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Improving access to and experience of GP services for older people living in care homes: practice survey



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Introduction

This practice survey was carried out between February and May, 2013.

It consisted of three focus groups of managers representing care homes from the voluntary and private sectors. Focus group 1 was attended by six managers of nursing homes who were members of the Royal College of Nursing. Focus group 2 was attended by eight managers of private sector nursing and care homes. Focus group 3 was attended by nine heads of homes in the voluntary sector, and their operational manager. In terms of the mix of nursing home/care homes, there were 18 care homes and seven nursing homes represented in the focus groups. In terms of the geographic spread, two managers were from the north of England and the remainder were from the south. There were 25 questionnaires sent to all managers in the focus groups with a response rate of 70 per cent.

In addition, we visited three care homes (one residential, two with nursing) to audit practice. The homes were 54, 36 and 34 bedded with no vacancies. We were, with permission, able to speak to 17 residents, two relatives, three care home managers (not from the focus groups), three nurses, two senior care staff and five care staff. We were unsuccessful in obtaining interviews with GPs although one GP with an interest in older people agreed to a telephone interview.

Summary of key points arising

- People who use services reported that they were happy with the service that they received from GPs, feeling that GPs took the time to listen to them and understand the specifics of their situation. Nevertheless, few people reported regular contact with their GPs, either because they felt they did not need it, or because sufficient care was provided within the home.
- The home managers described a wide range of practice in the ways older people in care were able to access GP services, and often in the standard of service received, so that it is hard to present a typical picture. Managers spoke of a postcode lottery, but it is also clear that services can vary widely even within one area.
- Managers of homes that use local enhanced GP services mostly reported that this system was working well, with the closeness between the home and a given practice seen as beneficial. However, there were also arguments put forward for why older people in care should continue with their existing GPs, particularly because the GP then had a longer term knowledge of the patient and wider family. Some people who used services noted how upsetting it could

be to have to break off a long-standing relationship with a GP on being admitted to a home, and would have liked to keep their existing GP.

- The key factors seen as promoting joint working between care homes and GPs were establishing good communication and building a close working relationship. The majority of home managers reported that they had a good, very good or excellent relationship with the individual GPs they worked with. Regular meetings and reviews with GPs were felt to be important in achieving this, although not all GPs were willing to do this. People who use services rarely reported any kind of fixed or regular GP reviews.
- Although home managers emphasised their close relationship with some GPs, this could cause difficulties when that GP was not available. One major problem reported by home managers was working with locums or out-of-hours GP services, where knowledge about individual residents was lacking, often leading to unnecessary hospitalisation.
- This was one part of a wider problem reported by home managers regarding record keeping and the way information was shared between the home and other health professionals. It was felt that there could be a greater role for technology in ensuring better practice in this area.
- Home managers reported that district nurse teams often provided the main link between care homes and GP surgeries. This could work well, providing a level of continuity of care, particularly if direct contact with GPs was difficult. Nevertheless, as with GPs, the quality and cooperation of district nurse services could vary widely, causing some difficulties.
- There was a sense among home managers, particularly those within the private sector, that some health service providers saw care home residents as already receiving a level of care within the home, and therefore viewed them as a lower priority compared to those in the wider community. This was particularly the case with mental health services.
- Homes often did not have specific mechanisms in place for collecting the perspectives of residents and their relatives on access to and experience of GP services, although this subject was often covered in broader quality assurance forms and Care Quality Commission surveys. Service users mostly reported a very positive experience of GP services, although home managers did note that this was a growing cause of complaint for some relatives of residents.
- Managers of homes reported that they would like a clearer protocol or agreed definition, at national or local level, of what services should be on offer from every general practice, and clearer information on how to access them.

Key perspectives

The resident's view

Margaret is in her 90s and has been resident in the nursing home for two years. She describes her health as good, apart from her broken hip, her rheumatoid arthritis and a difficulty she has in swallowing. She was admitted to hospital after falling and breaking her hip. She liked it there and wanted to stay, but after 100 days they told her she had to go, and she was discharged in to the nursing home. She is currently confined to a wheelchair and is in constant pain, but likes living in the home and says she is happy.

Before coming into the home, Margaret had been registered with the same GP for a long time. 'He knew me for 30 years and saw me through all my traumas.' He used to phone her up to have a chat, and she liked that. When she moved in to the nursing home, she was registered with another doctor. She doesn't mind this as she wouldn't want to drag her old doctor out to the home to visit her, although she only used to live about five miles away from the home she is now in.

Although Margaret has never seen her new GP, she says that she knows how to arrange an appointment. 'If I want to see a GP I tell a carer and the carer tells the nurse and they decide between them... If I wanted to see a GP I could because I've got a mouth and I know how to make myself heard.' She says that she is happy with the medicines she is currently taking.

The relative's view

June, in her 70s, is married to one of the residents of the nursing home, and visits her husband three or four times a week. He was admitted to the home about a year ago, following a stroke, his second, that left him paralysed down one side. He has found it hard to adjust to life in the home and often gets angry with June and the nursing staff, asking when he is going home. He is losing weight because he isn't eating, and June thinks he might be depressed.

Since being admitted to the home, June's husband has a new GP, who she doesn't know. She doesn't know whether he has seen the GP recently, what medicines he is on or what plans are in place for his care, although she does know that they have both signed to say that they do not wish to be resuscitated. She says that knowing more about what is going on with her husband would help her to understand how to be with him. She is surprised to discover that she can ask the GP about her husband's health and says that she would like to do this.

The home manager's view

Sarah is the registered manager of a 51 bed nursing home in London, where she has worked for 10 years. She is also a qualified nurse. The home, currently full, is part of a national group. Around three-quarters of the residents are funded by the local authority, and the remainder are self funding.

Some residents keep their existing GP when they come to the home, and Sarah says this works well as it means the GP has an interest in the resident. However, most GPs don't want to continue with a patient if they have moved outside of their catchment area, so Sarah often has to register new residents with local surgeries. This can be a

struggle, and often she has to go to up to five different surgeries before she finds one willing to take on a nursing home resident. 'It's age discrimination. It's illegal. I have to fight every time I go to register a resident. Basically, GPs don't want to take an older resident on because they cost too much in time, in resources, in medication, supplements, whatever, so it's very difficult.' Although she has complained about this to the local PCT, the situation has not improved. She now tends to register the residents at one particular local surgery, where she has a good relationship with the GP. 'She's kind, she cares and she's interested in older people. If you ring up and give your observations, she'll say, "I think he needs an antibiotic, but I'll come and see him at the end of surgery".' Sarah is not aware of any local enhanced service arrangements, and says that, although other homes in the group may pay a retainer fee for GP services, she refuses to do this. One GP asked for £3,000 a quarter to look after the home's residents. 'I said it is your duty. They are registered to your surgery, why should I pay you extra. It is your duty to care for the residents registered to you, so why should I pay you a retainer?'

Once the residents have been registered with a GP, it can still be difficult to get the required standard of care. Sarah recently contacted a GP to discuss one resident who had suddenly stopped eating. Rather than considering whether this might be the effect of the resident's dementia, or the impact of new medication, the GP's response was to say, 'oh well, she's 96, what do you expect?' Again, Sarah sees this as discrimination. 'If you went to your GP and she said, "oh well, you're 54, what do you expect?", I don't think you would be happy with that or tolerate it. What difference does your age have to do with it?'

There is also what Sarah calls 'a two-tier service', depending on whether or not the resident is fully funded by the PCT (funding for health and care). Only four residents are currently fully funded in this way, and they will receive specialist care (e.g. visiting cardiac nurses, diabetic nurses, tissue viability specialists) within the home. The other 47 residents, who only receive free nursing care, do not have access to these specialist services, and have to rely on the care provided by the home nurses and their GP. 'If my nurses are not up to it then [the residents] suffer.'

Sarah thinks there is a particular problem with out-of-hours care. She tells the story of one resident, nearing the end of life, who did not want to be resuscitated or admitted to hospital, a care plan that was known by the GP. However, when an out-of-hours doctor was called out, he was unhappy that the resident had not been sent to hospital earlier and reported the home to the local authority safeguarding team. The safeguarding team got in touch with the resident's relatives and it was decided not to proceed with the complaint.

To improve the situation, Sarah would like to see a change in the attitude of GPs and health professionals in general towards older people. She also thinks that there should be specialist GPs paid just to look after older people.

The care assistant's view

Leslie has worked as a care assistant in a 34-bed nursing home for about 18 months. This is her first experience of working in the care industry, having previously worked in a corporate job for 24 years. She works 32 and a half hours per week, plus extra hours when needed, working early, late or night shifts.

Leslie explains that it is not normally down to the care assistants to decide when to contact a GP. 'What happens is the nurses will make contact with the GP. If a resident is unwell or deteriorating or there are specific issues that need to be addressed, and of course for that you need a specific GP because of medication, because of referrals and specialists and so forth, then they will make the decision, of course, with the resident. The resident's family can also make requests and say "I think we need the GP for x, y and z", and they come here and visit the resident.'

Nevertheless, Leslie thinks that care assistants play an important role, acting in between the residents and the nurses. In caring for the residents, she will notice the details about the residents' day-to-day wellbeing and pass that information on to the nurses. 'If we do notice that there is a deterioration of any kind, or even an improvement, then our job is to report that to the nurse because all of that information is recorded and acted upon.' This observation is constant, across the shifts in the day.

Leslie has access to the residents' care plans, but she would like to be given more information. 'I think in some ways it would be helpful to really understand the medical background of the resident. It's not about being nosy or curious, it's just a knowledge about the medical conditions which could be helpful in the way that we treat someone or handle someone, to understand why someone might react in this way or that way.' Leslie also finds it hard when one of the residents passes away – care assistants, who work closely with the residents, can become 'the silent mourners, because no one asks us how we feel about it'. There is sometimes an opportunity to discuss this as part of the handover process at the end of a shift, but she would like more than this, perhaps in supervision. 'I think it's important for everyone, for all members of staff, to acknowledge that they have had a part to play in that life.'

Evidence from the interviews with older residents

The vast majority of residents interviewed stated that they were very happy with the service they received from their GPs. Interviewees reported that their GP 'was very good and understanding and would see to you straight away'; 'comes out and visits, treats [me] with dignity and is respectful and caring'; and was 'very nice, always very helpful... very good'. As one interviewee put it, 'it was like talking to a friend'. An important aspect of this was the feeling that the GP had sufficient time to listen and understand the specifics of their situation, and a number of interviewees commented appreciatively that they did not feel rushed during consultations. One of the few negative comments came from a resident who had been seen in the nursing home, perhaps significantly by a locum doctor, for only about five minutes. Overall, though, the residents' general satisfaction is best captured by one interviewee who stated: 'I have no fault with the GP.'

However, a number of other themes emerged in the interviews to complicate this picture of apparent satisfaction. Firstly, few of the interviewees reported any kind of regular contact with their GP. Some reported that they simply hadn't needed to see the GP – despite the fact that all were users of care home services (either as residents or day visitors), there was a tendency for the interviewees to describe themselves as 'very healthy', 'in good health generally', or '[without] any major health problems', and therefore not requiring GP care. Others were keen to emphasise the quality of the care

they received within the home, which likewise meant that contact with the GP was not necessary. Nurses in the home 'do the bulk of prescription organising and medication collection', as well as arranging things like blood tests and flu jabs. A number of those who had not seen their GP recently noted that they were confident that they could access GP care if they needed to – as one interviewee put it, she had never asked to see a GP but knew that 'if you were to ask for one you would see one'. However, another interviewee, who also stated that she knew that a consultation with a GP could be arranged through the home, could not remember the last time that she had seen a GP, did not know why she was taking the medication she was prescribed, and said 'I would love to see a GP but have not asked'. It is impossible to know how representative this experience is, but one possible solution to the onus being on the resident to ask for GP contact, namely regular review sessions, seemed to be rarely in place. Only one interviewee mentioned their home having GP reviews, and in this case they took place 'as and when'.

Secondly, a number of interviewees commented on the loss of continuity that came with having to change GPs, both through ordinary life events (e.g. the GP moving practice or retiring) and more specifically when the interviewee moved in to a care home and the GP was not able to continue to see them. They found it difficult to adjust to a new GP, became upset and experienced a feeling of loss. One resident who had been able to keep her own GP when she moved in to a home noted how important this was, as 'it can be traumatic with change'. Another reported that she would not have wanted to change her previous GP, although it was not clear whether or not she had in fact been required to.

A range of other issues emerged in the interviews with residents. One interviewee described problems accessing podiatry services, with appointments being cancelled five times before she was eventually seen in the home, and wondered why her GP had not intervened to speed things up. Another noted how important self-confidence was in getting a good experience from contact with the GP. She stated that if she wasn't happy or clear about an instruction, she would not hesitate to ask again. A third said that the nurses in the care home had been very helpful in chasing up medical appointments and dealing with other related matters.

Evidence from the home managers' questionnaires

1. For residents using local enhanced GP services, please say how this is working.

All respondents from homes where residents use local enhanced GP services reported that the system worked well. As one respondent described, 'residents meet the GP for initial contact who is allocated to them for assessment'. There were different ways of making contact with the GP, including through a Single Point of Access team, but on the whole GPs visited the homes on request. However, one respondent noted that there could be difficulties if the designated GP was not on duty, with cover 'patchy'.

2. For residents using own GP service, please say how this is working.

Responses regarding residents using their own GP service were more mixed. In the words of one respondent: 'Sometimes it is outstanding and sometimes it is difficult.' The system could work well, particularly because the GP brought a longer-term knowledge

of the patient and his/her family, and around half of those who responded to this question were positive about the system. One respondent noted that it was useful to develop contacts with practice managers, district nurses and other staff, rather than relying on individual GPs, and another stated that it was 'variable depending on which GP is available'. Those who were less positive about residents using their own GP service reported a range of difficulties. Some GPs were reluctant to come to visit residents, particularly if they had moved out of the GP's preferred catchment area, and re-registering a patient was problematic if they were only staying for temporary or respite care. There were also logistical difficulties: one respondent reported that their home was involved with six surgeries and 20 individual GPs for its 34 residents. Treatment could be delayed simply due to the time taken in contacting so many different surgeries.

3. In your experience, what are the factors that promote and hinder joint working with GPs or other health professionals?

The key factors that were felt to promote joint working with GPs and other health professionals were establishing good communication and building a close working relationship. Regular (weekly) meetings were recommended. Joint working was made easier when the home was dealing with fewer surgeries, and when GPs trusted the home to make decisions and referrals.

Following on from this, the factors that respondents felt hindered joint working were mostly those which made good communication and a close relationship difficult. One respondent suggested that 'over-enthusiastic gate keeping' made it hard to maintain communication with GPs, whilst others highlighted a particular lack of communication with locum or out-of-hours GPs. Technology that could have been used to improve the situation (a shared computer system) was not in place, and there could be 'lots of waiting on the phone and then not being able to get through to the right person'. One respondent pointed to the 'back covering' culture that is prevalent in the whole profession at the moment" as a stumbling block, and another also noted that the perceived gap between NHS and private sector workers could lead to 'negative attitudes'.

4. Do you have any mechanisms for collecting the perspectives of care home residents and their relatives on access to and experience of GP services? If you do, what are the main themes?

Most respondents mentioned quality assurance forms and Care Quality Commission surveys, in addition to residents' and/or relatives' meetings, although these were often more focused on the general home experience rather than relating to GP services in particular. As one respondent put it, 'the older generation seldom complains', and another noted that 'there has never been a cause of concern regarding experience of their GP services expressed' during the residents' meetings. Where feedback had been received it was mostly reported as positive, although one respondent stated that surveys 'show that the service offered by GPs is not always the best'. Two respondents reported that their homes did not have a mechanism for collecting residents' and relatives' perspectives on this subject. Another noted that 'residents' expectations are unrealistic so [we] would not consider presenting them', although in this case there were regular meetings with relatives.

5. How can registered managers, staff and relatives ensure care home residents benefit from the full range of GP services?

Three key themes emerged in the answers to this question: information, contact and multi-agency/multi-disciplinary working. Managers, staff and 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. One respondent suggested that the advertising of GP services could be improved, perhaps with leaflets sent to homes. Similarly, regular (weekly) meetings between home staff and GPs and other health professionals was felt to be an important way of maintaining contact. In the experience of one respondent, this 'really helped to improve access to GP services and [the] working relationship between care home staff and [the] GP'. Finally, the multi-agency/multi-disciplinary nature of building individual care plans was emphasised, as a way of achieving 'consistent planning to avoid crisis management'. One respondent suggested that GPs 'need to make time to involve themselves in this process and be encouraged to contribute to these proposed outcomes', whilst relatives 'need to become more involved and be encouraged to participate at whatever level they can'. Home managers and staff should be 'acting as a facilitator to bring all those involved together'.

6. Please tell us your experience of working with local GP services. We are particularly interested in your experiences of the following areas:

Post-admission assessment

Respondents reported a range of different practices. In some cases, post-admission assessment by a GP was standard practice and/or available upon request. In others this only happened when there were particular concerns. One respondent noted: 'We have no such thing!' A number of respondents commented on pre-admission assessment and information (such as a brief medical history) coming from the GP. In one case, the care home had been involved in designing the pre-admission assessment form, 'so it has the info we need to provide proper care'.

Regular review and assessment, including medicines review

Again, practice varied quite widely in relation to reviews and assessments. In about a third of cases, respondents reported a more or less fixed system of three-, six- or 12-monthly reviews. In other cases medication reviews could be carried out by nurses or consultants as required. However, some respondents found that reviews were 'not [carried out] as often as they should be', and one respondent noted that arranging reviews '[r]equires a great deal of chasing and nagging and sometimes intervention from external agents'. As reported in other questions, GP involvement was variable: 'Some GPs are good at this, others not.'

Continuity in care before and after admission

For some respondents, continuity of care worked well, and the role of GPs in supporting this (together with other health care professionals) was noted. However, this was not always the case; in the words of one respondent, such continuity could be 'problematic depending what time of day it is, what day of the week it is and what doctor you are talking to'.

Reviews, protocols, advanced clinical planning and advanced care planning for end of life

Planning for end of life was identified by most respondents as an important issue, although again there was a great deal of variation in how helpful GPs were in supporting this. Two respondents mentioned accreditation with the Gold Standard Framework, and another identified their home as end of life champions. GPs could be involved particularly with organising DNAR forms, although some respondents reported that GP involvement could stop here. Where GPs were helpful with end of life planning, it was often noted that homes chose to work with them for precisely this reason; as one respondent noted, 'not all GPs are equally forthcoming with this'. One respondent mentioned that the recent reporting of the Liverpool Care Pathway had left the GP reluctant to assist in this matter, leading to inappropriate hospital admissions.

Referral to secondary services

About a third of respondents reported that GP involvement in referring residents to secondary services worked well. However, delays were reported both in getting initial involvement from the GP and in appointments coming through once the referral had been made, particularly for mental health and dementia needs. One respondent also noted potential difficulties with '[p]ost-diagnosis support from the GP', when the GP needed to be involved in 'ongoing treatment / care' after hospital intervention. Another respondent noted that sending hospital discharge letters on to the GP helped to ensure they had up-to-date information, particularly if new medication had been prescribed in hospital. In one case, the respondent reported that referrals to secondary services were made directly by the home, and the GP was only then informed.

Consistency of clinical practice for care home staff to follow

Most respondents reported that consistency of clinical practice in these areas came from the support of specialist or district nurses. However, some respondents noted that consistency could be hard to achieve, as 'different doctors and nurse practitioners may have different ideas'. Poor communication between the different agencies involved was also given as a potential problem. One respondent reported that their home received no support with any of the issues mentioned.

Relationship between care home managers and GPs

The majority of respondents reported that their relationship with the GPs they worked with was good, very good or excellent. At best, this relationship was '[f]riendly, relaxed and informal whilst remaining professional', 'based on mutual respect and trust' and involved working 'as a team [to] discuss any issues arising'. One respondent noted that the GP they worked with most closely had given his personal mobile number to enable greater contact and access. However, some respondents emphasised that establishing this relationship required work on the part of the care home manager, and this was not always successful, particularly when the home was working with multiple GPs. One respondent reported that they had contacted GPs on a number of occasions to invite them to discuss the work of the home and implementing the enhanced service, without receiving any response from the GPs.

Information for relatives and residents on access to GP services

In most cases respondents noted that the home and/or the GP provided this information to residents on admission, although in some cases it was felt that GPs could be more active in this. One respondent suggested that a leaflet from the GP would be helpful. Two respondents noted that relatives were able to contact the GP if required.

Stakeholder perspectives

Respondents to this question mostly reported that stakeholder perspectives on the subject were positive: 'We have had no complaints'. One respondent noted that the situation was improving, as a result of building 'a network of contacts to support us rather than rely on individual GPs'. Another reported that nursing staff found it difficult to contact GPs directly 'without lengthy discussions having to take place with their receptionists'.

7. In terms of a guide for registered care home managers, what would you find most useful?

Respondents requested a guide that was approachable and accessible, that set out the different services on offer and how to access them. The guide 'should embed the principles of the national programme of the Gold Standards for Care Homes', that put forward joint standards and protocols, 'accepted by all and then made clear to all'.

8. Any other comments, themes or issues?

A wide range of points was raised in response to this question. There was a criticism of the high turnover of district nursing teams causing a lack of continuity, and of the unwillingness of the out-of-hours GP service to visit in person. One respondent highlighted the lack of out-of-hours service or crisis team for residents with dementia, who are seen as already being in a safe place, without taking into account the needs (and safety) of the other residents. Another pointed to the twin problems of '[m]anaging expectations and funding', suggesting that the focus should be less on extending the lives of residents, and more on 'the quality of the final stages of their lives'. Another suggested that their home's positive experience of enabling residents to access health services might indicate that 'small is best practice'. Finally, two respondents referred to the increased role of GPs within the new Clinical Commissioning Groups (CCGs), and the opportunities for care homes to work with CCGs in providing care for the elderly. This could help to prevent bed blocking, prevent unnecessary hospital admissions and give the elderly 'quality care and attention they may not receive in hospital'. As one respondent put it: 'Multi-disciplinary care planning has been the watch phrase for many years but it's now time to actually make it work.'

Evidence from the home managers' focus groups

In most cases, the specific arrangements individual homes had in place with local GPs were best captured in the questionnaire responses. Nevertheless, some issues emerged in more detail in the group discussions. One participant argued strongly in favour of a direct connection between the home and a given GP surgery, stating that 'when one surgery looks after one unit the entire service is better and healthier, it has continuity'. Despite this, enhanced GP services were not universally supported:

sometimes it meant better access, sometimes it did not. There could also be an argument for new residents maintaining contact with their existing GP, where continuity could be particularly important at a time when other life circumstances are changing. As in the questionnaire responses, concerns were expressed regarding out-of-hours care, and particularly the role of locums, who did not have prior knowledge and experience of the residents and so could offer less effective care and support. It was noted by one participant that, whatever the arrangement was in practice, it should meet the health care needs of the resident, rather than suit the GP or the home.

Focus group participants noted that it was often teams of district nurses who provided the main link between homes and GP practices. This could work well, but, as with GPs, the quality and cooperation of district nurse services could vary widely from one practice to another. The best nurses would often move on, and frequent reorganisations could also have a disruptive effect, leaving nurses having to reapply for their jobs. One manager of a private sector home had complained to the CQC regarding lack of cooperation from the district nursing service. The district nurses felt very over-stretched, and didn't want to provide services to private residential and nursing homes. They considered residents were at least receiving care there, and gave higher priority to people in the community with nursing needs. This sense of care home residents being seen as receiving some level of care and therefore given less priority was also reflected in mental health services, where crisis teams would not come to care homes out of hours. In the absence of appropriate health provision, focus group participants reported occasions when it had been necessary to call the police to have residents displaying disturbed or violent behaviour removed to a place of safety.

One theme which emerged strongly from the focus group discussions was the wide variation in practice regarding record keeping. In some homes, GPs and nurses (including CPNs) regularly wrote medical information in the resident's notes or care plan. One participant described how in their home, the GP made weekly visits and made notes of any consultation on a record system the home's nurses could access. Elsewhere, however, standardised record keeping like this was rare or unknown, and it was more common for the visiting GP or nurse merely to see the senior staff member on duty for a verbal handover before leaving. This raised concerns about the lack of a proper paper trail of evidence, particularly in cases where complaints had been made about a resident's care. In another example, the home and the resident were implementing a planned but unrecorded weight-loss programme recommended by the GP, but in the course of a CQC inspection, the inspector challenged the resident's weight loss and implied it was caused by inadequate diet for which the home was responsible.

One participant noted that there was still 'a postcode lottery' in terms of the range of services available, and the focus groups provided a number of examples of this. For instance, some GPs were willing to provide prescriptions for liquid foods and supplements for certain residents, particularly those with dementia, where it was felt to be a significant contribution to health maintenance. Other practices, however, declined to supply these materials on prescription, taking the view they fell outside the definition of medication for which the NHS was responsible, and should be funded by the home. Likewise, district nurses could be involved in deciding to authorise or block the provision of particular items of nursing equipment: the nurse could decide that some individuals

were or were not entitled to specific items, or that something could be loaned for a limited period, or that the home would have to purchase the item themselves. Service could vary widely even within one area: one participant reported that of the four local surgeries their home worked with, two were much better to work with, more proactive and more willing to support active planning for end of life than the other two. As a result of situations like this, participants noted the need for a clearer protocol or agreed definition, at national or county level, about what services should be on offer from every general practice. Such a protocol should be as simple and robust as possible.

More so than in the questionnaire responses, focus group participants reported that relatives of residents sometimes complained about GP services. A general increase in adult protection referrals relating to people in homes included some complaints about actions or the lack of action from GPs or district nurses. Other complaints from residents' relatives related to GPs prescribing over the phone without visiting to examine the resident, particularly for urinary infections.

Another theme which emerged particularly from the discussions of the group of RCN members was the extent to which home managers were called on to act as advocates on behalf of residents, sometimes taking on the role in the absence of the resident or a relative being able to advocate on their own behalf. This gave a particular character to the relationship between home managers and GPs: '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.'

A range of other issues were touched on during the focus group discussions. One participant raised the question of ageism within the NHS: professionals could be reluctant to put themselves out for an older person, either because they lacked the expertise or they felt it was a waste of their time. In contrast, one participant reported that their home worked with a GP surgery which took on trainee GPs, and arranged for every trainee to spend time in the home learning about the care of elderly residents. Another issue raised was the 'virtual ward' model of health care in the community, in which patients received the equivalent of hospital treatment and care in their own homes. It was suggested such a scheme could include some residents in care homes, to avoid the need for them to be admitted to hospital, or enable early discharge.

Conclusions

A number of themes emerge from the range of evidence in this practice survey. These include the apparent split between the perspective of people who use services (care home residents) and their relatives and the experience of care home managers; the tension between diversity and uniformity of practice; the key issue of access to knowledge in ensuring best practice; and the question of underlying attitudes and assumptions and how these might be addressed.

Perhaps the most striking finding to emerge from the different perspectives considered in the practice survey is the apparent split between the largely positive account given by residents and the more mixed picture presented by care home managers. On the one hand, the care home residents interviewed mostly stated that they were happy with the service they received from their GPs, and described the relationship with their GPs in glowing terms. On the other hand, care home managers, whilst presenting lots of good practice, also spoke of GPs who didn't want to travel to visit their patients in care homes or refused to register care home residents as new patients; who never replied to invitations to find out about the work of care homes and implementing possible enhanced services; or who dragged their heels over referring care home residents on for secondary services. There are a number of possible explanations for this split. Perhaps the simplest might be that care home managers go through these difficulties with GPs precisely so that residents don't have to – it is because managers weed out the less cooperative GPs that residents are able to report such a positive experience. However, one comment from a home manager points to an equally plausible explanation: 'the older generation seldom complains'. There is also a notable reluctance in the responses of some older people to be seen as a burden, or even to ask for what they apparently know they are entitled to: as in the case of Margaret, the resident, who didn't mind having to change her long-standing GP when she was admitted to a care home because she wouldn't want to 'drag' him the five miles that she had moved to visit her in the home; or the resident who wanted to see her GP, and knew that she could request an appointment through her home, but had never done so. In light of this, the problem seems to be not, as one home manager suggested, that 'residents' expectations are unrealistic', but that they are much too low. One solution to this comes in the response of the home manager who spoke of managers as having a role as an advocate, being 'the facilitator to ensure the client gets what they have identified they need'. Another is perhaps in making greater use of proactive systems of regular reviews to ensure that it is not down to the individual resident to have to ask for something they may not necessarily feel entitled to.

A second theme that emerges from the evidence is the tension between diversity and uniformity of practice. Particularly in the responses of the home managers, a wide diversity of practice was reported – in how services are accessed, in the quality of service accessed, in the processes put in place around the service and so on. In part, this is perhaps inevitable, reflecting the wide diversity within the care sector more generally, and may be seen in positive terms as the opposite to a 'one size fits all' policy. The homes considered in this practice survey are large and small, operating in the private and the charitable sectors, and offering services to a variety of user groups. Some diversity of practice might therefore be considered a good thing. Yet diversity is

also seen in very negative terms in the phrase used by one home manager, 'a postcode lottery', and in another manager's description of service varying 'depending what time of day it is, what day of the week it is and what doctor you are talking to'. The evidence suggests that GPs in different parts of the country, and sometimes even within the same area, offer widely differing levels of service to residents of care homes. The clearest example of this comes in the unwillingness of some GP surgeries to register any care home residents as new patients; likewise, the fact that some GPs will and some won't prescribe food supplements to older people with dementia who cannot or will not get all their nutrition from their normal diet. The response to this more negative sense of diversity therefore seems to be to search for uniformity, best captured in the home managers' request for a regional or national protocol, 'accepted by all and then made clear to all'. This tension between diversity and uniformity of practice, or perhaps between positive and negative meanings of diversity, remains to be resolved.

Much of the best practice uncovered by the survey centres on open access to information, whilst a knowledge deficit seems to characterise much in the system that doesn't work, and this is a third key theme. At one extreme, there is the experience of June, the relative, who did not know the GP her husband had been registered with when he was admitted to the nursing home, did not know what treatment or medication he was receiving, and did not even know that she was entitled to make contact with the GP to find this out. Likewise, the problems that arise with locum or out-of-hours doctors often stem from their lack of information about individual patients, sometimes leading to complaints or unnecessary hospitalisations. In this sense, therefore, lack of information can mean that services aren't accessed or that treatment is inappropriate. In contrast, the open sharing of knowledge between different stakeholders, and a valuing of the people in their care was at the heart of much of the best practice described by residents, carers and home managers. There is the knowledge that comes from hard-won experience, as in the managers who know which local GP to approach to get the best service or the quickest response. There is the knowledge that comes from long-standing relationships, which residents' existing GPs can often bring to their care, or from close day-to-day contact with residents, like that described by Leslie, the care assistant. Most importantly, there is knowledge that is shared between different stakeholders, as in the home which helped to design the GP's pre-admission assessment form so that they had the information they needed about new residents; or the home where GPs input the notes of any consultations with residents onto a record system so that nurses in the home can easily access the information. The evidence gathered by this practice survey would suggest that ensuring knowledge is exchanged freely between all stakeholders – residents, relatives, care assistants, nurses, home managers, GPs, district nurses and other health professionals – is central to achieving best practice in this area.

Finally, the practice survey suggests a number of underlying assumptions or attitudes surrounding older people's access to GP and other health services, and these may need to be questioned or addressed further in order to ensure best practice. Firstly, there is what some home managers were quick to identify as the discriminatory attitude demonstrated towards care home residents by some GPs. This could be seen in the refusal of some GP surgeries to take on residents as new patients, and in the reluctance of some GPs to follow particular assessment or treatment paths with older

people that would be standard for younger people. As Sarah, the home manager, put it, 'What difference does your age have to do with it?' In seeking a resolution to this problem, there is again a tension between diversity and uniformity: would it be better for GPs simply to treat older people the same as they would any other patient; or, as Sarah suggested, would specialist GPs working just with older people be preferable? The GP surgery mentioned by one home manager, which arranges for trainee GPs to spend time in the home to learn about the care of older people, seems to offer another possible solution. Secondly, there is the attitude apparently demonstrated by some healthcare professionals, sometimes connected to tensions between NHS staff and private sector homes, that care home residents are by definition receiving a level of care and so are given less priority than others in the community. Home managers reported that this attitude can lead to residents not getting the services they require, or to inappropriate treatment, including unnecessary hospitalisation and, in the case of disturbed residents not seen by the mental health crisis team but dealt with by the police. There was less of an indication from the evidence gathered of how this attitude might be challenged or addressed.

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