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Provision of medical care in care homes in the UK

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Workstream 2: Development and evaluation of interface geriatrics for older people attending an AMU

Workstream 3: Development and evaluation of improvements to health care in care homes

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Summary

- Within the normal contractual arrangements for General Practitioners in the UK, it is difficult for residents of care homes to have ideal access to their GP, at least in urban areas, because each practice can only provide this ideal service in the minority of homes where the majority of the residents are registered with them.
- GPs can, however, achieve high quality prescribing, particularly with close working with pharmacists, but do not have the time to fulfil necessary but complex roles such as end of life care.
- A likely necessary condition for high quality GP care is for each care home to have a weekly visit from a local GP who looks after all the residents. A preferred practice arrangement is likely to be required, but patient choice is cited as a reason against it.
- The role of the care home manager in the delivery of health care to the residents of care homes is significant. These social care practitioners make important health care decisions including end of life decisions. Where managerial arrangements are weak in a care home, it follows that health care will be poor. Health authorities do not have direct jurisdiction over care home staff, being mainly employed through the private sector.
- High quality health care is more than good GP support for a good care home manager. Providing good health care requires improving GP cover and ensuring high standards of management within care homes, but also access to a range of other health provision. Access to these services only though a GP, when GP cover is poor, has drawbacks. Access to these services by means that by-passes the GP also has drawbacks.

Introduction

The overall aim of the Medical Crises in Older People care home workstream was to improve the quality of health care to care home residents. The research objectives were to develop, implement and evaluate a better way to detect and respond to worsening health in care home residents and to reduce hospital admissions.

The care home workstream initially comprised the following research elements:

- A cohort study of a representative sample of care home residents, to describe their health, changes in their health, and their health resource use
- Literature reviews of guidelines and protocols for health problems in care homes, and of the RCT evidence on interventions in the care home setting
- An interview study of a variety of staff involved in the health care of residents of care homes
- An evaluation of a structured, proactive, individualised monitoring and response process in care homes.

This research was undertaken in Nottingham and Nottinghamshire. One of the tasks of the workstream was ensure that the research was embedded into clinical practice. This was for important practical reasons:

- Any clinical research requires the willing and constructive assistance of those involved. Clinicians need to see the purpose of the research and how it might help them deliver better care
- Pragmatic clinical research wishes to test interventions in naturalistic settings, so that the findings can easily generalise to ordinary practice.
- The success of this particular intervention will require an effective response of the whole health care system: there will be no point detecting changes in residents' health if no effective response ensures. This research not only needed to embed itself in clinical practice, but to help optimise it.

This report describes and reflects upon the primary medical care context in which this research took place: the care home sector, in Nottingham, UK, in 2009. The report is written using the structure of a scientific research paper (introduction, methods, results and discussion). However, the points made in the discussion are drawn from a variety of sources, not only the particular activities describe in the methods and the results section, as this is intended to be a personal commentary paper. Since this report is necessarily personally informed, I should first provide some details of my background and hence provide readers of the report with an appreciation of the perspective from which I come. As well as being a clinical academic, I have been working as a consultant community geriatrician since June 2004, a role I developed and piloted. I see patients at GPs request, and support community matrons and intermediate care services. I also see most care home patients referred to me, from whatever route, in their care home rather than in my hospital clinic. I lecture to undergraduate medical students about institutional long term care. I have undertaken many assessments of geriatricians in training in the UK. I have been active in the British Geriatrics Society in a number of roles related to health policy, clinical research and clinical practice in the care homes. I came to this research project with this background, largely agreeing with Black and Bowman's views that health care for care homes in the UK remains fragmented and the response to it idiosyncratic[1]. I must admit that I have little day to day experience of life or day to day medical care in care homes, and it was recognition that this limitation might reduce the success of the Medical Crises Care Home workstream that spurred me to undertake the clinical development activities described in this report.

Methods

The clinical developmental activities I undertook included visits to three local GP surgeries to discuss the matter of providing medical care to care homes with the GPs. These were three large and highly regarded teaching practices. I asked them about their patients in care homes and how they arranged their medical cover. I asked to see, as a clinician and subject to clinical governance, the records of their patients in local care homes. I then reviewed these records and provided a report back to each practice of my views. The report included clinical questions and queries, and offered further more face to face clinical action if wished – in fact this led to discussions with the care home managers. In effect this amounted to a quality assurance exercise (rather than research), wherein a pro-active clinical review by a consultant geriatrician of their care home patients was made. In this report I describe what happened and draw from the discussions I had and the reflections drawn from the clinical review process.

These practices were chosen because they were known to me through existing clinical and research contacts, as I hoped to use our pre-existing relationship to elicit honest and constructive views. I reasoned that these might be pilot sites for the implementation of our trial intervention in due course, and that it would be easiest to do this working with colleagues with whom a satisfactory relationship already existed. I presumed that what I observed in these practices might not be representative of smaller or non-teaching practices. I offered to pay the GPs for any additional costs incurred in any of the above work, but none requested any.

Results

Practice 1

The first GP practice I visited was a teaching practice with eight partners and other salaried doctors in a mixed class urban area of Nottingham. A search of the Care Quality Commission (CQC) website[2] revealed 17 care homes within 1 mile of the surgery (10 care homes without nursing and 7 with nursing). The partners had no formal list of the care home residents under their care, although they could generate one from their registers easily if a need arose: clearly no need to do so had yet arisen. They recognised most of the 17 homes from my CQC search, and felt they probably had one or two patients in most of them. They recognised three homes where they felt they had about half the residents. They had decided as a practice that one partner would visit one of these three each week. No enhanced contract or external pressure required them to do so, although they were aware in principle that there was a slight uplift in the capitation

fees received by the practice based on the number of nursing home residents (a complex calculation is made based on a number of population demographics to adjust the fees paid under the General Medical Services (GMS) contract to GPs, amounting to an extra payment of some £17 per nursing home resident per quarter). The GPs had previously considered the merits of their way of working. They did not feel that it had stopped requests for urgent visits on other working days, and were not even certain if it reduced this demand. They simply reasoned that this is what GPs need to do in fulfilling their duties as GPs. They saw these visits not as a means to provide pro-active or anticipatory care, but primarily as an efficient means of dealing with several home visits at one time
- in other words, efficiency. On reflection they appreciated that in building a relationship with care home staff, this in itself was helpful and they had received reports from homes comparing this arrangement favourably to those practices that did not visit its residents regularly. When asked if they would consider routine visits to other care with fewer residents under their care, they replied that this would be too time consuming (i.e. inefficient), given their other commitments.

Other than these visits, there were no specific policies or procedures in the practice for their care home population. They had regular medication reviews like other people, irrespective of residential status. No specific process for initial or annual assessment was in place.

During discussions, the GP partners were keen to make two points. One was that there was some concern about the co-involvement of health care services provided directly by local Primary Care Trust. [In the UK, Primary Care Trusts (PCT) are organisations that are responsible for the provision of health services for a defined geographical area, such as the city of Nottingham. Much of the primary care in a PCT is in fact delivered by health centres run by partnerships of General Practitioners, and 20 or more such health centres are to be found in each PCT. Some community health services, such as continence advisory services, are provided directly by the PCT and not by individual health centres.] An example was cited of partners receiving requests from various PCT employed clinical specialists to change medications (such as laxatives, prescribe a variety of nutritional supplements or vaginal oestrogens), without discussion with the GP involved, in some cases reversing decisions explicitly made by the GP or considered by the GP to be unwise. A similar issue was when GPs were asked to sign end of life documentation to authorise it, when they had not been involved in the discussions that had led up to it. These had been done by a specialist nurse from the PCT or member of the care home staff and GPs were understandably reluctant to apply their signature in such cases. The problem here arose from having two or more lines of responsibility, not linked to each other, both potentially making decisions.

The second point made was that the GPs were well aware of the things that they were not able to do, which they felt would be most appropriately performed by a GP: lack of time was the main issue. The example cited was end of life care planning. Since most residents have cognitive impairment, particularly those in whom end of life planning is warranted and likely to be of most help, according to the Mental Capacity Act 2005[3], any such discussion require an assessment of capacity and then the use of the best interests process, which itself involves consulting family and friends. This is not compatible with usual practice where GPs visit care homes between surgeries to deal with a number of minor health queries. It would require an input perhaps an order of magnitude greater than is currently possible, even in this diligent practice.

I reviewed the practice print outs of the residents of one (residential) care home looked after by one partner. Seventeen records were reviewed. The main variables I considered were the diagnoses, the current and previously prescribed drugs and the details of recent clinical contacts. As this was not done on a research basis, I did not abstract summary data, but commented on each case in turn. However I can summarise my findings are follows:

- I would estimate that the average number of clinical contacts was around six per patient in the last six months, and that around 1/3 of the residents had had an emergency admission in the last 6 months
- This GP kept very explicit notes and these demonstrated very good practice including attention to symptom control such as pain, judicious and informed use

of psychotropic drugs, advice on non-pharmacological options for symptom and behaviour control, assessments of capacity, recognition of issues of confidentiality when consulting proxies, and well-justified specialist medical referrals

- The skilled nature of the clinical process was also revealed by the prescribing patterns. For example, most patients were taking a small number of simple drugs. However, they also had a long list of previously prescribed, potentially hazardous, drugs that had been stopped.
- As expected, there was little evidence of end of life care planning
- The large number of calls to the GP reflected a groundswell of relatively minor issues – transient symptoms, rashes, and the like, many of which might did not require any specific medical input

On my return visit to the practice I was pleased to be able to report these positive findings. The partner herself, with genuine modesty, did not think that this performance was anything other than good practice that she would expect of any GP. She did not particularly see herself as having specialised in this aspect of care. Rather than going to see any patients of concern arising from this review of their notes, I asked to be introduced to the manager of the home, with the intention of exploring a little further how minor symptoms were dealt with and what made them consult the GP.

I met the manager of the care at the care home (Care Home 1). It was a 41-bedded care home without nursing, and part of a small chain of homes run by the Methodist church[4]. The manager had over twenty many years in the care profession, having started by being a care assistant and gradually rising in responsibility, with a career break for children, to her current position. First, she confirmed that she felt that the medical care provided by Practice 1 was of very high quality indeed, and without prompting provide several anecdotes of one or other of the partners "going the extra mile" to provide high quality care. She would direct new residents towards this practice if they had to move GP anyway.

She stated that Care Home 1 had residents from 7 different practices. I asked if she thought it would be helpful if there was one practice per care home. This arrangement is sometimes referred to as a "preferred practice" policy and is actively promoted by some PCTs. To my surprise, rather than express an unequivocal "yes", she was concerned that such an arrangement might lead to a care home being forced to have a GP that was not the one she preferred, or for residents to have their choices similarly limited – she believed that some residents are very attached to their GPs, having known them as their family doctor. She preferred to respect her residents' wishes to choose their own GPs even if they did not visit regularly or made it inconvenient for her, assuming that it was part of her job to be able to negotiate the system on behalf of her residents. Although reluctant to say so, she implied that there are some local GP practices that she would not wish to have instead of Practice 1, and hence some perceived variation in practice.

I asked about her understanding of health services other than GPs for her residents. I asked her if she felt health care services were fragmented and haphazard (citing multiple GPs to one home, multiple homes for one practice, some services available directly, others via GP referral). She agreed that the system was complex, but also argued that it gave her flexibility. For example, for a resident who is losing weight, she could refer to a dietician directly if it seemed to be a simple matter, but if she was concerned about an underlying medical issue, she would refer to the GP first. In this discussion I became aware that although she has no formal health care qualification or health care professional background, she had enormous informal health care expertise, a point remarked upon by Bowman and Bowman[5]. It also became clear that her role was critical for care home residents who, unlike most community dwelling older people, were not able to make decisions autonomously or to have a close family member to act on their behalf. In almost every resident, the manager played some role in indentifying a health care need, discussing preferences with the resident, discussing it where permitted or required with family members if they existed, and then liaising with health care services. To do this required skilled staff, a functional managerial system of recording staff's findings and communication with them, and the exercise of judgment (such as when a doctor should be called, and how urgently). Far from being restricted to a role of a mere paid caregiver, the manager of a care home does and must act as an advocate for her residents and, in effect, as a decision maker.

The level of input and expertise that can be demonstrated by a care home manager was revealed when I asked about end of life care matters. The manager took a very significant role in this. She was helped by the fact that care processes designed by and used in MHA (Methodist Homes for the Aged) homes facilitated this. In these homes, residents are asked to engage in the "Final Lap" programme[4]. This has been developed by the chaplaincy and spirituality section of MHA. It covers discussion about preferences for end of life care, and includes asking how residents want to live their last few months or years, as well as how they would like their dying processes and deaths to be managed. MHA trains its staff to do this. This process is not dissimilar to the "Gold Standards Framework"[6] in that it requires similar skills such as sensitivity, the assessment of capacity, confidentiality and the steps needed to respect best interests in those lacking capacity. The process is supported by documentation which, to be fully accepted by other health care professionals, would need signing by the GP. The manager implied that few of these documents were actually signed, but even as informal documents they were sufficient for her to take them into account when fulfilling her usual role as an advocate for the resident. Thus, important "clinical" decisions would commonly fall to the manager such as when to recognise that a person is dying, and what sort of support, if any, to request from the GP or other health care professionals. I specifically asked if she felt that in fulfilling this role she was straying outside of the realm of "social" care into "health" care, but she felt that she was properly trained for this role and this was integral to good social care. Indeed, she re-iterated that, since the manager plays such an important role in access to health care, it is essential for managers to undertake these end of life decisions. If she did not, then as the dying processes occur (and most people die in the care home eventually), there would probably be no-one to ensure that residents wishes were respected.

It was apparent from this care home that by and large it was well supported by GPs, and that it had a stable and skilled staff, working within a well organised and managed charitable organisation. When I asked about what key problems the manager felt existed, surprisingly she did not identify any primary or community care deficiencies. Indeed, when I asked about problem, I heard a long list of problems associated with the interface with the acute hospital: "I dread them going into hospital", "What you are told doesn't happen". Two unsafe hospital discharges in the last year were described where, in both cases, the manager and GP sorted out the problems.

Practice 2

The second practice I visited was a five partner urban teaching practice in Nottingham, with a sizable inner city catchment including areas of high deprivation. Forty three care homes (33 care homes without and 10 care homes with nursing) were identified from the CQC website within a mile of the practice. The partners did not recognise many of these care homes, and this is because this practice was in a much denser part of the city than Practice 1, with many other practices nearby. They recognised three homes locally where they had the majority of the residents. In contrast to Practice 1, they did not make routine visits to these homes. They reported that they had previously tried such arrangements but had felt that not only had it not reduced the number of calls on other days of the week, it had also appeared to encourage the referral of even more and even more minor requests.

> As with Practice 1, no care home specific processes or polices were in place, and care home residents had medication reviews as would similar community-dwelling people.

I reviewed 8 records from one nursing home where the practice had links. For historical reasons it had links to the psychiatric services and a large proportion of the residents had psychiatric disorders (other than dementia). The print outs of the records were not so easy to interpret as those from Practice 1, and I later discovered that I was unable to separate current from previously prescribed drugs. Nevertheless, my comments promoted the GP involved to review the patients himself and this resulted in a modest number of drugs being stopped. It is not clear if these drugs might have been stopped at routine medication reviews anyway. As in Practice 1, there were large numbers of consultations many for relatively minor conditions, not infrequent admission to hospital, and little reference to end of life care planning. The clinical records were not as explicit as in Practice 1, so it was not so easy to comment on the nature of the medical care. However, in response to my report to the GP, he himself reviewed the patients in the light of my comments and wrote back to me. In the latter letter, he more explicitly gave details of the clinical management which again demonstrated high levels of care over prescribing. In this letter he also raised two more issues:

- End of life care, he agreed, was not done well. He asked for more discussion about how this could be improved
- He again illustrated the ethical issues that complicate practice in this area. He was aware of the NICE guidance[7] that calcium and vitamin D tablets should be offered to ambulant care home residents to reduce the risk of fracture in the event of a fall but the issue of concern was how to obtain consent for such blanket and prophylactic prescribing, including the assessment of capacity, and how to ensure that best interests were being followed in those lacking capacity. The act of prescribing such agents is relatively straightforward, but establishing satisfactory ethical grounds for doing so is likely to be complex and time consuming. What is a practitioner with little time supposed to do?

Practice 3

The third practice was a four partner rural practice. Only 6 care homes (3 care homes with nursing and 3 without nursing) were within 2 miles of the practice according to the CQC, and the practice only dealt with 2 homes, one of which (Care Home 3) was a nursing home which received regular weekly visits from one of the partners. At the time of my visit, this practice looked after all the residents of Care Home 3.

In fact, my meeting with the practice became a meeting with this partner, to which the trainees in this and other local practices were invited to make it an educational meeting. Few new issues arose from this meeting, although I was able to undertake a straw poll part of the trainees and could confirm that some of these other practices had a one or more GPs who made regular visits to care homes and half did not (confirming that a "preferred practice policy" is not in place in this area, even though in this instance, due to geographical factors, there was only one practice for the residents of this home). Incidentally, the trainees reported no specific education or training in care home medicine or practice.

In this practice, I was invited to join the GP partner looking after Care Home 3 in her routine, 6 monthly, medication reviews. This was done at the surgery, in front of her computer screen with patient details, and with a community pharmacist present. The GP also had a set of forms prepared in advance by Care Home 3 on each person, listing current drugs, current symptoms (such as dizziness or nausea), current BP, drugs that were refused or not given, the amount of "as required" medication actually given, and so forth. The GP annotated these forms and intended to give them back to Care Home 3 with written advice (such as to stop certain medications and review). The use of these forms was initiated by the Care Home 3. With this information and from her regular visits, it was not seen to be a problem that the patients were not in front of the GP at the time of the review. Indeed, the GP opined that going to a care home without having the records to hand would be difficult: she did not have the facility to see her computerised records at Care Home 3, or any others. The GP had clearly been working to adjust medication over a long period of time in these patients. Examples of areas of activity included reducing antihypertensives, treating mild anaemia and adjusting haematinics, and checking U&Es in those on diuretics. The discussion between the GP and the pharmacist seemed to be helpful: the pharmacist could ask questions requiring the GP to justify the current prescription which stimulated a reflective stance. It was also clear that the care home manager was relatively expert and pro-active: she had generated these medication review forms and was clearly trusted to respond to the hand written comments from the GP.

An issue that arose during these medication reviews was the lack of information available to the GP especially for new patients. An example was a patient who has a diagnosis of multi-infarct dementia from one record and mention of intracerebral haemorrhage on another, yet the patient was prescribed aspirin. It was not clear if the information given to the GP was correct, or whether the decision to use aspirin had been carefully made or not. This particular home, being a nursing home specialising in dementia, had a relatively high turnover due to death, and the GP recounted several instances where a resident had died before her full medical records had been available.

As with practices 1 and 2, I felt there was no need for me as a consultant geriatrician to review any of the patients. Instead it seemed helpful to look at Care Home 3, so see how minor medical issues were dealt with, how easily that home dealt with this way of working with the GP, and the manager's experience of end of life care planning. I visited Care Home 3 and met the manager. The GP from Practice 3 was also present, as were two other members of the care home's staff.

Care Home 3 was a 27 bedded dementia registered care home with nursing. It manager was an experienced nurse who has run it as her personal business for several years. It was one of the first home locally to have engaged in the Gold Standards Framework (GSF)[6] process for end of life care. This is a highly structured three-stage process that eventually leads to accreditation by the National GSF Centre (a NHS body). The GSF covers planning for the last year of life, palliative care and treatment preferences during the last year of life, and terminal care. There are parallels between the GSF and Care Home 1's "Final Lap" process.

Rather like the experience of end of life management in Practice and Care Home 1, there was uncertainty about the roles of the GP and care home staff in end of life decisions and documentation. It is worth noting an incident cited as a driver towards the process to adopt the GSF in this home. An elderly lady resident with dementia developed a chest infection, and was being reviewed by a GP trainee attending the home on behalf of the GP partner who would normally visit. This trainee elected to admit the patient to hospital even though the matron did not think it was in the patient's best interests. As it happened, the resident survived the hospital admission although she succumbed a few weeks later. The resident did not appear to suffer from what happened, although the care home staff believed that her best interests were not served and that, in effect, her wishes were not respected. This episode exposed the potential problems in this setting when dealing with people who lack the capacity to make choices for themselves. The manager of Care Home 3 had developed extensive documentation to help support the GSF process. This detailed Do Not Resuscitate decisions, the presence of a Lasting Power of Attorney or living will, requests for organ or tissue donation, discussions with the patient, capacity assessments, if best interests processes or Independent Mental Capacity Advocates (roles specified in the Mental Capacity Act 2005 for England and Wales) were used, a record of communication to all necessary parties, and dates of review. For this information to be translated into a form that was afforded practical authority with local services, several documents were needed to be submitted to various agencies such as the offices of the telephone service often used for first line advice in the event of a medical emergency out of ordinary working hours (NHS Direct), the ambulance service, and so on. Without these documents, the information gathered as part of the GSF process might not be respected by the emergency services: it has been

made clear that paramedics are expected to perform cardio-pulmonary resuscitation on a patient who appears to have had a cardiac arrest unless a specific recognised form was available. These forms have to be signed by a "responsible clinician" (not necessarily a doctor).

Considerable discussion was had about the practical issues of establishing best interests. Just as in Care Home 1, it was clear that only the staff of the care home were realistically in a position to establish best interests in a valid and humane way. Only they were able to judge the right moment or hear and interpret the relevant expressions of desires and values that might be uttered late in the evening, un-prompted or in response to some event or occurrence. Only they, realistically, had the time to do this, as it is almost unheard of for people to enter homes with explicit plans already drawn up by themselves or their families. Furthermore, since the care home staff are the ones who provide the moment-by-moment care and hence are uniquely aware of the well being of the residents, they are fully aware of the consequences of the decisions that are being made in end of life care plans, and so these are not likely to be made lightly or to be uninformed. Finally, it is care home staff who have to decide to trigger or execute such plans. As was evident in Care Home 1, in practice it is within the gift of the care home staff to implement best interests decisions in many cases without any explicit approval or signature from a GP. Consider for example an elderly patient, for whom simple palliative measures only were recorded in her end of life preferences. Should she decline one evening, the care home staff would have the option of calling a GP, NHS Direct or other out of hours provider and risk her being whisked away or receiving an aggressive treatment. But they would also have the option of tending for her themselves, and perhaps informing the GP in the morning that the patient had passed away in the night.

In the case of the manager of Care Home 3, who seemed to me to exercise the highest degree of theoretical and practical understanding of the issues in end of life care, she felt that it was best for her to establish end of life preferences in the ways referred to above, but that professionally she should discuss these with the clinically responsible person (the GP) and that a GP signature on the forms would then provide her with the authority and backing to act in accordance with them. This seems reasonable as a safeguard or governance check, on someone operating at the limits of their professional competence. A problem may arise if the GP fails to support this course of action.

By the end of our meeting, admittedly between highly trained and motivated care home team and a similarly motivated GP, a working arrangement became clear that the GP was prepared to sign documents largely prepared by the care home staff, on the basis of trust that they are completed using best practice. The GP could be assured of that only because of her close working relationship with the home and its experience. It was, however, also felt that it should be possible to provide guidance to ensure that summary forms, such as those being submitted to the ambulance service, include not only the key management preferences, but also brief details of their justification. For example, not only should a form specify ”do not attempt resuscitation” but it should also specify the principal health conditions and the processes used to arrive at the decision: “Patient has vascular dementia. Process deemed medically futile, patient does not have capacity but has expressed opinion against CPR and these views are shared by her husband”.

Discussion and comments

Fragmented and haphazard: is there a care home sector?

The care home sector is increasingly being recognised by the NHS as a health sector, but this was not always so. When the expansion in care home numbers occurred in the 1980s, and while long term psychiatric hospitals were closing, there was a strong ethos against institutionalisation. Care homes were to be homes, not hospitals. Earlier, local authority funded old people homes ("Part 3 homes", named after the section of the 1948 National Assistance Act that mandated their provision) were viewed similarly. I have heard it said that nurses were discouraged or deemed ineligible to manage them - for fear that they might medicalise them. As the residents of care homes were simply community dwelling people, not patients, they were registered with their local GPs. No specific services were developed for them. Probably, the simple reason is that no-one thought to do so. As result, many GP practices, especially those in urban areas have patients in several local care homes, and those homes will have residents registered with several GP practices[8]. This is why medical cover for care homes is fragmented, as was illustrated in two of these three practices. These two practices may be unusually diligent ones, but even these were only able to attempt to be a bit less fragmented and more systematic for some of their patients who resided in care homes.

In the experiences reported upon here, ethical and legal issues are a major defining characteristic of what makes practice so challenging in care homes. What makes the provision of health care difficult in these residents is that many of them lack the capacity to look after their own health care. People who are new to the care home sector appear to be unaware of the high prevalence of mental impairment in this population and how much it interferes with ordinary medical practice where consent is typically assumed and capacity is not in doubt. Cognitively impaired residents may not notice the changes in their health, they may not understand them, they may not articulate them, they may not be able to communicate them, and they may not be able to make decisions about treatment choices. In such cases decisions will need to be made in their best interests. This is a process that is now well defined legally and requires consultation. This is time consuming. It is fraught with problems, such as those that arise from the conflicts of interests of the people who might be consulted.

The other obvious feature about residents of care homes is that not only are they often unable to make decisions about their health, they are also too disabled to use health services in the way that ordinary fit older people might do. Because of both mental and physical problems, they are unlikely to be able to perform much self management of their health conditions and they are unlikely to be able to access health care on their own. They are unlikely to be able to telephone their GP directly, visit the practice for an appointment (unless a relative or member of care home staff can take them). These two reasons are major factors why residents of care homes are not simple community dwelling people, and why arrangements tailored to their needs likely to be required.

GP cover for care homes

This work largely examined the role of GPs in health care in care homes. Even in this small sample there was evidence of a range of practice. Some GPs visited care homes regularly, others did not. Even the GPs that did visit their patients who were resident in care homes regularly did not visit all their patients in care home, but only those where it was convenient or efficient to do so. In the second paper in this series describing a consultation event, a wider range of GP responses are referenced, and the variable provision and access to a wide range of other health services available to care homes are discussed.

GP cover to care homes can range from personal contact with residents, to telephone contact with care home managers or others, or a remote review of their records. It can be reactive, or proactive. In this report, the main model observed was one with regular (weekly) visiting of a GP and discussion with a care home manager and targeted consultations with individual residents, with ad hoc visits and telephone calls as well. Where a close 1:1 relationship existed between a GP and the care home manager, I observed evidence of high quality care. These same practices had patients in care homes that they did not visit regularly, and the care homes had residents who were not visited as frequently as was observed here. It seems likely that the quality of care for people in care homes depends upon the presence of a close working relationship between a GP and a care home manager, such as in a preferred practice model. Sometimes I have heard the view expressed that the quality of health care for people in care homes depends upon whether there is a "good GP" involved. My experience is that perhaps a more relevant factor is the quality of the relationship between the GP and the care home and the degree to which one GP relates to a large proportion of a care home's residents. It follows that interventions to improve matters might not be to improve errant or bad GPs, but to facilitate such 1:1 relationships.

In the services I also observed for this report, the GPs were important in the oversight of the prescription of medications and in management of many of the long term conditions for which they were prescribed. The GPs also provided valued support to a rather vulnerable sector, but often for issues without a major pharmacological or medical solution (such as poor eating or behaviour problems). This finding suggests that changes to the health care arrangements to care homes that withdraws or reduces the role of the GP (for example by replacing them with a host of staff from the professions allied to medicine) could be detrimental unless they were similarly skilled and empowered.

A simple deduction from this report is that things might be better if GPs were better aligned to care homes (one practice per care home) so that the overall good practice I observed here could be expected routinely. At present the reasons not to do this include:

- respecting patient choice (it is not clear however how many patients would choose to be under the care of a new doctor that visited regularly or to stay under their previous GP even if he or she does not)
- geographical issues (unless well–planned, Practices in areas with high numbers of care homes might find residents transferred to them in high numbers but without a flow of resources to match)
- resources (given that these good practices could not find the resources to provide the

same level of care for all their care home residents within existing contracts, it follows that additional resources will be required to raise the level of service)

- leadership (to realign GPs cover and patients is likely to require a top down approach).

These reasons are not insurmountable. One possible financial lever to do so is to introduce an "Enhanced Service" contract such as that used in the NHS in Wales[9]. One limitation of such an approach is that it is optional and hence likely to be unevenly taken up, and another is that it is not easy to be certain that the terms of such contracts are adhered to. Furthermore, I observed evidence of high quality care without such arrangement being in place, so they are not a necessary condition.

It must be acknowledged that, although the preferred practice model can increase the likelihood of a good relationship developing between a GP and a care home manager (and hence facilitate high quality care), I cannot argue that it unfailingly would so do so, as perhaps not all GPs will be as skilled, motivated, or organised as the few I observed.

Role of the care home manager

Good GP care would appear not to be solely in the gift of the GP. The quality of care a GP can administer is highly dependent upon the quality of staff in the care home itself. For example, the GP from Practice 3 could not have performed her medication reviews so easily without the forms created by care home 3, nor could she reasonably be prepared to sign Do Not Attempt Resuscitation and other end of life documents without great trust in the professionalism of the staff in Care Home 3. In Care Home 1, the manager clearly had to make careful choices about if, how and when to contact a GP. Although not observed in the work recorded here, though noted in other parts of the Medical Crises in Older People care home workstream, I am aware of local care homes where the managerial arrangements are not like this – for example one home where there have been several managers in as many months. One can only speculate what the quality of medical care might be in such a home, particularly if no single GP had any significant engagement. Herein lays a significant problem for health services to exert a direct influence. Whereas a PCT could negotiate and implement a preferred practice arrangement and enhanced services with GPs, it cannot insist on the working practice or clinical expertise of the care home staff, since these are, by and large, in the private sector and so the PCT has no direct jurisdiction over them.

Good primary medical care is only one set of health care skills that are needed. Others include tissue viability, occupational therapy and physiotherapy. Arrangements for the provision of these services are explored further in the second discussion paper in this series.

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