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Relationships, Expertise, Incentives, and Governance: Supporting Care Home Residents' Access to Health Care. An Interview Study From England



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A B S T R A C T

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Objectives: To explore what commissioners of care, regulators, providers, and care home residents in England identify as the key mechanisms or components of different service delivery models that support the provision of National Health Service (NHS) provision to independent care homes.

Methods: Qualitative, semistructured interviews with a purposive sample of people with direct experience of commissioning, providing, and regulating health care provision in care homes and care home residents. Data from interviews were augmented by a secondary analysis of previous interviews with care home residents on their personal experience of and priorities for access to health care. Analysis was framed by the assumptions of realist evaluation and drew on the constant comparative method to identify key themes about what is required to achieve quality health care provision to care homes and resident health.

Results: Participants identified 3 overlapping approaches to the provision of NHS that they believed supported access to health care for older people in care homes: (1) Investment in relational working that fostered continuity and shared learning between visiting NHS staff and care home staff, (2) the provision of age-appropriate clinical services, and (3) governance arrangements that used contractual and financial incentives to specify a minimum service that care homes should receive.

Conclusion: The 3 approaches, and how they were typified as working, provide a rich picture of the stakeholder perspectives and the underlying assumptions about how service delivery models should work with care homes. The findings inform how evidence on effective working in care homes will be interrogated to identify how different approaches, or specifically key elements of those approaches, achieve different health-related outcomes in different situations for residents and associated health and social care organizations.

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approval from the University of Hertfordshire ethics committee reference (ref HSK/SS/NHS/00040).

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In England, there are almost 3 times as many care home beds as National Health Service (NHS) hospital beds, and the number is projected to rise.¹ The care home sector provides 24-hour care for older people with enduring disability who can no longer be supported in their own home. The sector is largely independent (for-profit, not-for-profit, and voluntary). Care home residents in England rely on NHS physicians, known as general practitioners (GPs), for their medical care and access to specialist services.² In care homes without on-site nursing, NHS-funded community nursing and specialist nursing support services also will visit. However, apart from a statutory duty to provide registration with a primary care provider, the particular obligations of NHS commissioners in England for the provision of community and specialist health care to care homes are not specified. A survey³ of primary care organizations' provision to care homes found no consensus on the range, or responsiveness of services needed by care home residents. Models of service delivery to care homes range from the provision of specialist teams that either have a generic focus or target specific issues (eg, end-of-life care, prevention of falls) to the provision of primary and community services that do not differentiate between care home residents and older people living at home.⁴

Care homes are both a solution and a problem to the NHS and of increasing health policy interest in England.^{5,6} They are a solution in that they provide long-term and end-of-life care for a vulnerable population who would otherwise need hospital care. They are a problem if the health care provided is suboptimal and leads to increased and inappropriate use of NHS services. Care homes have been crucial in the service response to the rapidly increasing number of people with dementia who need continuous care and support. More recently, they have taken on specialist roles in intermediate and end-of-life care. Internationally, it is recognized that there is a need to focus on the needs of residents in care homes, particularly research that investigates different models of care and their impact on residents' function and well-being.⁷

There is an evidence base specific to the care home context; for example, in end-of-life care and in medication management, to suggest that targeted support by NHS health care services can improve outcomes for older people in care homes.^{8–11} However, how this should be implemented is less well developed and requires alignment with policy, resource allocation, and workforce issues. It is unclear how particular models of service delivery or key attributes within these different models work and if they are more or less likely to achieve particular resident and organizational outcomes.

This article reports on the findings from interviews with a range of stakeholders with direct experience of commissioning, providing, monitoring, and receiving health care services delivered to care homes. The aim of this study was to explore with participants what they thought were the necessary features of service delivery models to care homes associated with positive outcomes for residents. Although the research was conducted using care homes in England as our case study, these outcomes have wider resonance for the delivery of long-term care across the developed world.

Methods

The interviews were completed as the first stage of a realist review of the evidence of what supports effective working between health care providers and care homes in England. Realist review is a systematic, theory-driven approach for making sense of diverse evidence about complex interventions applied in different settings. To achieve this, it brings together multiple sources of evidence to develop possible explanations for the way in which particular interventions are thought to work and the way in which change occurs because of an intervention. This involves identifying the ideas,

assumptions, or “programme theories” that explain how key elements within health service provision to care homes works. To complement a scoping of the relevant policy and evidence on how health care services support care homes, the stakeholder interviews explored the necessary preconditions for improving health care for older people resident in care homes. The purpose of the interviews was to identify these “theory areas” and linked questions so as to frame how the evidence on health care interventions for care homes would then be interrogated.¹² A more detailed description of the study methods is provided elsewhere.^{13,14}

The interviews reported here focused on stakeholder groups and their representatives. These either had responsibility for the commissioning, organization, or monitoring of NHS provision to care homes or direct experience as care recipients. To capture a range of experience that reflected regional, historical, and organizational differences, we identified a purposive sample of NHS and Local Authority commissioners, senior managers from care home organizations, and the care regulator for England (the Care Quality Commission [CQC]) (Table 1). They were recruited and defined as stakeholders on the basis that they were able to characterize the view of a group or organization and would enable us to capture a range of relevant views.¹⁵ The sample was chosen to be able to speak authoritatively about the organization of health care to care homes and to theorize about what achieved the best health-related outcomes for residents, while acknowledging competing explanations. The sample was identified through the CQC; national care home provider representative organizations, residents, and relatives' representative groups; and National Health and Local Authority commissioners for care homes in the east of England and the Midlands. A small sample of care home residents was also interviewed.

Interviews were face-to-face unless a participant requested a telephone interview. Participants were specifically asked to provide a stakeholder view; in other words, to use their experience and expertise as, for example, a care home manager to inform what a good service should look like rather than provide a solely personal account. To facilitate this, the interview prompts addressed current patterns of commissioning and provision. Residents' prompts focused on what they believed good health care to care homes should comprise. Interviews asked about examples of success and failure, how continuity of care was achieved, what “good” working between NHS services and care homes looked like, and the mechanisms or particular service models necessary to achieve the desired outcomes.

The resident interviews conducted for this study were supplemented with a secondary analysis of 34 resident interviews from an earlier study that had focused on access to NHS health care.¹⁶ These interviews had specifically asked about health and the health care services received and what was seen as effective. This additional sample was included because of the challenges of identifying residents who had the capacity to participate and their difficulties in extrapolating from their own experience of health care to consider what good health care provision for care homes should look like. This being the case, rather than conduct more interviews, we decided to

Table 1
Stakeholder Interviews

Role	Number
Care home organization owner/representatives	7
Residents' representatives	4
Care quality commission (regulator)	4
Commissioners of health and social care for care homes: clinical commissioning groups (health) and Local Authority: (social care)	6
Care home residents (34 secondary data analysis)	37
Total	58

use the previously conducted interviews from the earlier study that also had asked about residents' health care experiences.

Data were initially mapped against the interview prompts. There were 3 stages to the analysis. First, there was a process of familiarization and decontextualization and segmenting of data into separate and defined categories close to participants' categories. Second, comparison was made within and between categories and the identification of preoccupations, difference, and themes. The third stage of interpretation was the identification of relationships and emergent hypotheses about how the favored approaches worked, and what was necessary to support their implementation.

The protocol was reviewed and supported by the University of Hertfordshire ethics committee reference (ref HSK/SS/NHS/00040).

Results

All the stakeholders stated that residents are entitled to the same health care that older people who live at home receive. These statements were generally of moral imperative rather than a description of legal entitlement. The following are the 3 overlapping themes of what was perceived as central to the provision of quality health care:

- Interventions that supported relational working between NHS practitioners and care home staff
- Provision of age-appropriate care
- Contractual and governance systems to guarantee care homes' access to NHS services.

Across the 3 themes there were shared elements; for example, access to a GP when needed and the importance of a person-centered care approach, particularly for people with dementia. However, the 3 themes could be differentiated by the emphasis on what had to be done to provide effective health care and what supported or enabled that process. Thus, a person-centered care approach or access to a GP was important for residents' health, but they were described as an enabler rather than the driver for quality health care delivery to care homes. The different emphases on what was contextual and what was seen as essential informed how effective models of service delivery were conceptualized. Each of these 3 themes is now discussed.

Relational Working

NHS service delivery models that supported relational working were seen as addressing the difficulties of working across health and social care systems, agreeing what was publicly funded health care and what came under the jurisdiction of the care home, maintaining continuity of information and reconciling the different priorities of care homes and health care providers. To achieve relational working required investment of resources, dedicated staff time, and the creation of formal and informal opportunities for health care and care home staff to work together. In the examples given, this could happen organically over time or as an explicit intervention with resources allocated to facilitate the process.

Relational working could thus be realized by the identification of key people to work within the care home, the creation of care home specialist roles to provide ongoing support to care home staff, or the maintenance of working relationships within existing models of working with primary care services. Examples focused on models of care in which health care staff visited regularly and predictably, provided teaching and support to care home staff, and were accessible for advice. It was where core activities supported cross-organizational working. One Local Authority commissioner identified the importance of nominated care home staff (champions) being allocated to work with visiting NHS staff to structure how they

collaborate together and enable resolution of residents' health problems in situations of pressure and limited resources.

*I think there has to be buy in on all sides, there's got to be an understanding that certainly in this day and age care home settings are very tight on staff and budgets and sometimes it's getting the right people from these particular homes **to have that spare time to come along and get involved ... It's having champions, it's making sure that each home has their particular champion on particular (health) topics and the they've got ownership of that particular subject** (Local Authority Commissioner)*

Similarly a GP commissioner drawing on personal experience saw that it was possible to maintain continuity and the desired outcomes of care, such as avoiding unplanned hospital admissions, if visiting NHS staff knew that there were what she called "designated care coordinators" to work with. This role was seen as fostering integrated working.

I think the key to successes, individuals are absolutely key, in care homes having a key professional, someone who takes responsibility for each patient (sic), you know you need someone who is trained enough to coordinate that care, which is about integrated care and about, as I say, having patients' co-coordinators, a key worker, whatever you want to call them. (GP Commissioner)

A less formalized method of supporting relational working was described by one care home manager (SH9) "as working like a team." Team working involved shared training events with district nursing staff, care home staff being invited to the NHS provider meetings, and mutual confidence built on previous experience of having jointly resolved problems. She gave the example of being able to work with a liaison nurse to access residents' notes when they were admitted to hospital.

Similarly, another care home manager described how residents' needs were addressed and hospital admission rates were kept low because she knew that GPs would come when asked, listen to their assessment of residents' needs, and support care home staff to provide care. She described this relationship as "lucky." They had, however, learned how to work together over a prolonged period of time. The perceived success was predicated on the fact that there was continuity in their working relationship. Although the GP was identified as the lynchpin, it was the quality of the association that was emphasized as key.

But they (GPs) are very good; they come out and respond, we can ask the GP to phone us, we have a good relationship

Interviewer what makes it such a good service?

*I think the **clinical knowledge of the nurses** and the fact that **we are in a very rural community and we have had families of GPs as patients** and they chose us because of our sound clinical knowledge. We can phone and say ABC, we have ruled out a UTI, we have listened to his chest and the blood sugar is normal, can you come and have a look? (Care Home Manager)*

Provision of Age-Appropriate Care

Other stakeholders saw good working relationships as important but secondary to ensuring that residents received age-appropriate health care. This was expressed in terms of providing health care services equipped to address the health care needs of residents who were frail. The ability of a person or a service to integrate health and social care, or promote relational working, was not seen as sufficient to achieve the desired outcomes of improved resident health and reduced use of secondary services. For these stakeholders, it was the clinical expertise of the visiting health care professionals and equity

of access that was important. There was a need to redress what were known to be serious gaps and failures in how services were currently organized for care homes. A model of health care provision was needed that was sufficiently specialist to assess and address a frail older person's health care needs. It was also an issue of access and equity.

People are very worried about paying extra for physio, for chiropody, for the kind of services that are intrinsic to people's conditions. People are very worried about poststroke patients not having the kind of rehab they'd get if they were at home or staying longer in hospital...it's not just GPs, think about dental care.... you know you really need people like geriatricians who are specialist in the care of older people... the people who specialize in old age psychiatry also need to have a key role...there needs to be an all-round service plan. (Stakeholder From Resident Representative Organization)

The 3 residents interviewed struggled to extrapolate from their personal experience of NHS service delivery to how it should be provided generally to care homes. Nevertheless, their interviews and the secondary analysis of how residents had talked in general about their experiences of health care reiterated the theme about expertise, how seeing the practitioner who understood their health care needs meant that problems were resolved. For example, this resident wanted to see a physiotherapist to help her regain some independence:

I can't stand, but I have said to the manager that if I had proper physio I think they could get me to stand, but nothing has happened about that. Before, I used to get from this chair to my wheelchair and move myself along to the loo and back again. Then when I got this shingles it seemed to take the stuffing out of me. (Resident)

The secondary data analysis of residents' interviews presented a picture of residents in the center of a flow of visiting health care professionals who may or may not be able to address their particular health care needs. They found it unsatisfactory that their health problems were not always addressed. This was linked both to limited access to the clinicians whom they wanted and limited control over how or when they could be referred to services.

This resident saw that her needs were secondary to the needs of other possibly more ill residents. She described a process that could be quite protracted, whereby progressively more senior staff decided if a health care professional should be called to look at her leg wound.

Well that I don't know. I just feel I'm on a sort of, waiting, I'm not as ill as a lot of people so I think I'm just left to tick over...Well I think they've got more dying people to deal with... this morning, I was seeing the senior nurse who comes with the others (care staff), and tell her and she's had a look and she's going to be in touch, get in touch with somebody else who is higher up still, who is going to look at it this afternoon.

It was an assumption of the residents interviewed that information would be shared but they did not know for sure, or the process by which it was done, and as this quote shows, they did not always feel able to participate in the decision making.

One representative of care home providers suggested that the reason the provision of age-appropriate care did not occur was because of agism and stigma. Residents' needs were not recognized or prioritized because older people and care homes were not valued by society. She compared provision to children's residential care homes and suggested that there was inequity across the age groups and that commissioners and providers had considerable discretion in the number and type of services offered. She advocated medical consultant-led services both for their expertise and status within the

medical hierarchy and gave an example of where it had been effective:

It was a multidisciplinary team. Headed by a consultant geriatrician and of course he had the status to be able to pull other people into his work, whereas I think if you don't have that status in medicine you would find that you would struggle. One of the things he did was corral the GPs and force them to do things that they weren't doing before. If you have got a consultant geriatrician saying "you should have visited," it's a bit of grit in the oyster." (Stakeholder From Care Home Representative Organization)

Governance and Incentives

Stakeholders who had responsibilities for the monitoring and regulation of services to and within care homes emphasized interventions that reinforced good health care practice either through the use of incentives or performance management. If the proper governance were in place, this would guarantee residents' access to evidence-based, age-appropriate health care, as well as continuity of care. An awareness of concerns about elder abuse, the need for vigilance, and examples of suboptimal care and avoidable deaths were given as the reasons why such systems needed to be in place. Outcomes, such as the prevalence of pressure sores and reduction of prescribing antipsychotics for people with dementia were emphasized as important within such frameworks.

This commissioner with responsibility for commissioning health and social care services for care homes gave the example of how using existing audit processes to improve end-of-life care for care home residents could improve health-related outcomes:

*End-of-life care is a health care issue, but what we do say in the (contract with the care home) specification is that we would expect that care homes are well versed around end-of-life care, that their staff are appropriately trained, **and that's part and parcel of the audit.** So our annual audit looks at how geared up a care home is in meeting the needs of patients who are at the end of life.*

These systems were seen as setting a minimum standard for how services should be provided to care homes. For these stakeholders, clear protocols and contract compliance were essential. This stakeholder worked for the CQC (the regulator) and acknowledged the importance of a good GP care home relationships but saw that this was consistently achieved only when there were explicit agreements in place and a planned approach:

It's where they've got a proper agreed arrangement with that GP surgery around, you know, they visit at certain times of the week and they can be contacted if there are any problems... ensuring then that people have a properly planned package of care that is really focused on their needs

One GP commissioner saw financial incentives for GPs as essential in recognition of the extra work that was entailed and drew on personal experience:

This care home has 41 beds and those are not the equivalent of 41 patients. They are like my second family. I have been doing a surgery once a week, colleagues have been in most days, they have multiple conditions and changing needs, I have greater responsibility; there is no way this is the equivalent to the work of 41 patients at home. (Commissioner)

This GP commissioner argued that financial incentives worked in 2 ways. First, to recompense extra work that care homes generate, and second, to provide GPs with the incentive to learn how the system works and improve current practice. He gave the example of

where a specialist nurse working with the GP had reduced prescribing costs, and supported more residents to die at home. This could be rolled out further to help GPs work more efficiently with other services:

You are looking to pay for the process of change, once the average GP has learned the system and learned who does what, then they should be able to come into the system and do what they do well and not much else, and work more effectively in an integrated system. (Commissioner)

Context Mechanism Outcomes: What Works When In What Setting With What Outcomes?

The basic unit of analysis in a realist review is not the intervention but the ideas and assumptions that underpin it, also referred to as program theories. The interviews identified 3 provisional theories (Mechanisms) of health service delivery to care homes and likely barriers and enablers (Contexts) to improving residents' health care in specific areas (Outcomes). Thus, what one stakeholder hypothesized as essential to achieving improved resident outcomes, for example, a contractual framework for clinician involvement in care homes, another identified as the enabler for activities that promoted shared learning and relational working.

Table 2 summarizes how these were configured by the participants and the contending positions of the different stakeholders. These hypothesized Context Mechanism Outcome configurations are the basis for the next step of interrogating the evidence and provide a framework for how the effectiveness of different models of service delivery to care homes is understood.

Discussion

The English model of health care provision to care homes with visiting physicians is common across the world.¹⁷ These data show that there was a broad consensus about what were the elements or characteristics of quality health care provision to care homes by the NHS. These were as follows: consistent and predictable access to expertise in geriatric medicine, investment in resources, and good working relationships and structured approaches to care that could be monitored. We found, however, that different individuals accorded different weights to these elements and had different views about what embeds good practice, what was essential, and what was desirable. For example, there was less agreement about whether specific professionals needed to be closely monitored and performance-managed or if investment in the training of care home staff should always be a joint enterprise with visiting care home professionals. It also was unclear if the use of financial incentives and sanctions, or the creation of sustained trusting working relationships, were the drivers (or mechanisms) for effective working or whether these represented enablers (or contextual factors) supporting residents' access to health care. For some participants, a single element, for example access to expertise in geriatric medicine, was sufficient in and of itself to improve quality of care; however, this was not the predominant view. Where this was seen as one of several core elements, it was accorded differing importance, or weighting, by different respondents. We were not able to explore why assumptions were held to be more or less true by different respondents as part of this study. What combination of elements and the "dose" of each are required to achieve optimal outcomes for care home resident(s) has implications for how services are designed, prioritized, and resourced and who is identified within the system as responsible for service delivery.

The insights provided by participants drew on anecdote, hearsay, and personal experience. It was what stakeholders believed "should"

Table 2 Possible Context Mechanism Outcome (CMO) Configuration of What Supports Effective Health Care Delivery to Care Homes

Underlying Assumptions	Possible Enablers (Context: C)	Possible Barriers (Context: C)	Possible Drivers (Mechanisms: M)	Range of Possible (Outcomes: O)
Relational: Activities that foster partnership working between care homes and visiting health care services to develop complementary expertise in the care of older people for the long-term benefits of residents Age-appropriate care: Activities that focus on the health care needs that will optimize residents' health care	How long groups have worked together (C1) Expertise in care of older people (C2) Designated GP to work with care homes (C3) Shared documentation and use of protocols (C4) Proximity to centers of geriatric medicine (C1) Explicit criteria for resident entitlement (C2) GP collaboration with specialist geriatric services (C3) Training and support of care home staff in needs assessment (C4)	Staff turnover (C5) Previous negative experiences of working together (C6) Capacity of the visiting health care service to work with care homes (C7) Continuity of input difficult to establish with other service demands (C6) Limited resources (C7) How generalist and specialist services work together to provide services to care homes unclear (C7)	Nominated people to work with health care professionals (M1) Investment in teaching and support to care home staff (M2) Regular meetings, shared decision-making (M3) Provision of specialist clinicians/teams for care homes (M1) Introduction of Comprehensive Geriatric Assessment embedded into care home procedures (M2) Care home/resident control over referral and access to services (M4)	Resident and staff satisfaction with health care provision Avoidance of prescribing errors and improvement in medication management Avoidance of unplanned use of secondary care Reduction in use of out-of-hours and emergency services Reduction in hospital length of stay
Governance: Organizational incentives and contractual obligations ensure that residents' health care needs are anticipated and addressed	History of good working relationships (C1) GP interest and commitment to working with older people (C2) Incentives to participate are significant to both care home and visiting staff (C3) Use of evidence-based assessment and treatment protocols (C4)	Quality of documentation and monitoring difficult to sustain (C5) Contracts perceived as punitive and bureaucratic or unrealistic (C6) Increased specification of service reduces flexibility and responsiveness of service (C5)	Financial incentives and sanctions for specified areas of health care delivery (M1) Targets to reduce unplanned use of health care services by care homes (M2) Named GP accountable for care home (M3) Regular performance management and audit (M4)	

work and reflected a range of theories about how to implement evidence-based practice and manage risk in primary health care,^{18–20} about frailty,²¹ approaches to comprehensive geriatric assessment,²² and what supports integrated working between health and social care.²³

The findings have captured the range of perspectives and interested parties: commissioners, providers, and recipients of care. Although only 3 older people living in care homes participated in the study, the study was fortunate to have access to 34 previously conducted interviews that enabled the study to obtain a resident-focused perspective on what good care looked like.

Conclusion

The findings from this study reinforce Bowman and Meyer's²⁴ observation that the organization of care for older people resident in care homes represents an emerging "medical space." The 3 models, and how they are exemplified as working, provide a rich, combined picture of the stakeholder perspectives. Given what is known about the heterogeneity of care home markets and their residents and the range of context-sensitive variables that shape how services are provided, these findings mean that it is unlikely that a particular service specification for health service delivery can promote effective working for all care homes. Rather, there will be key features or explanatory mechanisms, already manifest within multiple models and potentially applicable across multiple models, that will influence the delivery of optimal care. The next step is to test and refine these theories by a review of the relevant evidence to identify the necessary conditions under which the provision of health care services to care homes optimizes residents' health.

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