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Empowerment of care home staff through effective collaboration with healthcare

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ABSTRACT

Integrative local health delivery models in the UK, under the framework of Enhanced Health in Care Homes (EHICH), have been developed to improve joint working between health and social care to benefit the patient. Despite this drive toward health and social care integration, research on the barriers, facilitators, and impact of partnership working on role of care home staff is underdeveloped. This study set out to explore views on how closer working between health and social care can impact on the role of care home staff and any barriers to effective integration. Staff from 25 care homes and GPs from their partnered practices were interviewed to explore the impact of the partnership. Homes receiving regular visits from the same health professional found the relationship between the two sectors had benefitted both residents and staff. The development of trusting relationships, access to support and information, and recognition and respect were all seen as facilitating the partnership and enhancing patient care. Regular and effective interactions with health-care professionals were key and had the potential to empower and increase confidence of care home staff in their role around health care. Factors negatively impacting on strength of relationship such as visits by inconsistent professional and high turnover of care home staff were a barrier to successful partnerships. Experiences of poor interactions with those from health-care services where there was an absence of a trusting relationship were disempowering to care home staff and remain a barrier to effective wider health and social care collaboration.

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Care home; integration; interprofessional working; empowerment; patient care

Introduction

There are approximately 418,000 people living in UK care homes (LaingBuisson, 2016), this population have complex health-care needs, high levels of frailty, dementia, and multiple comorbidities (Gordon et al., 2014; Oliver et al., 2014). The care home workforce is responsible for the day-to-day care of residents and play a key role in the quality of care provided to this vulnerable population (Royal College Nursing, 2012). Residents also rely on general NHS medical and community health services to meet their medical needs, but reports have shown that residents experience variable and sometimes poor access to a range of quality health services (British Geriatrics Society, 2011; Healthwatch, 2017; Smith et al., 2015). Preventable failures of care and unplanned hospital admissions from care homes have been reported, resulting in homes being regarded as a drain on limited resources, making unwarranted demands on the healthcare system (British Geriatrics Society, 2011; Glendinning et al., 2002; Humphries et al., 2016; Robbins et al., 2013). Both health and social care sectors[1] are under pressure to improve care, and a range of integrative local health delivery models under the framework of Enhanced Health in Care Homes (EHICH) have been developed to encourage joint working between health and social care to benefit the patient (NHS England, 2016). It is expected that such schemes which encourage continuity of care for residents and improve transparency of information shared between sectors will improve patient care. Addressing the lack of research involving those working in care homes, this study focusses on their experience of interprofessional team working.

Effective interprofessional collaboration and teamworking is critically important in delivering high-quality patient care and for the successful integration of services (Firth-Cozens, 2004; Suter et al., 2009). However, there is a lack of understanding between sectors about how they should work together effectively across organizational boundaries to meet the needs of residents (Gage et al., 2012). Reductions in hospital admissions have been reported when health and social care work effectively together (Baker et al., 2016), yet other evaluations have shown limited results. Successful partnerships need to be underpinned by strong interprofessional relationships and dependent on the local context of services and practices (Baylis & Perks-Baker, 2017).

Background

Health organizations such as the NHS with professionalized staff function differently to smaller privately owned care homes, which employ many staff without formal qualifications. The care home environment is a challenging one, challenges include low pay, insufficient staff training, low levels of respect and fewer opportunities for career development (Alzheimer's Society, 2017; Dromey & Hochlaf, 2018). These challenges are likely to be disempowering for those employed in care homes and a 30% staff turnover rate has been reported across social care services (Skills for Care, 2020). Effective partnerships have the potential to empower those working in care home to be able to deal with arising health-care issues in partnership with health-care services. The care home workforce is

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underrepresented in research and in terms of medical support, they typically work in an isolated capacity relying on outside health professionals.

Interprofessional working in health care has mainly been examined through a focus on teamworking in hospitals or primary care teams located together (Karam et al., 2018). There is a lack of qualitative research documenting interprofessional teamworking within care homes or the experiences of staff from different areas of healthcare working together, and behaviors of professionals working within such teams (Bowers et al., 2003; Jones & Jones, 2011). Research with nurses identified that having the ability to practice collaboratively and build professional relationships was perceived as essential to empowerment (Williamson, 2007). Empowerment is thought to increase nurses' commitment, ability to cope with adversity and willingness to act independently and increase job satisfaction (Conger & Kanungo, 1988: Thomas & Velthouse, 1990; Yang et al., 2014), as well as a reduction in job stress and reduced turnover (Laschinger et al., 2001; Laschinger et al., 2013; Li et al., 2018).

Interprofessional collaboration and teamwork is widely discussed in health care, yet, little research, has explored how collaboration between health and social care works and can potentially empower those working in care homes. This article reports on a research project which explores the perceptions of care home staff and primary care staff regarding their experience of a primary care/care home alignment scheme aimed at achieving improved health care of residents. Integrated care between care homes and GP practices represents horizontal integration, which involves multi-disciplinary teamwork between health and social care professionals, without the formal integration of organizations (Goodwin et al., 2012). Typically, when measuring the effectiveness of health and care home integration, the outcome measures reflect the priorities of health-care professionals rather than the care staff and residents (Davies et al., 2011). The current study explores the relationship between care home employees and health professionals in practice and examines the impact of the increased interactions between primary care and care home workers. In addition, how care home staff work collaboratively with the wider healthcare system is explored. A better understanding of how the more structured working relationship impacts on those involved is necessary to identify ways to ensure more successful integration between health and social care.

Study setting

The study was set in one East Midlands Clinical Commissioning Group (CCG). The CCG which comprised 38 member practices and a registered population of 288,000, had implemented a scheme whereby care homes in one area were aligned to a GP practice, which was responsible for providing regular visits of a nurse or GP to monitor resident's health. The CCG covered a mix of rural and urban localities and the registered population aged over 75, was 9.1%, greater than the UK average.

The qualitative evaluation of this service improvement program included the following aims: to explore how this scheme was affecting patient care and the practices of the care home and health-care staff and to explore the perceptions of staff of the effects of the scheme and on how working together had changed. Perspectives and barriers to effective collaboration between care home staff and the wider healthcare system was also explored.

Method

An exploratory qualitative case study design was utilized to examine variation in the success and experience of GPs and care home working together and integration between social care and health care. Yin (2009) describes case studies as investigations of a contemporary phenomenon within its real-life context, addressing a situation in which the boundaries between the phenomenon and context are not clear. Case studies utilize a variety of data sources and enable differing aspects of the phenomenon to be examined both in relation to each other and as a whole process within a total environment. The study used embedded case studies of GP practices and their linked care homes to look at how the program was working. Data was collected from different sources including, semi-structured interviews with those in primary care, interviews with care home managers and where available practice and CCG documentation around the scheme were examined to identify how system was working in each practice. Ethical approval for the study was granted from the University of Derby, Health and Social Care Ethics Committee.

Sample

The local CCG provided researchers with the contact details of eleven GP practices that were part of the alignment scheme and thirty care homes that were aligned with them. The researchers directly contacted these for a suitable representative take part in a face-to-face interview with a researcher. Semi-structured interviews with those from primary care and those working in care homes from the eleven aligned GP practices, were conducted to determine their views on the interprofessional partnership developing through the alignment scheme. The professions of care home respondents were either carers (C) or nurses (N), and they were either managers/deputy managers or senior carers. There was a mixture of residential (r), nursing (n) and dual-purpose (rn) homesinvolved in the study. From the GP practices, the final respondent profile included fourteen respondents – nine practice managers, one care-coordinator, two nurse practitioners and two GPs from nine of the eleven GP practices (two remaining practices did not respond to requests to participate). Representatives from twenty-five care homes agreed to participate, of the five who did not participate, two had closed, one refused, and two could not arrange a suitable time for interview. All interviewees were provided with information about the study and provided written informed consent before taking part.

Data collection

Semi-structured interviews were conducted with representatives from the care homes, who were asked about their experiences of the scheme. Managers from each GP practice provided background on how the scheme was working and identified those involved in visiting the homes. GPs and/or advanced nurse practitioners were also invited to take part in an interview. A semi-structured interview guide explored the relationship between primary care and care home since the alignment. Experiences related to collaborative working were evoked by asking about interactions with different professionals and focussed on their role in the health of residents. Both authors, experienced researchers, conducted the interviews. Most interviews were carried out face-to-face in a private space in the care home or GP practices, three were conducted by telephone. Interviews were digitally recorded and lasted between 30 to 90 minutes.

Data analysis

The data were analyzed to identify categories and themes involved with interviewees experiences of closer collaboration and how the relationship had altered since the onset of more structured collaborative working scheme and the impact it had on their roles as well as on resident health care Interviews were transcribed verbatim and anonymized before coding with the aid of NVivo 11 software.

Framework analysis was used applying a 5-step process to organize and analyze the data: 1. Familiarization, 2. Identifying a framework, 3. Indexing, 4. Charting, 5. Mapping and Interpretation (Srivastava & Thomson, 2009). An initial thematic framework was derived from the in-depth reading of a small number of transcripts before being adapted to reflect the emerging themes. The researchers met regularly to ensure the validity of the thematic framework and to discuss any differences before a coding framework was finalized and applied to the transcripts. Indexing was undertaken to identify sections of the data which correspond to the existing themes and codes (Gale et al., 2013; Srivastava & Thomson, 2009). Once coded, data was charted in a spreadsheet under each theme to aid summary and interpretation of the data (Gale et al., 2013). Data was then analyzed to map linkages and patterns between phenomena. Constant comparison, combining simultaneous coding and analysis of the data was used to review the quality of our approach (Taylor & Bogdan, 1998). Initially, the responses in each single (practice) case were analyzed to highlight differences or patterns in the responses from care home and primary care. Second, responses from different GP/care homes cases were analyzed to compare patterns in responses. It became apparent that the themes were emerging across all cases, thus the findings are discussed in relation to the cross-case analysis.

Results

Benefits to residents, care homes and primary care were identified as resulting from closer working. Barriers to effective and wider collaboration between the two sectors were also voiced. Table 1 summarizes the main benefits identified from perspectives of both health and social care professionals. The following results, primarily focus on how the care home workforce has experienced the closer collaboration with health care and its effect on their work. The impact on care staff is discussed under interrelated themes: improved health care, development of trusting relationships, increased access to information and support and increased respect and recognition for care home role. Barriers to wider effective health and social care integration are discussed throughout.

Improved healthcare of residents

The increase in regular person-centered and proactive care resulting from the scheme was felt to be improving the health care of residents. Regular monitoring by primary care, was felt to ensure health issues were addressed before becoming serious:

Table 1. Summary of benefits of closer collaboration from perspective of both health and social care.

PERSPECTIVE	BENEFITS TO RESIDENTS	BENEFITS TO CARE HOME	BENEFITS TO PRIMARY CARE BENEFIT	BARRIERS TO COLLABORATION
Primary Care and Care Home	Patient centered care. Continuity of Care Proactive Care Regular Medication Reviews	Improved Communication & relationship Increased healthcare knowledge Better organization	Increased Knowledge of care home & residents Less Call outs	High workload from visits
Primary Care	Enhanced Monitoring Timely Medication Reviews	Provision of contact for care home staff Regular meeting with health care.	Reduced hospital admissions	High turnover of care home staff High turnover of patients Cost High workload from visits Bank Staff overnight/weekends Home expecting too much
Care Home	Improved End of Life Care and dementia care. Care plans implemented in more timely manner	Increased access to support and information. Increased recognition of limitations and expertise Increased Competence and confidence in healthcare matters	Reduction in different GPs attending throughout week.	Use of Locums Missed Visits Misunderstanding from other healthcare professional's hospital Out of hours GPs and paramedics Lack of understanding of resources available in homes. Problems contacting surgery

> "The system works. We're nipping things in the bud as opposed to waiting for them to be at crisis point and the GPs or the nurse practitioners are seeing them regularly. So, changes are picked up on, sooner rather than later." (C_Manager_r25)

Regular visits also enabled health-care professionals to construct a better picture of the residents and their health-care needs. Frequent monitoring of resident's health, was also felt to be reducing the frequency of GP/emergency callouts:

> "We only ever responded to their immediate need on an acute basis, so if somebody had a chest infection or things like that then they'd be seen as a GP visit, now what we do is actually manage these patients rather than just responding to urgent need, so all their existing problems are cared for (GP_Surgery5)

Development of trusting relationship between home and primary healthcare

Prior to the scheme, care home respondents discussed the difficulty in maintaining relationships with primary care and a lack of understanding how each sector worked. This was particularly apparent when dealing with multiple practices. Increased interactions with a consistent health professional were felt to enable the development of trusting relationships:

> "You obviously build up relationships with certain people when they're the ones coming in regularly. So, they get to know the home. They get to know the staff. They get to know the residents." (C_Deputy_r12)

And:

> "We understand more now from their point of view, and I think they can understand more from our point of view. I wouldn't say we were ever working against each other, but it was like the GPs were the GPs and the care home was the care home. Now it feels more amalgamated" (C_Manager_r30)

Factors which negatively affected the development of a relationship such as infrequent visits, use of locums or inconsistent professionals visiting was seen as a continued challenge, and a barrier to effective integration. Similarly, those from primary care felt high turnover of care staff and use of bank staff meant they had to continually rebuild relationships:

> "The turnover of staff is often means that you try and build something up and then you are starting off again." (GP_practice4)

Access to support and information

A key benefit of the improved relationship was increased access to support and information which was felt to positively impact on the role of care home staff. Increased access to support and information are conditions which are known to foster structural empowerment in the workplace. The relationship with health care enabled care home staff to feel comfortable accessing guidance and support around the health of residents. GPs were perceived as more 'approachable,' and it was felt that 'barriers have broken down' since the partnership. Support with ordering prescriptions, managing right care plans, End Of Life care and dealing with referrals were all felt to have improved.

> "The main benefits of regular contact I suppose a feeling, we do feel more supported, more like the practice is there ready for us, to listen to us "(N_Deputy_n27)

Care home staff acknowledged they were more confident asking questions and requesting support from the medical staff. GPs also noted care staff were more comfortable seeking support and advice:

> "I think there seems to be that confidence that they can just give me a ring and I'll give a quick ABC or just say yes or no and things like that" (GP_practice5)

Accessing non-judgmental advice from GPs meant care home staff were also increasing their knowledge of age-related conditions. Increased support was perceived to be ultimately impacting on their residents and keeping them out of hospital unnecessarily.

> I think the nurses are far more confident. And we are much clearer now for the End-of-Life clients who shouldn't be hospitalised, and the doctors are more anticipatory providing us with anticipatory meds. Everything is here so we don't need to send people to hospital, it has made a difference. (N_Manager_rn18)

In contrast feeling unsupported by health care left care staff vulnerable and increased the likelihood of needing to request emergency care calls for residents:

> "Having that complete confidence to ring GP for advice and know that it is fine. Previously, I was told off by GP for ringing up before because he was too busy. I was upset and distressed about that because I never need to feel I can't ring a GP" (C_Senior _r3)"

Care home staff discussed the challenges involved in monitoring the health of residents without sufficient information about their medical history. Previously, despite their carer role, health care did not routinely share information with them.

> "We can only work on the information that we're given and if people don't give us the information; I have families coming here and saying, "well you've got all his medical records, so you know" - no we don't know what's wrong with your dad, it's all news to us because we're not told we have to put things together" (C_Deputy_r15)

The increased access to medical information was enabling care staff to perform their role more effectively.

> "Senior carers are more knowledgeable now as they sit through the doctors' visits and are able to see records and comorbidities that may have not been known before" (C_Manager_r10).

Increased information and support meant some homes also implemented their own systems and new way of working to improve monitoring of residents and educating staff:

> "We now look at our care plans, not just mental health needs but awareness of physical medical needs (diabetes, pacemaker) how it can impact patient, and it helps that on care plans we have what diabetes is not just they are diabetic, it's sharing of information, as long as we have background info, we can pass it on" (N_Manager_r21).

However, lack of information sharing remained a challenge when working with the wider healthcare system, particularly when care home staff felt their role in the care of residents was unacknowledged.

> "I think it's lack of communication from the hospital, we've had times where we haven't had discharge letters and had to chase it but it's vital that we get discharge letters and know what has happened and changes in medication" (C_Deputy_rn5).

Primary care also voiced how the scheme was helping to increase shared learning between the two sectors.

> "if the care home team come across something they need to know, we will come out and show them how to do something. It is a two way thing and we learn from them too" (PM_Practice2)

Increased recognition and understanding of the role of care home staff in health of residents

Care respondents considered their expertise and contribution to health care was their holistic knowledge of their residents, enabling them to identify deterioration and recognizing when to call for medical help. Their reliance on the GP and emergency medical services to then respond to their concerns were emphasized:

> "I think it's a joint partnership, because the doctor isn't based here, she has to go on guidance from what we see, changes or what we have got concerns about and then for her to follow through with monitoring bloods and health conditions, she's knowledgeable and qualified to do so – we're not medically trained so I like to think we're the eyes and ears and she's the fixer" ((C_Deputy_rn5).

Prior to the scheme, lack of recognition from healthcare professionals on how the type of home (nursing or residential) dictates how much staff can deliver in terms of medical care was considered a barrier to effective collaboration. Care staff felt the GP now understood both their limitations and expertise and acted accordingly. Care staff reported a change in the doctors' perceptions and behaviors toward them from one of dismissal of their views to one where the GPs take seriously the concerns raised by them.

> "The doctors do listen to us. I think early days there was a bit .you know with doctors you don't know our job but we know" But now they realise, because they have come in they work with us they see what we do and know that whilst we can't say this is what is wrong but we know when there is something wrong and sometimes we can say "we think this" and they will take your word for it and say yes you are right" (C_Deputy_r15)

Improved communication between the homes and GPs enabled them to jointly agree on a strategy for managing a resident's medical problem, including agreeing to wait for the next planned doctors visit rather than having an emergency GP callout. Care home staff now felt a more valued and respected part of the health-care team and in certain areas, they were regarded as the expert.

> "They rely heavily on our knowledge of wound care for instance, as it's not the GPs particular field, they will take guidance on what we require and will certainly respond to what we need" (N_Manager_n2)

Incidences where care home team felt unfairly judged and treated by health professionals were recounted by some managers, particularly when their role as the expert in 'knowing their residents' was questioned by health professionals. Care staff were made to feel vulnerable if their expertise or concerns were either not recognized or acted upon.

> "I felt I was being judged she really did belittle me for the fact that I didn't do observations, but I'm not trained to do observations and I can't say it enough I'm not trained, and I'm not insured to do them" (C_Deputy_r9)

Increased recognition of the support needs of the care home was also accepted by primary care staff as being key to the success of the scheme.

> "Building your relationships with the staff in the care homes is a two-way process – you need to consider their needs rather than just expecting them to do what we want." (GP_practice6)

Other practices had identified and arranged training for care home staff, so they were able to carry out some basic medical procedures and increase their skills dealing with medical issues.

Barriers to effective collaboration between health and social care

Although the scheme had improved the relationship between home and GP, challenges remained when working with the wider healthcare system. A lack of respect and recognition shown to care home staff from some health professionals was regarded as a key barrier to progressing effective integration. Care staff discussed experiences of disempowering interactions with some health-care professionals.

> "Paramedics can talk down to you, it's awful. Yes, they're here to do their job, I understand that, but we've had to deal with it before you got here, don't talk down to us, at the end of the day we're on a level peg, don't come into our environment and dictate and start being funny with us" (C_Manager_r26).

Care home nurses voiced their frustration at feeling undervalued when hospital nurses failed to recognize their expertise.

> "There is an issue with opinions of people in the NHS because they have no clue, they have no idea what we do our capabilities. We get spoken to so badly by ward staff when they ring up; they have no idea what we do" (N_Manager_n19)

This disrespect afforded to them by other healthcare professionals was attributed to the negative stereotypes that persist around care homes and their staff and a lack of understanding around the role of care homes:

> "It is lack of understanding on their part (NHS) that they really don't quite know exactly how much you have to deal with sometimes in care home. I think people's perception of a nurses in nursing homes are pretty much retired nursing doing it because it is easier (N_Manager_n25)"

Care home staff articulated how they were constantly having to balance not putting their residents at risk and calling out the GP/healthcare services out unnecessarily.

Rather than other areas of the healthcare system being supportive and recognizing the frequent judgments homes must make around the care of their residents, there was a sense that those in care homes were vulnerable to blame if things went wrong.

> Throughout this whole organisation of care, people have to have a scapegoat, there has always got to be someone to blame, especially for the elderly as they are a vulnerable group and it always falls to the primary carers which are us, we push for things otherwise we get blamed (R_Deputy_r14)

A better understanding of social care from the wider healthcare system was felt to be required to ensure effective health and social care collaboration and integration. All areas of the healthcare system need to better understand the care home role, including their limitations and the capabilities of care home workers to deliver care to residents. Encouraging health-care professionals to spend time or training in care homes was suggested by care home respondents as one way to improve understanding and reduce negative stereotypes of care homes.

Discussion

Meeting the required health-care needs of care home residents demands effective collaboration between health and social care. Through the EHICH program, the NHS is encouraging more partnership between health and social care to benefit residents care (NHS England, 2016). Typically, measuring the effectiveness of health and care home integration, reflect the priorities of health-care professionals rather than those of the care home staff and residents (Davies et al., 2011). This paper has provided insight into how closer working with health-care professionals can impact on care home staff and their role. Perspectives on the barriers to wider collaboration and integration between health and social care were also explored.

Regular visits from GPs were felt to be directly improving the health care of residents through the provision of more proactive, person-centered care. Closer working relationships between the two sectors had resulted in an increase in the availability of non-judgmental healthcare support and information about their residents, which was increasing care staffs' confidence. Confidence in dealing with health issues, feeling able to challenge primary care and asking for advice and reassurance were all improving. Using the health-care professional as a mentor, is a potentially important resource, particularly as care home employees can be isolated from other health-care professionals and not always exposed to alternative practices or recognize gaps in their knowledge (Smythe et al., 2016). Factors detrimental to the development of a trusting relationship, such as irregular visits, inconsistent professionals visiting the homes and high turnover of care staff were all seen as a barrier to the success of the scheme.

Research has shown that effective managers provide access to resources information, support, and opportunities in work settings, which is empowering and enables employees to do their job properly (Kanter, 1993; Laschinger et al., 2001; Laschinger et al., 1999; Manojlovich, 2005). Increasing perceived empowerment is thought to promote a collaborative and participative decision-making process in health care (Patrick et al., 2011). Care home staff explained how they now felt the health care of residents was more a shared responsibility between themselves and primary care. Training and support can lead to changes in staff priorities and practices(Marshall et al., 2018), and care managers talked of implementing new practices to monitor health and educate staff. Regular interactions with primary care professionals meant training opportunities could now be identified to upskill and further empower care home staff.

Successful interprofessional partnerships involve an awareness of each other's organizations resources goals, capacities, and training (Ervin, 2004) as well as an understanding of roles and to respect, trust, and recognize each other's expertise and limitations (Bradley et al., 2012; Dey et al., 2011; Gaboury et al., 2009). The attitude of those in primary care was considered to have gone from one of dismissal to one where the care home managers felt listened to and their expertise and limitations were recognized. The availability of more tailored support reduced the vulnerability care home staff experienced when negotiating resident's healthcare.

Collaboration between health and social care professionals can be problematic (Reeves et al., 2013), and care home staff felt tensions persisted when interacting with some other health professionals with whom they had not built a relationship. The issues raised by respondents about the potential difficulties associated with closer integration with the NHS related to a lack of understanding of roles and capabilities by wider NHS staff and are not too dissimilar to the issues that care homes reported experiencing from general practice before taking part in the alignment scheme. Research has documented that care home employees are often frustrated by the failure to be recognized for their expertise and skill in their work (Bowers et al., 2003; Broockvar et al., 2000). Challenging interactions with hospitals and emergency care were disempowering for care home staff, particularly when they were left to feel vulnerable when it came to a resident's health.

Health and social care services working together as one local care system, rather than fragmented services, is deemed essential if levels of quality and access to health and care services are to be sustained (Ham & Alderwick, 2015; NHS England, CQC., HEE & PHE, 2014). Closer collaboration with primary care, was ensuring the health care of residents was now a partnership between the care home and the GP. However, negative stereotypes held by some health-care professionals about the care given in care homes, was felt to be a reason care home staff felt were frequently and unfairly judged. This is concerning as research indicates nurses who perceive their public image as negative report a more negative self-concept, lower job satisfaction and have less engagement with other professionals (Takase et al., 2002). Educating health-care professionals and encouraging more interprofessional working with social care, during training of those who frequently interact with care homes, on the expertise and limitations of different care homes and how best to support them and work more effectively together could potentially reduce negative stereotyping and encourage more effective integration.

Unfortunately, not all homes identified to take part in this study took part, these care homes may have had different views of how the partnership was working. Similarly, care home respondents were primarily mangers, deputy managers or senior carers/nurses, further work should incorporate views from all levels of the care home workforce. Exploring views of other health professionals who work with homes would have provided better context and understanding to some of the views about the relationship between home and these professionals expressed by the care home respondents in this study. Finally, future research should include service-user perspectives which are central to the delivery of integrated care.

Conclusion

Caring for older people in care homes is a key priority for the health and social care system in England, however both the needs of residents and staff working with them are often overlooked, an issue which became even more apparent during the Covid-19 pandemic. Successful collaboration between health services and care homes is typically measured through analysis of reduction in hospital admissions and emergency call out data. However, this study provides qualitative evidence on what care home staff value about working collaboratively with health care and how it can impact on their working practices and achieve better health care for residents. Care home staff considered continuity as key to success of the scheme. Continuity of care was considered to have been provided when the same clinician or clinicians regularly provided clinics within the care home, enabling both the delivery of person-centered quality care to residents and the strengthening of the relationship between the two sectors. The growing confidence generated by improved recognition of their role and increased support encouraged a more informative and empowering relationship between care home staff and their aligned GPs, this ultimately impacts positively on residents' care.

To build and maintain a skilled and experienced care homework force, it is important that social care professionals feel valued as a key part of health system. Primary and Secondary Care NHS bodies, and commissioners need to understand the potential value-added value offered by closer relationships with care homes and invest in provision of support for such relationships. Future development and commissioning of EHICH services should continue to highlight the factors that maintain and strengthen the relationship between health and care home to ensure maximum benefits to all involved. Furthermore, through encouraging wider healthcare services to address individual care home needs rather than basing judgment on preconceived ideas of homes, there is the potential to reduce the isolation and vulnerability experienced by some care home staff when dealing with healthcare issues of their residents.

Note

1. In this paper the term social care workers will be used to describe all care home staff as in the UK nursing and residential care homes are considered part of the social care system.

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