and other forms of regular contact contribute to positive relationships, trust and confidence (BGS, 2011a*; Briggs and Bright, 2011; Seymour and Froggatt, 2009; Turner et al, 2009; Donald et al, 2008; National Council for Palliative Care and National End of Life Care Programme, 2007*; Jacobs, 2003).

However, in the SCIE practice survey, care homes reported that when residents used their pre-admission GP, this could facilitate good relationships between the GPs, 'their residents' and the care home staff.

'Very often the question of end-of-life pathway drugs has been brought to us by the nursing staff [here] and always appropriately, as far as I'm concerned.... I mean we're probably more familiar to them here than any other practices because we spend so much time here. So I think that helps really because the more you know people the more you come to trust them, or you could put it the other way, I suppose.' (GP, Seymour and Froggatt, 2009, pp 14)

'I suppose if you've only got one resident registered with a GP then you don't have as much contact with them, whereas if you've got half a dozen, you know, if they're round the corner, say, so you do tend to build up relationships with local GPs that you use regularly. Whereas if it's a GP you only called out once in a year then there's no real relationship.' (Care home manager/owner/matron, Jacobs, 2003, pp 115)

'It's the continuity of care that really counts for the patient. The home knows me and I know them. I can tell if they're not feeling well. And so if I get called by the home it will be something that's relevant. They know I'm coming on a weekly basis.' (GP, BGS, 2011a*, pp 27)

Features of relationships between care homes and GPs

According to care home staff, GPs and other stakeholders in several studies, relationships between care homes and GPs need to be trusting and supportive, and involving sensitivity, recognition and respect, to have the most impact on partnership working and the medical care of residents.

Participants from wider social care and the NHS spoke at a seminar about care home staff and NHS staff (not GPs specifically) having a clear understanding of and respect for each other's role, knowledge and expertise, organisational culture and external pressures (Owen et al, 2008*). This is mirrored in other studies and reports (which refer to the need for GPs to respect and trust the knowledge of care home staff about individual residents, and the skills, referrals and decisions of care home staff; see, for example, Gage et al, 2012* BGS, 2011a*; Seymour and Froggatt, 2009; Jacobs, 2003; SCIE practice survey). This can be facilitated by training and support for care home staff, and regular visits and contact, for example, when using end-of-life tools.

'... and then we'll probably contact them and say, "We've done the urinalysis, it showed bla di bla, we've sent a specimen off to the hospital" and they'll tend to just say, "Oh all right, I'll write you a prescription for antibiotics, can you come and collect it?" Because they trust us.' (Care home manager/owner/matron, Jacobs, 2003, pp 117)

However, several studies report that some care home staff see health professionals generally, and GPs specifically, as sometimes patronising, even 'discriminatory' and not listening to them. Care home staff find it difficult to gain support, respect and trust from health professionals (Gage et al, 2012*; Davies et al, 2011; Wild et al, 2010; Seymour and Froggatt, 2009; Turner et al, 2009; Owen et al, 2008*; Jacobs, 2003). For example, in one study, care home staff mentioned "use of language that excluded them" (Wild et al, 2010, p 33), and said that it was disempowering when GPs declined to visit on request. Some GPs have negative stereotypes of care home staff, informed by GPs' perceptions that care home staff lack skills and knowledge (see 'Skills, judgements, knowledge and confidence of care home staff'). These perceptions and attitudes can be barriers to the implementation of end-of-life tools (Turner et al, 2009).

Conversely, care home staff can hold negative stereotypes about health professionals, such as care home staff reporting that healthcare professionals sometimes acting "in a 'policing' rather than an advisory capacity" (Davies et al, 2011, p 14), or health professionals "covering people's backs" and being over-preoccupied with safeguarding ("safeguarding has gone mad", SCIE practice survey). In one action research study, nursing home staff considered assumptions they were making about the GPs, and thought of the ways in which they communicated with GPs when making decisions about end-of-life care (Watson et al, 2006*). It was reported that this approach was effective in building up trust and getting GPs to collaborate with nursing home staff in using end-of-life documentation.

'... carers work with the residents every day and know when something is wrong, but the GPs don't always agree. Doctors come out with things I don't know what they're on about – [I] stand back from doctor.' (NVQ3 carer, Wild et al, 2010, pp 33)

'But at times you get, definitely in care homes, there's a great differential; I mean of course we look after the dying, that's the same as nursing homes. But you're just sort of looked down upon as care assistants I find. You know, when professionals, nurses and people come in, they just look; but you have to be quite highly trained nowadays.' (Care home manager, Turner et al, 2009, pp 15)

*'Other challenges have been GPs have either been very supportive or needed a lot of support to begin to appreciate what care home nurses can do. It's certainly made me realise that the way the relationship between a care home nurse and a GP is quite different from that of a district nurse and a GP.... The GPs have got far less confidence, certainly at the beginning, with care home nurses, and that's something we'd had to, and still do, have as a challenge really, just trying to prove to them that we're trying to provide *care home nurses with the knowledge and skills to make better decisions....'* (LCP facilitator, explaining challenges in preparation of care home nurses, Seymour and Froggatt, 2009, pp 16)

Three studies including a systematic review of international literature (Gage et al, 2012*; RCN, 2012*; Davies et al, 2011) and seminar participants (Owen et al, 2008*) discuss how care homes and health service practitioners (not specifically GPs) have different professional values, priorities and working cultures. They say that these differences contribute to poor working relationships.

Seminar participants report a power dynamic, with health professionals (not specifically GPs) feeling more powerful, professional and higher status than care home staff, which makes equal partnership working difficult (Owen et al, 2008*). This seminar report suggests challenging negative attitudes and stereotypes about care homes and their role in the wider health and social care system. In a national survey, some residential care homes mentioned working practices dictated by NHS methods of delivery and priorities for care (not specific to GPs), rather than those of the care home or residents. They reported that care home staff did not have 'enough say' when working with NHS staff (Gage et al, 2012). In another study, nurses did not feel comfortable influencing a GP's decision and would "go along with what was suggested even to the detriment of the resident" (Watson et al, 2006*, p 238). In contrast, nurse qualified care home managers participating in the SCIE practice survey said that their status as registered nurses meant that GPs listened to them if they said there was clinical need.

Similarly, in a systematic review of international literature on joint working between care homes and health services (not specific to GPs), studies and interventions focused on health service-defined problems and outcome measures without acknowledging the skills of care home staff (Davies et al, 2011). All the studies in this review were led and conducted by healthcare professionals. There was no evidence of care home staff being involved in the definition or focus of the studies.

Communication between GPs, care homes, residents and relatives

Effective communication involves personal contacts and good working relationships based on trust and respect; effective information sharing; agreed roles, rights and responsibilities; written information for residents and relatives; and local networking including local forums and meetings. These specific aspects, as well as communication in the context of joint review and assessment of individual residents, and joint learning, training and reflective practice, are covered elsewhere.

Several studies and reports note a lack of communication and ineffective communication (sometimes associated with a lack of communication skills) between GPs and care home staff, among GPs and between GPs, pharmacists, hospitals, other health professionals and out-of-hours/locum services (The Health Foundation, 2011*; Barber et al, 2009; Clarence-Smith, 2009; Seymour and Froggatt, 2009; Turner et al, 2009; Watson et al, 2006*; SCIE practice survey). In some cases, 'over-enthusiastic gatekeeping' by GP practice staff could impede communication between care homes and GPs. There could be "lots of waiting on the phone and not being able to get through to the right person" (SCIE practice survey).

Relatives/carers in two studies reported feeling frustrated that they weren't told by care home staff or GPs about important developments in their relatives' care, or involved in shared decision-making (The Health Foundation, 2011*; Clarence-Smith, 2009). They said GPs tended to visit care homes when family or carers were not there. There were rarely mechanisms in place to enable carers to be present during visits so they could talk to a GP about medication, or be updated about medication changes afterwards. Relatives would not be told about the outcomes of GP visits. Likewise, Watson et al (2006*) reports the lack of a forum for discussion and decision-making that involved nurses, carers, families and GPs.

However, an evaluation of an enhanced service agreement found communication between GPs and care home staff to be mainly of a high standard, for example, in communicating changes to medication treatment plans (Briggs and Bright, 2011). Care home staff and GPs valued their contact out of hours, using a variety of media (email, fax, mobile phone) and regular meetings (see also SCIE practice survey). Regular meetings between GPs and care home management teams were valued in a multidisciplinary GP and secondary care team "to develop partnership and pursue opportunities for training" (Donald et al, 2008). Similarly, a care home reported that regular meetings "really helped to improve access to GP services and [the] working relationship between care home staff and [the] GP" (SCIE practice survey).

'We have brilliant communication. Although we are just around the corner, they [care home staff] have access to my out-of-hours number, my direct line, and fax number. They tend to fax requests across outside regular visits but also they fax for medication and dressing. It all works very well. We also have the regular meetings with the care home manager to discuss little details around communication on medication or anything which might be topical at the time. We recently had meetings to discuss swine flu so we

talk about the potential consequences.' (GP, Briggs and Bright, 2011, pp 8)

Outcomes

Poor communication between residents, relatives, GPs, pharmacists, hospitals and care home staff can contribute to inappropriate hospital admissions and resulting deaths in hospital (Ong et al, 2011; The Health Foundation, 2011*; Watson et al, 2006*), a lack of consistent practice (SCIE practice survey) as well as medication errors (The Health Foundation, 2011*; Barber et al, 2009).

In one case study home:

'I think it [the GP and nursing home relationship] is excellent with [rural care home]. It's not quite so good with others I don't think. I think we get much poorer communication and the information sharing's not as good. So sometimes you go and nobody seems to know why you've been called or what's going on or, you just get the impression that nobody really knows, you know, has got a particular handle of what's going on in certain patients.... I think just to make sure that, you know, you have all the information to hand on both sides really. Because, you know, there have been occasions where they've passed on a message here and it hasn't necessarily got through to us and then you go and you're not quite sure what you're looking for.' (GP, explaining why relationships with other care homes are sometimes strained, Seymour and Froggatt, 2009, pp 24)

Studies and reports mention the importance of effective communication in promoting joint working between GPs and care homes, better service efficiency, obtaining medication when needed, reducing hospital admissions and deaths and reducing medication errors (see, for example, Gage et al, 2012*; Riley and Simon, 2012*; Briggs and Bright, 2011; The Health Foundation, 2011*; Barber et al, 2009; Clarence-Smith, 2009; Donald et al, 2008; Watson et al, 2006*; SCIE practice survey).

Facilitating good communication

In one study, nursing home staff considered, in collaborative learning groups and action learning sets, how they worded requests to GPs, what assumptions they were making about the GPs, and ways in which they could make options more explicit when making decisions about end-of-life care (Watson et al, 2006*). They found that this approach worked well in building up trust, and resulted in some GPs collaborating in the use of end-of-life documentation.

One evidence-informed report makes the case that enhanced GP training will provide GPs with improved communication skills to promote teamworking with nursing home staff and reduce medication errors (Riley and Simon, 2012*). Using end-of-life tools can help to enhance communication (Turner et al, 2009), as can integrated working with the NHS which provided opportunities to discuss residents' care (Gage et al, 2012*).

Networking, joining local forums and service development groups

This section is about GPs and care home staff developing relationships and communication through local multiagency forums and service development groups. Joint meetings in the context of joint review and assessment of individual residents, and joint learning, training and reflective practice, are covered in other sections of this review (see 'Joint training, learning and reflective practice' and 'Reviews, care planning and assessments').

The literature includes examples of care home staff and GPs both attending multidisciplinary service development groups (Evans, 2009*; Seymour and Froggatt, 2009) and service monitoring groups (Saysell and Routley, 2004*). In one study, care home staff attended multidisciplinary PCT end-of-life strategy meetings that took place in local GP surgeries (Seymour and Froggatt, 2009). They reported that as a result they had developed support from a wider network, reducing their reliance on GPs. However, a different care home in the same study reported that its staff were not invited to multidisciplinary PCT meetings even though the care home manager had asked for this several times. As a result, the care home reported feeling isolated from end-of-life practice in the locality. A Macmillan nurse said that GPs preferred that a designated person at the meeting liaised with the care home). A GP who was interviewed perceived potential benefits if care home staff attended:

'At the moment, our MDT (multi disciplinary team) meetings really are the sort of Gold Standard meetings, and the district nurses come to them and, you know, Macmillan nurses and whatever, but as yet I mean the folks in the care homes haven't come. But I mean there's nothing, there's no reason why we couldn't invite them if they felt that it was appropriate. Having said that, I mean, you know, they seem to be happy with the information that they get from us as far as I can see. So it may not contribute a lot. Apart from the fact, I suppose it may, you know, if you're actually working in a nursing home, you know what you're doing but you don't know what anybody else is doing. So I mean they may benefit from the exchange of information, not just about their patients but about others, about what's being done elsewhere and, you know, could you try this and whatever....' (GP, reflecting on the possible inclusion of care home staff at GSF meetings, Seymour and Froggatt, 2009, pp 25)

Record keeping, information sharing and use of technology

Poor practice and problems in record keeping and information sharing

Several studies report problems with record keeping and sharing information:

- unclear, incomplete, poorly written, out-of-date or inconsistent or poor visibility of medical records and care home records

- hospital input (for example, outpatient and discharge letters) not recorded in care home or GP records (Barber et al, 2009), or inconsistent with care home or GP records (Briggs and Bright, 2011)
- records not available to GPs or hospital doctors or out-of-hours doctors when they visit care homes (Riley and Simon, 2012*; BGS, 2011a*; Ong et al, 2011; Gladman, 2010; Jacobs, 2003), especially if they have recently moved into the home (for example, respite or emergency care) or have changed GP or been discharged from hospital (BGS, 2011a*; Briggs and Bright, 2011; Ong et al, 2011; The Health Foundation, 2011*; Gladman, 2010; Barber et al, 2009)
- no shared computer system (Thames Valley HIEC, 2013*; SCIE practice survey)
- no prescribing technology in care homes – GPs have to return to the surgery to prescribe (Briggs and Bright, 2011) or prescribe in the home without computerised notes and fail to update surgery records (Alldred et al, 2010)
- residents entering hospital without an accurate record of their medications and preferences such as their care plan (The Health Foundation, 2011*).

Gladman (2010) reports that GPs in one practice had no formal list of care home residents, although they could easily generate one if needed. Riley and Simon (2012*) note that automatic health prompts that remind GPs to perform routine health checks when seeing patients in the GP surgery are absent in care homes.

Respondents in the SCIE practice survey said that standardised record keeping was rare. Visiting GPs commonly saw the senior staff member on duty for a verbal handover before leaving. This meant that there was no paper trail of evidence, which was especially a problem when a complaint had been made about a resident's care. Even where medical records exist, they may not be checked, according to relatives/carers in the context of medication safety (The Health Foundation, 2011*).

'The home called to say my mother had come out in a very distressing rash all over her body and would I call in and see her. I asked what she had eaten or taken. They said that she had a chest infection and that her GP had prescribed penicillin. She is allergic to penicillin. This is on her care records in the home but no one had checked.' (Relative/carer, The Health Foundation, 2011*, pp 13)

Where records exist, staff may not be willing to share information. In a national sample survey of 89 residential care home managers (only 16 per cent response rate), over half of the 45 managers who reported working with the NHS felt that NHS staff in primary and community services (not specifically GPs) were reluctant to share information with care homes. Managers commented that 'sharing' documentation and assessment tools could be one way. "Not sharing per se; more they look at our notes. We then get a copy of any letters produced for Drs or family, but not access to their notes" (Gage et al, 2010). Relatives reported that care home staff might not give them information about

the outcome of GP visits and changes in medication, although a family GP would be happy to share information with relatives in this way (The Health Foundation, 2011*).

Outcomes from ineffective information sharing

One study found that prescribing and monitoring errors in medication were linked to problems with records, especially prescribing without computerised notes or software, and conflicting records on medication. Monitoring errors were associated with greater harm than other forms of error, and failure to monitor residents was suggested as being linked to practice systems and software (Barber et al, 2009). Relatives/carers raised similar issues (The Health Foundation, 2011*):

'Although my mother's medical records were clearly marked "No codeine" both at the surgery and the care home, GPs still kept prescribing them and the care home would either not see this in her records or chose to ignore it and give her the tablet. Several times over the years we had to make it clear ... [but] it happened again and again. When my mother was given this she became extremely ill which on one occasion resulted in her having to go to hospital. This would happen more when out of hours GPs visited who were unaware of her medical history. Even though the prescribing GP was at fault, the care home records did nothing to deter this medication being prescribed.' (Relative/carer, The Health Foundation, 2011*, pp 5–6)

Effective records and information sharing

Effective information sharing relies on good up-to-date records, compatible electronic or paper-based systems, and the willingness to share and make use of information and records. In a national sample survey of 89 residential care home managers, about 60 per cent of managers reported sharing documents with the NHS (not specific to GPs), although this survey had just a 16 per cent response rate (Gage et al, 2012).

Good practice by GPs in keeping records may include keeping detailed notes on residents on symptom control, use of medication, advice on non-pharmacological options, assessments of capacity, medical referrals and issues of confidentiality (Gladman, 2010). GPs may keep residents' medical notes securely in the care home (Jacobs, 2003), have a practice computer in the care home (Alldred et al, 2010), use a laptop (Briggs and Bright, 2011), use prescribing technology (Thames Valley HIEC, 2013*; Briggs and Bright, 2011) or update medication logs or care plans in the care home (Briggs and Bright, 2011; SCIE practice survey). GPs need to update out-of-hours services (Turner et al, 2009).

It would be good practice by care homes to keep administrative records updated, for example, with changes to medication (Briggs and Bright, 2011). Home managers in the SCIE practice survey said they faxed requests to GPs for referrals for secondary services, so that they had a paper trail if referral did not take place or was delayed. One care home said that they sent hospital discharge letters to GPs to ensure up-to-date information, especially if new medication had been prescribed in hospital.

'The GP lists changes to medication on a professional log and fills it in each time she visits. Then we issue prescriptions and then we

would transfer them to service user administration records, and update the process. If she comes with the computer she can generate the prescription right after her visit – sent straight to the home. She has her own laptop and all the information is on there. It is pretty good.' (Care home manager, Briggs and Bright, 2011, pp 8)

Relatives/carers suggested, in the context of medication safety, that homes should have a protocol for making sure that residents enter hospital with an accurate record of medications and care preferences, in line with any mandatory regulation. This could be part of the care plan (The Health Foundation, 2011*). There also needs to be a handover of resident information if a resident changes GP on entering a home (BGS, 2011a*; The Health Foundation, 2011*).

There was no evidence found that evaluated or measured outcomes for potentially helpful information sharing practices and interventions.

Facilitators to effective record keeping and information sharing

Seminar participants from independent care homes and the wider social care and NHS sectors said that effective information sharing could be facilitated by building better relationships between care homes and GPs (Owen et al, 2008*).

Effective information sharing could be facilitated by preferred practice arrangements or enhanced service schemes (for example, Thames Valley HIEC, 2013*), having a small number of GP practices or just one GP practice per care home, and integrated primary/secondary care home healthcare teams (Donald et al, 2008). These potentially enable a central shared database (Thames Valley HIEC, 2013*), and money for the use of specific information-sharing technologies in care homes such as laptops, printers, mobile prescription tools ('pods') and other prescribing technology. However, one enhanced service provider found that "providing IT into every care home was complex as 'homes have different levels of internet capability'" (Thames Valley HIEC, 2013*, p 8). They also stated in their report that the Information Governance Statement of Compliance (IG SoC) is obligatory and complicated (Thames Valley HIEC, 2013*).

Barber et al (2009) suggest that information-sharing problems may be reduced by programmes in the NHS information technology programme (NPFIT) at the time of writing, such as the Summary Care Record (a GP record which can be accessed by others), GP2GP (electronic transfer of patients' notes between GPs) and the Electronic Prescription Service (electronic transfer of primary care prescriptions).

Joint training, learning and reflective practice

Two reports discuss the importance of:

- education, training and learning
- opportunities to identify, develop and share good practice (for example, shared learning networks)

- reflection on error reporting or audit to support quality improvement, that is, joint or shared between care home staff and health service practitioners (not specific to GPs) (BGS, 2011a*; Owen et al, 2008).

In a national sample survey of 89 residential care home managers, about 60 per cent of managers reported engaging in joint learning and training with the NHS (not specific to GPs), although this survey had just a 16 per cent response rate (Gage et al, 2012).

The research literature accessed for this review included no detailed examples or evaluations of explicitly joint training, learning or reflective practice between GPs and care homes. In one enhanced service scheme, audit interviews helped both the provider of enhanced services and the nursing home manager to identify improvements made in working practices (NHS West Midlands, 2011*).

There are examples of GPs and other health professionals delivering training to care home staff, and these are covered in a separate section of this review, 'Skills, judgements, knowledge and confidence of care home staff'.

Use of telephone and other media for communication

Studies report how GPs and care homes use the telephone (BGS, 2011a*; Briggs and Bright, 2011; Gladman, 2010; Jacobs, 2003; SCIE practice survey). This may be for advice, or for requests for prescriptions, equipment and medical tests, especially where a GP:

- thinks they know enough about a particular resident and their medical conditions (Jacobs, 2003)
- trusts the care home staff and has a good relationship with them (BGS, 2011a*; Jacobs, 2003; SCIE practice survey)
- has regularly scheduled visits to the home (BGS, 2011a*).

GPs may specifically use the telephone as a strategy to reduce workload created by face-to-face visits to the home (Jacobs, 2003).

GPs and care home staff may be happy with the use of the telephone (BGS, 2011a*; Jacobs, 2003).

'Sometimes if they've got a urine infection because we're able to test here and we can usually tell if they're symptomatic and then we'll probably contact them and say, "We've done the urinalysis, it showed bla di bla, we've sent a specimen off to the hospital" and they'll tend to just say, "Oh all right, I'll write you a prescription for antibiotics, can you come and collect it?" Because they trust us.'
(Care home manager/owner/matron, Jacobs, 2003, pp 117)

'It's the continuity of care that really counts for the patient. The home knows me and I know them. I can tell if they're not feeling well. And so if I get called by the home it will be something that's relevant. They know I'm coming on a weekly basis so little things that can cause a lot of work for the practice now don't happen

because they can talk to me over the telephone.' (GP, BGS, 2011a*, pp 27)

However, some care home staff (Gage et al, 2012*; Jacobs, 2003) and relatives (SCIE practice survey) have concerns about telephone prescribing and consultations without visiting to examine the resident, a practice that was said to be common in one home for urinary infections (SCIE practice survey).

'This doctor in particular, he does prescribe over the phone. He'll have the notes in front of him or up on the screen in front of him, but he doesn't come and actually see, he's taking our word for it. So we could tell him the biggest load of twaddle and he'd prescribe something completely different, and he's quite happy to do that over the phone.' (Care home manager/owner/matron, Jacobs, 2003, p 117)

'GPs in this area generally do not like to visit and prefer to diagnose over the phone, which we find unacceptable. We really struggle to get them to visit their patients....' (Care home manager, Gage et al, 2012*)

They also report that there could be "lots of waiting on the phone and then not being able to get through to the right person" (SCIE practice survey).

Telephone, fax and email are used for contacts out of hours, which care home staff and GPs may appreciate (Briggs and Bright, 2011; SCIE practice survey). However, if the telephone replaces visits out of hours, this may be a factor in increasing hospital admissions (Ong et al, 2011).

'We have brilliant communication. Although we are just around the corner, they [care home staff] have access to my out-of-hours number, my direct line, and fax number. They tend to fax requests across outside regular visits but also they fax for medication and dressing. It all works very well.' (GP, Briggs and Bright, 2011, pp 8)

One enhanced service scheme offered a GP available on the telephone out of hours (nights and weekends) to advise care homes on care plans (Thames Valley HIEC, 2013*). Usual out-of-hours GP services were still available if a resident needed a GP visit.

Roles of nurses in relationships between GPs and care homes or as substitutes for GPs in ongoing clinical care

The literature includes examples of nurses and nurse-led teams (for example, nurse clinicians, advanced nurse practitioners, Macmillan nurses and community matrons) mediating the relationship between care homes and GPs, pharmacists and specialist services (BGS, 2011a*; Seymour and Froggatt, 2009; Owen et al, 2008*; Jacobs, 2003). These include operating a 'nurse triage system' to regulate GPs' workload (Jacobs, 2003), or acting as informal advocates for the care home in communications with GPs (Seymour and Froggatt, 2009). GPs may send practice nurses when judged as appropriate for requested visits (Jacobs, 2003). Nurse qualified care home managers

participating in the SCIE practice survey said that their status as registered nurses meant that GPs listened to them if they said there was clinical need. Their clinical knowledge helped to make them better advocates for residents.

'... in my experience the carers are treated more like relatives of the patient so it's like "oh, this person isn't feeling too well will you come and see her?" and they will give advice but not any treatment, whereas nurses, it's more "yes, get it done".'

(Registered nurse, SCIE practice survey)

Participants in the SCIE practice survey reported that district nurses often provided the main link between care homes and GP practices. This could work well, but problems included the varying availability and quality of district nurses, frequent reorganisations and district nurses giving higher priority to people in the community.

Nurses may take a lead role in care homes, working in partnership with GPs to different degrees, for example, leading on end-of-life documentation and asking GPs to sign documents without involving them in preceding discussions (Gladman, 2010). One report suggests that nurses working as case managers could compensate for gaps in usual primary care (not reported as specific to GPs) (BGS, 2011a*). One GP extended service scheme suggests that nurse prescribers, in place of GPs, could issue repeat prescriptions (not yet implemented) (Thames Valley HIEC, 2013*). In this scheme, a nurse was responsible for chronic disease management issues in care homes. In another extended service scheme, nurse practitioners made proactive weekly visits to care homes, and took on care home liaison roles (Donald et al, 2008).

The literature includes an evaluation of an intermediate care unit within a care home to provide respite and terminal care. This was managed and supervised by a clinical nurse specialist employed by a hospice organisation in conjunction with GPs and nursing home staff. Patients' own GPs took responsibility for medical management. GPs discussed admissions with the nurse specialist, authorised admissions and assessed patients within 48 hours of admission. The five older people who completed questionnaires (19 per cent response rate) were 'extremely positive' about the care. Eight of the nine responding GPs (53 per cent response rate) thought that the unit should continue, and the same number said that basic nursing care was good quality. However, there was no evaluation data reported on the GPs' role (Saysell and Routley, 2004*).

Specialist nurses may also take a local leadership role and involve GPs. The authors of one study suggested that the NHS should commission a specialist nurse to monitor healthcare in care homes (not reported as specific to GP care) (Clarence-Smith, 2009). There is an innovative practice example of the Local Care Trust and a lead cancer nurse from the local hospital meeting with a care home manager and local GPs at an early stage in preparing for the implementation of the Liverpool Care Pathway³ in a nursing home (National Council for Palliative Care and National End of Life Care Programme, 2007*).

³ Use of the LCP has been discontinued in the NHS in light of the Neuberger report, *More care, less pathway* (DH, 2013). The Department of Health is giving end-of-life issues careful consideration before it publishes revised guidance.

Outcomes

There was no controlled evaluation found in UK literature that gave evidence on outcomes when nurses partially replace GPs in medical care. There is an evaluated model of a care home support service run by a nurse clinician and a pharmacist. The nurse clinician and pharmacist carried out clinical care and GP liaison in partnership working with care home staff and GPs. The GP or an independent prescriber signed clinical management plans, but the evaluation paper does not describe any other ongoing GP role. The before/after evaluation (no comparison or control group) reports that the number of GP call-outs has reduced by more than 85 per cent, which provides a cost saving, making the cost of the nurse clinician cost-neutral. GPs “developed trust in teamworking and generally feel comfortable in handing over care of patients to other prescribers” (Winstanley and Brennan, 2007*, p 236).

The evaluation paper reports that residents’ and relatives’ satisfaction increased, with residents feeling more informed about their health issues. As a result of dedicated time by the nurse clinician (a half-day per week in each home with an open clinic, requested visits and telephone consultations and regular monitoring of residents) and pharmacist, each resident has received a clinical management plan, medication review, resulting in ‘massive cost savings’ (reduced hospital admissions and prescribing costs) (Winstanley and Brennan, 2007p 234). Limitations of the nurse clinician carrying out day-to-day care are that hospital consultants have always written back only to the GP and not to the nurse who refers, and if the nurse has visited a person who subsequently dies within 14 days, a post mortem may be requested, whereas this would not happen if the GP had visited (Winstanley and Brennan, 2007*).

Gladman (2010, p 19) makes the case that the GPs provide valued expertise to care homes. He discusses that there could be negative outcomes if other healthcare staff replace GP roles, unless ‘these staff were similarly skilled and empowered’.

Reviews, care planning and assessments

Research on record keeping and information sharing relating to formal written care plans, reviews and assessments is covered in ‘Record keeping, information sharing and use of technology’. Other sections of this report (‘Medicines management’ and ‘An integrated strategic approach at an organisational level including end-of-life tools’) cover medication reviews and end-of-life tools.

Current practice

In a nationally representative survey of 570 care home proprietors and managers with data collection over 10 years ago, 45 per cent of care homes had regular medical reviews of named patients by all GPs, 71 per cent by at least some GPs, and 29 per cent by no GPs (Glendinning et al, 2002). In a more recent survey, 37 per cent of GPs did not know whether new residents would have a medical and nursing care plan within one month of admission (BGS, 2011a*). Other studies also report a lack of or variable practice in carrying out advance care plans, initial (pre or post-admission) assessments, end-of-life plans, decisions and regular medical reviews involving or carried out by GPs (CQC, 2012*; Ong et al, 2011; Gladman, 2010; Clarence-Smith, 2009; SCIE practice survey). One respondent in the SCIE practice survey noted that arranging reviews

“[r]equires a great deal of chasing and nagging and sometimes intervention from external agents”.

In a national survey of 89 care homes, approximately 60 per cent of care home managers reported engaging in integrated care planning with the NHS (not specifically GPs) (Gage et al, 2012*; 16 per cent response rate).

Reviews and assessments may be signed by GPs but written by other health professionals (Gladman, 2010; Evans, 2009*; Winstanley and Brennan, 2007*). In one practice, GPs were reluctant to sign and authorise end-of-life documents when they had not been involved in preceding discussions (Gladman, 2010). A specialist PCT nurse or member of care home staff had written the documents.

Potentially good practice

Themes emerging from interviews on good practice by health professionals (not specifically GPs) and care homes included reviews, advanced clinical planning and advanced care planning for end of life. These could facilitate more effective healthcare and support care home staff's decisions. They might reduce unplanned hospital admissions and inappropriate medical care at the end of life (BGS, 2011a*). This report recommends that service planners and commissioners require 'a holistic review for any individual within a set period from their move into a care home, leading to healthcare plans with clear goals. This will guide medication reviews and modifications, and clinical interventions both in and "out of hours"' (p 4). It also recommends that "Care home residents should be at the centre of decisions about their care. An integrated social and clinical approach should support anticipatory care planning, encompassing preferred place of care and end-of-life plans" (p 4).

The literature includes examples of GPs working in partnership with care homes and health professionals (for example, geriatricians and ambulance staff) to carry out assessments, reviews and end-of-life plans (BGS, 2011a*; Evans, 2009*; Seymour and Froggatt, 2009; National Council for Palliative Care and National End of Life Care Programme, 2007*; Saysell and Routley, 2004*). GPs can lead and initiate proactive care (Evans, 2009*). In a survey, 14 per cent of geriatric medicine departments reported a regular forum where GPs, geriatricians and nurses could discuss challenging or complex patients (BGS, 2011a*).

In one GP practice, the care home manager, care home staff and GP discussed together that care staff, rather than GPs, were best placed to facilitate decisions about healthcare and end-of-life care. The care home manager had a lead role to identify residents' healthcare needs, act as residents' advocates, discuss residents' preferences with relatives and liaise with health services (Gladman, 2010).

One enhanced service scheme aimed to make residents' wishes central. The scheme asked residents and families about preferences, recorded them in care plans, made sure they were carried out, and then audited the care given to check whether this had taken place. They carried out a 'gap analysis' where medical care did not follow the plan. GPs worked proactively, carrying out a new resident review, medication reviews and Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms, and reviewing preferred priorities of care forms (Thames Valley HIEC, 2013*).

In one study, relatives/carers suggested that relatives could have a more structured role in care planning in 'care partnership' groups (The Health Foundation, 2011*). The 'care partnership' would include the resident, the care home manager, staff, a carer or relative where appropriate, the GP, and other health and social care professionals (for example, community pharmacist).

Outcomes

A lack of care planning, reviews and multidisciplinary decision-making is reported to be associated with inappropriate hospital admissions and deaths in hospital (Ong et al, 2011; Watson et al, 2006*).

The BGS (2011a*, p 30) report says that there is evidence that 'detailed multidisciplinary assessments prior to an individual moving into a care home can identify remedial problems and ongoing healthcare priorities'. This report and a systematic review (Davies et al, 2011) report that shared assessments and plans can facilitate continuity of care when there is high turnover, shift working, or a change of GP or other healthcare professional. In the SCIE practice survey, care homes emphasised that care plans should be multiagency/multidisciplinary (including GPs and relatives) to achieve 'consistent planning to avoid crisis management'. Home managers should act 'as a facilitator to bring all those involved together'.

In one case study home, the care home manager and lead nurse attended local GP practices' palliative care meetings to discuss residents' needs with GPs. The care home manager reports that, as a result, GPs have become aware of residents' situations and responded more appropriately (Seymour and Froggatt, 2009).

Regular reviews and assessments are often part of enhanced service schemes, related to additional payments to GPs (see, for example, CQC, 2012*), and facilitated by regular GP visits and scheduled surgeries (see previous sections). Regular GP reviews as part of enhanced services are linked with better monitoring of residents' health and preventative actions (BGS, 2011a*; Briggs and Bright, 2011).

'Before LES, patients with chronic illnesses were seen more regularly and some missed out because they didn't have discernable problems but now [because of LES implementation] we are reviewing them regularly. As a result, we can better pick up and can monitor patients.... Now patients with chronic diseases have a higher standard of living, they are covered better so we can get round to everyone on a regular basis to check, for example, to see they are not losing weight, and ensuring they don't get depressed.' (GP, Briggs and Bright, 2011, pp 7)

Individual GPs may assess specific residents in response to ad hoc requests from care home staff. One care home not using end-of-life care tools reported that when a resident was approaching end of life, the GP would regularly visit the resident to reassess and agree care. This home reported that no resident had been admitted inappropriately to hospital and died there (Turner et al, 2009).

There is international research evidence on outcomes from joint case review and planning involving GPs (Davies et al, 2011; Szczepura et al, 2008*), but this is non-UK evidence and therefore has not been included in this review.

Medicines management

Inappropriate prescribing and poor practice

Studies and reports describe deficient, inappropriate and harmful prescribing by GPs (Riley and Simon, 2012*; The Health Foundation, 2011*; Shah et al, 2011; Alldred et al, 2010; Barber et al, 2009; Watson et al, 2006*; Fahey et al, 2003), including:

- under-use of aspirin, ACE inhibitors (angiotensin-converting enzyme inhibitors) and beta blockers for coronary heart disease. Although one more dated study showed no difference between older people with coronary heart disease in care homes and those who were living in the community for older people (Fahey et al, 2003), another more recent, larger-scale study showed less prescribing of these for older people in care homes (Shah et al, 2011). Both these studies used controlled analyses of medical records comparing care home and community groups of older people
- over-use of antipsychotic and neuroleptic drugs (for example, for non-cognitive symptoms of dementia). A controlled analysis of medical records, comparing matched nursing home and community groups of older people before the new primary care contract, found that these drugs had been used for a higher percentage of nursing home residents (Fahey et al, 2003)
- possible inappropriate use of laxatives. Laxatives had been prescribed for a higher percentage of nursing home residents than of older people living in the community (Fahey et al, 2003).

Analysis of medication errors among 256 residents in 55 care homes, based on observation, interview and review of records, found mistakes in prescribing, monitoring, dispensing and administering medicines. Approximately 70 per cent of the residents had been subject to one or more medication errors. About 40 per cent had a prescribing error, 1 per cent had a monitoring error, 22 per cent had an administration error and 37 per cent had a dispensing error. Prescribing errors were 'incomplete information' (38 per cent of prescribing errors), 'unnecessary drug' (24 per cent), dose/strength error (15 per cent) and 'omission' (12 per cent). The mean number of errors per resident was 1.9 (Alldred et al, 2010; Barber et al, 2009).

Harm was estimated in this study from observed errors on a 0 (no harm) to 10 (death) scale. Most errors had negligible consequences, and no cases of harm caused by errors were observed during the study. However, harm can develop over time, so harm from observed errors was estimated, using a 0–10 scale. The mean harm (and range) for each type of error was: prescribing 2.6 (median 0.2 to 5.8), and monitoring 3.7 (median 2.8 to 5.2) (Alldred et al, 2010; Barber et al, 2009).

Inappropriate and harmful prescribing are linked by care home staff and relatives in qualitative studies (Briggs and Bright, 2011; The Health Foundation, 2011*; Barber et al, 2009; Seymour and Froggatt, 2009; SCIE practice survey) to:

- lack of a systematic approach and lack of clarity around lead responsibilities

- information and record keeping issues (see ‘Record keeping, information sharing and use of technology’) including badly written care plans; inconsistencies between different records; patients transferred between GPs and between care home and hospital without information about medical history and medications; and care home staff not changing medication on instruction from relatives following GP appointments which relatives attended with residents
- lack of communication between GPs, relatives and care home staff, between GPs, and between GPs, pharmacists and secondary care, including conflicting prescribing between GPs and hospital doctors
- no follow-up visits from GPs after hospital discharge, and repeat prescriptions being issued without review
- GPs prescribing for urinary infections on the basis of a telephone conversation with the care home, without visiting the resident
- lack of prescribing technology in care homes, and GPs prescribing without having their computerised notes and prescribing software to hand (sometimes on returning to the practice, they did not update notes)
- lack of confidence among some GPs about end-of-life medications
- care home staff not challenging GPs when they think there may be errors.

‘The staff had sent for the GP thinking he would say “enough is enough” and they would then think about the “care pathway”. The first GP came out and started antibiotics and diuretics, which they could not give because the resident was no longer swallowing.’
(Care home staff, Watson et al, 2006*, pp 238)

‘Although my mother’s medical records were clearly marked “No codeine” both at the surgery and the care home, GPs still kept prescribing them and the care home would either not see this in her records or chose to ignore it and give her the tablet. Several times over the years we had to make it clear ... [but] it happened again and again. When my mother was given this she became extremely ill which on one occasion resulted in her having to go to hospital. This would happen more when out of hours GPs visited who were unaware of her medical history. Even though the prescribing GP was at fault, the care home records did nothing to deter this medication being prescribed.’ (Relative/carer, The Health Foundation, 2011*, pp 5–6)

‘The home called to say my mother had come out in a very distressing rash all over her body and would I call in and see her. I asked what she had eaten or taken. They said that she had a chest infection and that her GP had prescribed penicillin. She is allergic to penicillin. This is on her care records in the home but no

one had checked.' (Relative/carer, The Health Foundation, 2011*, pp 13)

There are issues in care home staff's skills, behaviours and knowledge relating to medication (Briggs and Bright, 2011; The Health Foundation, 2011*; Barber et al, 2009). In one study, GPs felt that inexperienced 'agency workers' in care homes could lead to medication problems and affect their workloads (Briggs and Bright, 2011). Relatives/carers in one study thought that health specialists already working with the home (for example, the GP and community pharmacist) could provide more information and support to care home staff (also see Seymour and Froggatt, 2009).

'I do medication reviews each six months, then every time someone is in hospital we will look at what they have been discharged on. I look at most on a weekly basis and find the carers are on the ball. In the dementia home, however, the agency people are not that qualified and lack common sense.... I also try and make it absolutely clear what to do so the pharmacist will write it out but even despite this, at times they don't adhere to the instructions. Because of that I have more work.' (GP, Briggs and Bright, 2009, pp 8)

In one study of relatives/carers, relatives said they were not informed about changes in medication, for example, following a GP visit that they did not attend. Often a family GP would be happy to share information with a carer when taking a relative to an appointment, treating them as an advocate. However, the care home did not view the carer's role in the same way and would not share information or take instruction from them (The Health Foundation, 2011*). Some relatives said they kept their own detailed list of their relative's medication. This was difficult when information was not shared with relatives (The Health Foundation, 2011*).

'Because I was involved in my mother's care with her own GP and psychiatrist they would advise me when visiting that they would be stopping a certain medication, or changing the amount of another. The problem was I was left to speak to the care staff about this and of course they would not be able to act on what I said. Therefore until written confirmation was received from the GP or psychiatrist the medication would still be given to my mother.' (Relative, The Health Foundation, 2011*, pp 20)

Potentially good practice in linking medication reviews to care planning, and in record keeping and the use of technology, is summarised in 'Reviews, care planning and assessments' and 'Record keeping, information sharing and use of technology'. One care home reported that sending hospital discharge letters to GPs helped to ensure up-to-date information, especially if medication had been prescribed in hospital (SCIE practice survey). In one study, a GP looked at discharge drugs when a resident left hospital (Briggs and Bright, 2011).

'We have a plan for each of our residents to identify what would potentially cause this person to go into hospital so look at what can be done to prevent this happening. I don't want them in

casualty and coming out with drugs which I am going to stop again.' (GP, BGS, 2011a*, pp 27)

Medication reviews

Current practice

Medication reviews are viewed as enhanced services. In a nationally representative survey of 570 care home proprietors and managers, with data collection over 10 years ago, 65 per cent of care homes had regular medication reviews by all their GPs, 79 per cent by at least some of their GPs, and 21 per cent by no GPs (Glendinning et al, 2002). However, a more recent 2010 survey of GPs found that 67 per cent did not carry out a medication review on each resident every six months (BGS, 2011a*). In a survey of PCTs, 67 per cent held the view that care home residents did not need additional medication reviews (BGS, 2011b*). The authors of one evaluation, a nurse clinician and pharmacist providing a medical support service for care homes which included medication reviews, had the view that GPs did not have the time to monitor and follow up medication in older people who were stable. They said that GPs' attitude seemed to be 'why fix something that is not broken' (Winstanley and Brennan, 2007*, p 235).

A care home's residents were more likely to receive regular medication reviews when the home paid GPs (statistically significant, $p=0.002$) (Glendinning et al, 2002). Enhanced service schemes may include medicines management and review (Thames Valley HIEC, 2013; BGS, 2011a*; Briggs and Bright, 2011; Patterson, 2009).

Medication reviews may be conducted in the care home with residents, families and/or care home staff present, or with a pharmacist in the GP practice without residents, families and care home staff. They can involve medication forms provided by the care manager (Gladman, 2010). Studies describe or suggest ways in which pharmacists can work in partnership or jointly with GPs and care homes on medication reviews (The Health Foundation, 2011*; Gladman, 2010; Barber et al, 2009; Patterson, 2009; Winstanley and Brennan, 2007*), as well as conduct them on their own or with nurse clinicians in place of GPs (Barber et al, 2009; Patterson, 2009*). However, in one practice, GPs received requests from PCT-employed clinical specialists to change medications for care home residents without discussion with the GP. In some cases, this reversed the GP's decisions (Gladman, 2010).

Potentially good practice

Relatives/carers in one study felt strongly that medication needed to be monitored closely and reviewed regularly, preferably as part of a formal process of case review, involving support given to care homes by health professionals. They hoped that this would mean that care home staff administered the right medication with less chance of side effects or confusion. They also suggested that medication should be formally reviewed by a 'care partnership' group which would include the resident, the care home manager, staff, an appropriate carer or relative, the GP, and other health and social care professionals (for example, community pharmacist) (The Health Foundation, 2011*).

The same study states that medication should be part of a holistic approach to care to ensure that decisions are always made in the interests of the resident and their voice is

heard. Relatives/carers in this study wanted to question and talk to GPs about medication (The Health Foundation, 2011*).

'It would be good to have a more formal structure around medication reviews. Ideally a person's medication should be reviewed every six months but in reality it's a lot more ad hoc.'
(The Health Foundation, 2011*, pp 13)

Outcomes

GPs, enhanced service providers and a care home support service report outcomes from medication reviews that include:

- stopping potentially hazardous drugs (Gladman, 2010)
- adjusting medication (Gladman, 2010)
- reduced dosages of antipsychotic drugs (Thames Valley HIEC, 2013*)
- reduction in medication costs (by over 17 per cent in Thames Valley HIEC, 2013*; see also Winstanley and Brennan, 2007*), although one enhanced service scheme found that prescriptions for antipsychotic drugs did not reduce (Thames Valley HIEC, 2013*).

Care home staff using an enhanced service scheme with regular medication reviews reported streamlined medication and prescribing procedures as a benefit for residents as a result of the enhanced services (Briggs and Bright, 2011).

'[The GPs are] very good, they listen to you and they will help you. I see mine for all sorts [thyroid problems and multiple sclerosis] and they give me all sorts of medication. I don't have much pain now. They had to find out about the medication so it took a little time but now it is precise.' (Resident, Briggs and Bright, 2011, pp 9)

Enhanced service schemes and other services have attributed cost reductions to regular medication reviews. In an enhanced service scheme with medication reviews, the item per prescription cost fell from £13.10 to £10.90 an item. This was a 17 per cent reduction in prescribing costs (and did not include the significant sums saved by reducing the use of specials). There was a projected saving of £85,000 on item per script cost over the course of a year (over £200 a resident) (Thames Valley HIEC, 2013).

Leadership roles for GPs, pharmacists, care home staff and relatives

In studies of medicines management, system-wide issues were noticed which could contribute to medication errors (The Health Foundation, 2011; Barber et al, 2009). In particular, no one had ownership of or was overseeing the whole system or was in a position to show leadership in reducing error across general practice, pharmacy and care homes. There was no systematic approach and a lack of clarity around lead responsibilities. However, where there was a good relationship between the care home and the GP, the GP played an important role in overseeing drug safety.

Two studies suggest a leadership role for GPs, pharmacists, relatives or care home staff or nurses on ensuring medication reviews are carried out regularly, overseeing medication reviews, attending regular medication reviews and having overall responsibility for medicines use in one or more care homes (The Health Foundation, 2011*; Barber et al, 2009), for example, a 'medication liaison officer' (The Health Foundation, 2011*). One study suggests that GPs commission services (Barber et al, 2009). A report recommends that GPs need organisational and communication skills to ensure that medication reviews occur and reduce medication errors (Riley and Simon, 2012*). GPs can be important in oversight of prescriptions (Gladman, 2010).

'I can choose my own GP but there should be another GP overseeing that particular care home to make sure people are getting the correct medication and they're not over or under prescribed.' (Relative, The Health Foundation, 2009*, pp 17)

The Health Foundation study suggests that when a care home has keyworkers for residents, the keyworker can have a formal role to be aware of medication issues and update family and carers of any changes. Particular members of staff could be assigned 'medication champions' for the home. Relatives also strongly felt they needed to play a lead role in understanding and monitoring medication as their family member was not able to (The Health Foundation, 2011*).

Issues with obtaining and storing medication

One study (Seymour and Froggatt, 2009) and one innovative practice example (National Council for Palliative Care and National End of Life Care Programme, 2007*) state that GPs may be reluctant to prescribe advance medication for palliative and end-of-life care. This may be partly due to concern about costs (Seymour and Froggatt, 2009). There may also be legal and ethical issues around consent for anticipatory and prophylactic prescribing by residents lacking capacity (Gladman, 2010), and around storage of drugs in the care home for future end-of-life care (Watson et al, 2006*).

Respondents in the SCIE practice survey said that some GPs provided prescriptions for liquid foods and dietary supplements for specific residents, particularly those with dementia, where they were felt to significantly contribute to health. Other GPs would not prescribe these, taking the view that they did not fall within the definition of medication for which the NHS was responsible, and should be funded by the home.

Getting medication through out-of-hours services may be a problem (Seymour and Froggatt, 2009). GPs may consider it to be their responsibility to pre-emptively prescribe before holidays and weekends (Briggs and Bright, 2009; Seymour and Froggatt, 2009). However, one of these studies notes that "this did not always provide the solution to unexpected problems" (Seymour and Froggatt, 2009, p 22).

'Sometimes he is on holiday but it doesn't matter. He always orders the prescriptions monthly or something and they are sent over automatically – he is very [conscientious].' (Resident, Briggs and Bright, 2009, pp 9)

One study reported difficulties in ordering repeat prescriptions due to GP practices' systems:

Q: 'Tell me about the kind of little niggly things that you said happen between your different practices.' A: 'Well some like us to ring after 10.00 am for prescriptions, some it's after 12.00 pm, some say afternoon, some have up until 3 o'clock, and it just varies so much that it's hard to remember which is which.' (Care home manager/owner/matron, Jacobs, 2003, pp 115)

Better relationships and communication between care home staff, pharmacists and GPs, for example, through using end-of-life tools, can improve medication issues (Briggs and Bright, 2009; Seymour and Froggatt, 2009; National Council for Palliative Care and National End of Life Care Programme, 2007*). Two studies reports that care homes use a fax or telephone to ask GPs for medication (Briggs and Bright, 2009; Jacobs, 2003), for example, when the GP felt that they knew enough about a particular patient and their condition.

'Sometimes if they've got a urine infection because we're able to test here and we can usually tell if they're symptomatic and then we'll probably contact them and say, "We've done the urinalysis, it showed bla di bla, we've sent a specimen off to the hospital" and they'll tend to just say, "Oh all right, I'll write you a prescription for antibiotics, can you come and collect it?" Because they trust us.' (Care home manager/owner/matron, Jacobs, 2003, pp 117)

'We can always fax them, phone anytime, and can get prescriptions quickly. She always gets back to [us] if she can't get here then the practice nurse will call'. (Care home manager, Briggs and Bright, 2009, pp 9)

However, some care homes (Gage et al, 2012*; Jacobs, 2003) and relatives (SCIE practice survey) had concerns about telephone prescribing:

'This doctor in particular, he does prescribe over the phone. He'll have the notes in front of him or up on the screen in front of him, but he doesn't come and actually see, he's taking our word for it. So we could tell him the biggest load of twaddle and he'd prescribe something completely different, and he's quite happy to do that over the phone.' (Care home manager/owner/matron, Jacobs, 2003, pp 117)

Enhanced service schemes can facilitate solutions to medication supply (Briggs and Bright, 2011, NHS West Midlands, 2011*). One enhanced service scheme concludes that nurse prescribers could potentially help with repeat prescriptions (Thames Valley HIEC, 2013*). In another scheme, as a result of GPs not being able to prescribe in the care home, care home staff found it difficult to collect prescriptions, or relied on deliveries from hospital or pharmacists, which could not always take place on the same day. Sometimes residents waited for two days before they had their prescribed medication (Briggs and Bright, 2011). GPs, local pharmacies and care homes worked together to establish delivery systems to ensure medication was received by care homes on the day it was prescribed (Briggs and Bright, 2011).

Joint working can be complicated, however, when care homes work with multiple pharmacies. This was unavoidable for one enhanced service provider given that different care homes had business relationships and loyalties with specific pharmacies. Sometimes deals were arranged nationally if the homes and pharmacies were national providers (Thames Valley HIEC, 2013*).

Factors predominantly under control of care homes

Information for residents and relatives

Relatives of care home residents with dementia were unclear or ill informed about the roles of primary care and other health professionals (Clarence-Smith, 2009). For example, they were unclear about how or why residents were registered with a GP, and whether they had any choice. They were also unclear about how the care home made a decision for a GP visit, and had poor feedback on the outcome of visits. Care homes responding to the SCIE practice survey thought that relatives could ensure that residents benefit from the full range of GP services by “keeping informed about all services on offer” and “knowing what is available to them” and how to access it.

Clarence-Smith (2009) suggests that residents and relatives would find it helpful to have written information about local NHS services including GPs, so that they could understand their rights, entitlements and responsibilities, and what to do if they were not satisfied. An analysis of ‘special’ inspection records from a small random sample of 81 care homes in a purposive sample of nine PCTs (30 per cent of these homes were for adults with learning disabilities) by CQC (2012*) showed that just over half of the homes (54 per cent) did not provide residents with information about which healthcare services were included in the home’s basic fees in their care contract and agreement.

Leadership roles for care home managers and other staff

Several studies and one report note the importance of leadership, persistence and relationship-building work from care home managers and other care home staff in their relationship with GPs to support healthcare and health professionals’ decisions (BGS, 2011a*; The Health Foundation, 2011*; Gladman, 2010; Seymour and Froggatt, 2009; SCIE practice survey). They also discuss the importance of managers and staff’s healthcare decisions about residents because “they are with them all the time” (BGS, 2011a*, p 27). One geriatrician argues that healthcare for residents will be poor if care home management is poor, but that health authorities do not control care home staff, who are mainly employed through the private sector (Gladman, 2010).

Care home managers can act as proactive advocates on behalf of residents, especially when residents and relatives cannot take this role themselves (Gladman, 2010; SCIE practice survey). This can involve identifying residents’ healthcare needs, discussing residents’ preferences with family members and liaising with healthcare services (Gladman, 2010). Care homes participating in the SCIE practice survey thought that managers and staff could make sure that residents benefited from the full range of GP services by “keeping informed about all services on offer”, and “knowing what is available to them” and how to access it.

‘The GP is the person who is delivering bits of service and the nursing home manager is the facilitator to ensure the client gets what they have identified they need.’ (RCN member in focus group, SCIE practice survey)

There are examples in the literature of care home managers taking a proactive role, for example, initiating regular scheduled visits from GPs (Seymour and Froggatt, 2009),

providing forms for medication reviews involving the GP and community pharmacist (Gladman, 2010) and designing pre-admission assessment forms (SCIE practice survey). Care homes in the SCIE practice survey suggested that home managers and staff should act as facilitators “to bring all those involved together” in multiagency and multidisciplinary care planning involving GPs and relatives.

‘It was something that they suggested, and we weren’t quite sure at first how it would work out because we don’t do it with other nursing homes and whatever but I feel it works very well.’ (GP, Seymour and Froggatt, 2009, pp 23)

Relatives and carers suggested that care home staff should be ‘medication champions’ in the context of managing medication and reducing errors. A keyworker should be assigned to each resident, with a formal role to be aware of medication issues and update family and carers of changes (The Health Foundation, 2011*).

Care home managers’ proactive role can extend outside care homes. One manager had to be persistent to get involved with local multidisciplinary PCT meetings hosted by local GP surgeries, because of initial reluctance among other practitioners about the participation of care home staff (Seymour and Froggatt, 2009). However, persistence did not always lead to the desired outcome. Care home staff in another home in the same study were not invited to PCT meetings even though the care home manager had asked for this on a number of occasions. They reported being isolated from wider end-of-life care practice locally. The Macmillan nurse said that GPs preferred to ask someone attending the meeting to liaise with care homes.

Leadership from the care home manager facilitates training, according to a systematic review of international evidence (Davies et al, 2011). This systematic review found that low turnover among managers could facilitate collaborative working with healthcare professionals. Conversely, high staff turnover worsened a lack of skills, confidence and knowledge among care home staff. This lack of skills and confidence, power relationships between care home staff and GPs, and GPs not trusting care home staff could be barriers to care home staff taking leadership roles.

End-of-life tools and frameworks may facilitate leadership roles for care home managers (Seymour and Froggatt, 2009; Turner et al, 2009), for example, providing staff with a framework for advocating for their residents’ needs with GPs in light of protocol guidance (Seymour and Froggatt, 2009).

‘We have found the GSF programme has definitely improved end-of-life care.... We are more confident in speaking to GPs, especially if the resident does not wish to be admitted to hospital. We are actually planning care and anticipating need, therefore our crisis admissions have reduced. I am so interested in it that I am assisting my manager to plan an end-of-life strategy across our group of care homes.’ (Care home manager, Turner et al, 2009, pp 19)

In the systematic review, seven intervention studies employed external project staff. This suggests that integrated working between care homes and health services (not

specifically GPs) may benefit from external facilitation beyond care home staff and GPs (Davies et al, 2011).

One study notes in its conclusions that community health professionals, in particular GPs, should 'better appreciate the burden of responsibility carried by home managers and their staff ... reassess their own responsibilities towards residents as NHS patients' (Wild et al, 2010, p 42). The same study, an evaluation of upskilling care workers (see 'Skills, judgements, knowledge and confidence of care home staff') comments that if GPs show a lack of interest and support, increased responsibility could be taken up by care staff, 'leaving these staff to make decisions beyond their expertise' (Wild et al, 2010, pp 42).

Skills, judgements, knowledge and confidence of care home staff

GPs, nurses and relatives report that care home staff lack confidence, skills and access to training. This affects care home staff's interactions with GPs, GPs' and relatives' perceptions of care home staff and how information is recorded. It contributes to medication errors (BGS, 2011a*; Briggs and Bright, 2011; The Health Foundation, 2011*; Barber et al, 2009; Seymour and Froggatt, 2009; Watson et al, 2006*; SCIE practice survey).

Relatives in one study reported a lack of basic skills and English language skills in relation to technical vocabulary (also reported in the SCIE practice survey), and a lack of specialist skills in the management of people with dementia, among care home staff. These deficiencies were not reported as specifically affecting relationships with GPs (Clarence-Smith, 2009). In another study, relatives/carers identified training needs for care home staff including drugs knowledge, safety issues around dispensing drugs and holistic interaction with residents. Relatives said that they, rather than the care staff, often noticed a change or deterioration in the resident's condition, and asked for a GP to be called out (The Health Foundation, 2011*).

There were examples of nurses or other care home staff who did not feel confident or did not have the knowledge to advocate for residents or influence a GP's decision, and could "go along" with what was suggested even to the detriment of the resident (BGS, 2011a*; The Health Foundation, 2011*; Watson et al, 2006*).

'Although my mother's medical records were clearly marked "No codeine" both at the surgery and the care home, GPs still kept prescribing them and the care home would either not see this in her records or chose to ignore it and give her the tablet. Several times over the years we had to make it clear ... [but] it happened again and again. When my mother was given this she became extremely ill which on one occasion resulted in her having to go to hospital. This would happen more when out of hours GPs visited who were unaware of her medical history. Even though the prescribing GP was at fault, the care home records did nothing to deter this medication being prescribed.' (Relative/carer, The Health Foundation, 2011*, pp 5–6)

The systematic review of partnership working between care homes and health services (not specific to GPs) found that a lack of knowledge and confidence among care home

staff (exacerbated by lack of access to training, and high staff turnover) were barriers to partnership working (Davies et al, 2011).

'...when I was training district nurses, we'd look at say somebody who was dying and some of the difficult symptoms they had and what would they do, they would come up with some solutions and some way of maybe overcoming this, but what happened with the care home nurses, straight away I realised that their first best solution was to ring the doctor. They wouldn't come up with solutions themselves because I think often they lacked the confidence ... it's made me realise that the pace of them developing the skills to take on the Liverpool Care Pathway is going to take much longer because as well as learning, they've got to build up their confidence much more than say a district nurse would. That's been a bit of an eye opener really.' (LCP facilitator, explaining challenges in preparation of care home nurses, Seymour and Froggatt, 2009, pp 16)

'I think some of GP's lack of confidence has been founded, historically.... They've been right to have that concern because maybe they'll go and visit and they'll say well we'll start a syringe driver and the nursing home nurse will say well we don't know how to do that or we don't, we're not sure how to do that. Plus the fact, the GPs had a lot of complaints from their district nurses because they have to go into the care homes to do it.' (Community matron, Seymour and Froggatt, 2009, pp 24)

'I do medication reviews each six months, then every time someone is in hospital we will look at what they have been discharged on. I look at most on a weekly basis and find the carers are on the ball. In the dementia home, however, the agency people are not that qualified and lack common sense. They are nice people, but it is typical of dementia homes; they [some of the staff] are not well paid and not well respected. It is a horrible job but their training is variable and I think without a doctor going in twice a week, they would be all over the place. I also try and make it absolutely clear what to do so the pharmacist will write it out but even despite this, at times they don't adhere to the instructions. Because of that I have more work.' (GP, Briggs and Bright, 2011, pp 8)

Outcomes

The poor judgements, skills, low qualifications, high turnover or staff shortages of home staff were identified by GPs and relatives/carers in studies as contributing to their overall workload or affecting the quality of medical care for residents (Briggs and Bright, 2011; The Health Foundation, 2011*; Gladman, 2010; Barber et al, 2009; Seymour and Froggatt, 2009; Jacobs, 2003). One relative in a study reported that these staff weaknesses could cause harm to residents who were prescribed or administered the wrong medication by GPs without intervention by care home staff (The Health

Foundation, 2011*). GPs perceived these difficulties to be a particular problem in residential homes (Jacobs, 2003) and with agency workers (Briggs and Bright, 2011). They were thought to influence both the perceived appropriateness of requests for visits (for example, for relatively minor conditions that didn't need medical attention; see Gladman, 2010) and the frequency of visits, sometimes (according to GPs) to a greater degree than the dependency of residents.

Two studies report views that care staff can be reluctant to contact a doctor, especially if there is not a good working relationship with the GP (Watson et al, 2006*) or a lack of interest from the GP in visiting (The Health Foundation, 2011*), so compromising medical care (Watson et al, 2006*).

'Within my mother's care home there always seemed some trepidation to call a doctor. One particular GP made it quite clear that it had to be extremely urgent for him to be called.'
(Relative/carer, The Health Foundation, 2011*, pp 17)

Conversely, GPs and care home staff say that high levels of confidence, skills, professional status (for example, registered nurses) and appropriate judgements among care home staff can facilitate relationships with GPs, increase GPs' confidence and trust in care staff's work and enable care home staff to discuss with GPs when a resident does not wish to be admitted to hospital (BGS, 2011a*; Seymour and Froggatt, 2009; Turner et al, 2009; Jacobs, 2003; SCIE practice survey). In one report, interviewees emphasised that care home staff are the most important contributors to residents' health and wellbeing because they are with them all the time. They also emphasised the importance of care staff in supporting healthcare regimes and the decisions of healthcare professionals (BGS, 2011a*).

'The staff are very good and wouldn't ask us to see things that were just completely not requiring somebody being seen. They're very good at sorting things out....' (GP, reporting on arrangement to visit a home weekly, Seymour and Froggatt, 2009, pp 23)

'It's important to increase the confidence of care home staff ... previously the nurses would say a minimum about why they wanted a patient to be seen and wait for the doctor to see them. Now they say "this is what's going on and if you could do xyz, this is how we should be dealing with this".' (GP, BGS, 2011a*, pp 27)

'... in my experience the carers are treated more like relatives of the patient so it's like "oh, this person isn't feeling too well will you come and see her?" and they will give advice but not any treatment, whereas nurses, it's more "yes, get it done".'
(Registered nurse, SCIE practice survey)

This is mirrored in another study in which care home staff valued how their skills, medical facilities, judgements and knowledge positively affected relationships with GPs (Jacobs, 2003). Care homes reported in the SCIE practice survey that it was easier to work jointly when GPs trusted care staff to make decisions and referrals.

'Very rarely have we called a GP out and it's not been needed. We do, particularly our permanent people, we do know them, we do

recognise changes, although we're not medically trained, so we're very quick on picking up urine infections. [So we] phone up and say, "Can we send up a urine sample?" and nine times out of ten it is an infection. So we never get refused or have any problems having a GP out.' (Care home manager/owner/matron, Jacobs, 2003, pp 116)

'Sometimes if they've got a urine infection because we're able to test here and we can usually tell if they're symptomatic and then we'll probably contact them and say, "We've done the urinalysis, it showed bla di bla, we've sent a specimen off to the hospital" and they'll tend to just say, "Oh all right, I'll write you a prescription for antibiotics, can you come and collect it?" Because they trust us.' (Care home manager/owner/matron, Jacobs, 2003, pp 117)

Strategies to increase care home staff's skills, knowledge, judgements and confidence

The literature includes examples of GPs and other health professionals identifying areas for quality improvement, and of care home staff discussing drugs with GPs (The Health Foundation, 2011*; NHS West Midlands, 2011*; Seymour and Froggatt, 2009; Donald et al, 2008). Relatives in one study thought that health specialists already working with the home (for example, GPs and community pharmacists) could provide information and support on medication safety (The Health Foundation, 2011*). A systematic review of international literature concluded that support and training for care home staff by health professionals (not specifically GPs) may be facilitated by structurally integrated services such as when dedicated health service teams support care homes (in contrast to joint working at the micro level) (Davies et al, 2011).

Collaborative learning groups and action learning sets were used in an action research study to facilitate critical thinking among nursing home staff (including untrained carers) about how they could overcome a lack of partnership working by GPs to implement an end-of-life pathway (Watson et al, 2006*). The authors report that this facilitation can make a bigger difference compared to traditional education. Staff considered how they worded requests to GPs, what assumptions they made about GPs, and how they could communicate explicit options when making decisions about end-of-life care. They found that this approach worked well to build up trust and facilitate GPs' collaboration. The staff were not given advice about what they should do but learned how to address contextual issues like this themselves.

One study reports that end-of-life tools can enhance care home staff's confidence. A care home manager reported that staff started to challenge GPs' decisions if these conflicted with residents' wishes (Turner et al, 2009).

'We have found the GSF programme has definitely improved end-of-life care.... We are more confident in speaking to GPs, especially if the resident does not wish to be admitted to hospital.' (Care home manager, Turner et al, 2009, pp 19)

In an evaluation of the impacts of upskilling care home staff into 'new roles', one home thought that new role working had moderately decreased GP workloads. The report

discusses that if 'new role' staff have greater confidence, knowledge and skills, this can benefit relationships between GPs and care home staff. However, there is a risk that if GPs lack interest in engaging with residents, care home staff could take on responsibility beyond their expertise (Wild et al, 2010).

Leadership from the care home manager facilitates training, according to the systematic review of international literature. Integrated working was facilitated by dedicated (protected) time and finance from managers, including learning contracts with staff, and a 'bottom-up' approach for healthcare professionals (not specifically GPs) to train and support all levels of staff (Davies et al, 2011).

Methods and studies for the evidence review

SCIE carried out systematic searches of eight bibliographic databases, specialist web sources and specialist websites – this was not as comprehensive as would be undertaken for a systematic review. The databases/web sources were the Allied and Complimentary Medicine Database (AMED), Social Care Online, PsychINFO, Applied Social Sciences Index and Abstracts (ASSIA), Health Management Information Consortium (HMIC), Cochrane Collaboration, Google and Google Scholar. This was supplemented by citation searching from selected included studies. The first searching stage focused broadly on user views of health service provision, not solely GPs. Most references from this stage (766 unique records in total) came from AMED and Social Care Online. A second searching stage focused on GPs' provision of services to care homes. It yielded 103 unique references.

Records were screened against inclusion criteria related to relevance (GPs and care homes); geography (only UK studies or reports); date (published from 2003 onwards, with the exception if nationally representative, for example, Glendinning et al, 2002); and study type (only research reports, journal articles or evidence-based reports, for example, policy, guidance, practice examples from an authoritative source). The care homes in the studies (both residential and nursing homes) needed to be predominantly those that provided care to older adults. This screening stage gave 34 unique studies (37 reports/papers) that were subject to data extraction using a structured pro forma.

All 34 studies underwent quality appraisal using EPPI Evidence for Policy and Practice *Information and Co-ordinating Centre* quality and relevance criteria: (i) trustworthiness of results judged by quality of study design and method; (ii) appropriateness of study design to review questions; and (iii) appropriateness of focus of study for answering review questions. Studies were rated 'low', 'medium' and 'high' on each of these criteria.

All 34 studies were included in the evidence review. However, studies are marked with the superscript * after the reference, throughout this report, if they have a 'low' quality appraisal overall, or a 'low' rating for quality of study design/method or for appropriateness of the study design to the review questions. Evidence reviews with no systematic elements, non-research reports (for example, practice examples and policy/practice guidance) and research with no explicit methods were all given 'low' for quality and appropriateness of study design, as were some research studies.

The studies and reports (note that some reports/papers comprise more than one method, so there is double counting below) comprised:

- 1 systematic review of international literature (including UK studies)
- 2 non-systematic research reviews
- 8 reports of practice examples with reported evaluation or outcomes data
- 6 research evaluations/action research (qualitative and/or quantitative)
- 7 qualitative/ethnographic studies including qualitative case studies, which are not evaluations of specific interventions

- 4 analytical quantitative analyses of survey or observational data or administrative records/GP records, which are not evaluations of specific interventions
- 8 quantitative surveys (may include qualitative analysis of free text responses), which are not evaluations of specific interventions
- 1 analysis of CQC inspection reports
- 2 evidence-informed reports
- 1 seminar report

Overall quality ratings were:

- 4 high-quality studies
- 18 medium-quality studies
- 12 low-quality studies

There were no controlled evaluations or intervention studies, that is, those involving a matched comparison group or control group. Clinical trials may be regarded as unethical in this field. There were no studies that gave robust data on independently measured outcomes. Only a few studies reported residents' or relatives' views and experiences.

References

- Allred, D., Barber, N., Buckle, P., Carpenter, J., Dean-Franklin, B., Dickinson, R., Garfield, S., Jesson, B., Lim, R., Raynor, D., Savage, I., Standage, C., Wadsworth, P., Woloshynowych, M. and Zermansky, A. (2010) *Care home use of medicines study (CHUMS): Medication errors in nursing and residential care homes: Prevalence, consequences, cases and solutions*, Report to the Patient Safety Research Portfolio, Birmingham: Department of Health and University of Birmingham.
- Barber, N., Allred, D., Raynor, D., Dickinson, R., Garfield, S., Jesson, B., Lim, R., Savage, I., Standage, C., Buckle, P., Carpenter, J., Franklin, B., Woloshynowych, M. and Zermansky, A. (2009) 'Care homes' use of medicines study: prevalence, causes and potential harm of medication errors in care homes for older people', *Quality and Safety in Health Care*, vol 18, pp 341–6.
- British Geriatrics Society (2011a) *Quest for quality: An inquiry into the quality of healthcare support for older people in care homes: A call for leadership, partnership and quality improvement*, British Geriatrics Society.
- British Geriatrics Society (2011b) *Failing the frail: A chaotic approach to commissioning healthcare services for care homes*, British Geriatrics Society
- Brand, P. (2013) *Care homes 2013: Improving access to and experience of GP services for older people living in care homes*, SCIE Practice Survey, London: Social Care Institute for Excellence.
- Briggs, D. and Bright, L. (2011) 'Reducing hospital admissions from care homes: considering the role of a local enhanced service from GPs', *Working with Older People*, vol 15, no 1, pp 4–12.
- Clarence-Smith, B. (2009) 'Healthcare for people with dementia in care homes: family carer experiences', *Journal of Dementia Care*, 17(16): 36–38.
- Care Quality Commission (2012) *Health care in care homes: A special review of the provision of health care to those in care homes*, London: CQC.
- Davies, S., Goodman, C., Bunn, F., Victor, C., Dickinson, A., Iliffe, S., Gage, H., Martin, W. and Froggatt, K. (2011) 'A systematic review of integrated working between care homes and health care services', *BMC Health Services Research*, 11:320.
- DH (Department of Health) (2013) *More care, less pathway: A review of the Liverpool Care Pathway*, London: The Stationery Office.
- Donald, I., Gladman, J., Conroy, S., Vernon, M., Kendrick, E. and Burns, E. (2008) 'Care home medicine in the UK – in from the cold', *Age and Ageing*, 37, (6), pp 618–20.
- Evans, G. (2009) 'Improving end of life care for the person with dementia: a practical approach from general practice', *Dementia: The International Journal of Social Research and Practice*. 8(3): 363–376.
- Evans, G., Grimley Evans, J. and Lasserson, D. (2012) 'Questionnaire study of the association between patient numbers and regular visiting by general practitioners in care homes', *Age and Ageing*. 41(2): 269–272.

- Fahey, T., Montgomery, A., Barnes, J. and Protheroe, J. (2003) 'Quality of care for elderly residents in nursing homes and elderly people living at home: controlled observational study', *British Medical Journal*. 326: 580.
- Froggatt, K. and Payne, S. (2006) 'A survey of end-of-life care in care homes – issues of definition and practice', *Health & Social Care in the Community*. 14(4): 341–348.
- Gage, H., Dickinson, A., Victor, C., Williams, P., Cheynel, J., Davies, S., Iliffe, S., Froggatt, K., Martin, W. and Goodman, C. (2012) 'Integrated working between residential care homes and primary care: a survey of care homes in England', *BMC Geriatrics* 12(1): 71.
- Gladman, J. (2010) Provision of medical care in care homes in the UK, Medical Crises in Older People, Discussion Paper Series, Issue 1, . The University of Nottingham.
- Glendinning, C., Jacobs, S., Alborz, A. and Hann, M. (2002) 'A survey of access to medical services in nursing and residential homes in England', *The British Journal of General Practice*. 52: 545-548.
- Goddard, M. (2008) Quality in and equality of access to healthcare services in England, CHE Research Paper 40, York: Centre for Health Economics, University of York.
- Health Foundation, The (2011) Learning report: Making care safer: Improving medication safety for people in care homes: Thoughts and experiences from carers and relatives, London: The Health Foundation.
- Jacobs, S. (2003) 'Addressing the problems associated with general practitioners' workload in nursing and residential homes: findings from a qualitative study', *British Journal of General Practice*. 53: 113–119.
- Joseph Rowntree Foundation (2008) Improving care in residential care homes: A literature review, York: Joseph Rowntree Foundation.
- National Council for Palliative Care and NHS End of Life Care Programme (Henry, C., Sutton, L. and Cole, A.) (2007) Building on firm foundations – Improving end of life care in care homes: Examples of innovative practice, London: Department of Health.
- NHS West Midlands (2011) Clinical support to care homes and nursing homes: Examples of innovation in the West Midlands, Quality, Innovation, Productivity and Prevention (QIPP) Development Team, NHS West Midlands.
- Ong, A., Sabanathan, K., Potter, J. and Myint, P. (2011) 'High mortality of older patients admitted to hospital from care homes and insight into potential interventions to reduce hospital admissions from care homes: The Norfolk experience', *Archives of Gerontology and Geriatrics*. 53(3): 316–319.
- Owen, T., Meyer, J., Bentley, J., Heath, H. and Goodman, C. (2008) 'Better partnership between care homes and the NHS: findings from the My Home Life programme', *Journal of Care Services Management*. 3(1): 96-106.
- Patterson, M. (2009) Postcode tariff: PCTs and GP retainers in care homes, London: English Community Care Association. [Reproduced in Brunswick Healthcare Review. Volume 4 (30): 20–27.

- Royal College of Nursing (2012) Persistent challenges to providing quality care – An RCN report on the views and experiences of frontline nursing staff in care homes in England, London: Royal College of Nursing
- Riley, B. and Simon, C. (2012) Preparing the future GP: The evidence for enhancing leadership skills, London: Royal College of General Practitioners.
- Saysell, E. and Routley, C. (2004) 'Pilot project of an intermediate palliative care unit within a registered care home', *International Journal of Palliative Nursing*. 10(8): 393–398.
- Seymour, J. and Froggatt, K. (2009) End of life care in care homes: understanding and mapping innovative solutions, Nottingham and Lancaster: University of Nottingham and Lancaster University.
- Seymour, J., Kumar, A. and Froggatt, K. (2011) 'Do nursing homes for older people have the support they need to provide end-of-life care? A mixed methods enquiry in England', *Palliative Medicine*. 25(2): 125–138.
- Shah, S., Carey, I., Harris, T., DeWilde, S. and Cook, D. (2011) 'Quality of chronic disease care for older people in care homes and the community in a primary care pay for performance system: retrospective study', *British Medical Journal*. 342:d912.
- Szczepura, A., Clay, D., Hyde, J., Nelson, S. and Wild, D. (2008) Models for providing improved care in residential care homes: A thematic literature review: Annotated Bibliography University of Warwick and University of the West of England.
- Thames Valley Health Innovation and Education Cluster (HIEC) (2013) Delivering an integrated GP and medicines management service for the residents of care homes, Integrated Service to Care Homes Project Report v3.1.doc., Oxford: Thames Valley HIEC.
- Turner, M., Payne, S. and Froggatt, K. (2009) Evaluation of end of life care initiatives in care homes on the Fylde Coast, Lancaster: International Observatory on End of Life Care, Lancaster University.
- Watson, J., Hockley, J. and Dewar, B. (2006) 'Barriers to implementing an integrated care pathway for last days of life in nursing homes', *International Journal of Palliative Nursing*. 12(5): 234–240.
- Wild, D., Szczepura, A. and Nelson, S. (2010) Residential care home workforce development: the rhetoric and reality of meeting older residents' future care needs, York: Joseph Rowntree Foundation.
- Winstanley, L. and Brennan, W. (2007) 'Advanced practice and support in prescribing and medicine management for care homes', *Journal of Care Services Management*, 1(3): 233–244.

Evidence review on partnership working between GPs, care home residents and care homes

This report is a review of research and other evidence from literature accessed by the Social Care Institute for Excellence (SCIE) through systematic searches (see 'Methods and studies for the evidence review' at the end of the report).

Studies were subject to systematic screening, data extraction and quality appraisal. The report provides a compendium of detailed evidence (including quotes from qualitative studies) to inform the practice guide, with summary statements.

Social Care Institute for Excellence
Second Floor
206 Marylebone Road
London NW1 6AQ
tel 020 7535 0900
fax 020 7535 0901
www.scie.org.uk