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"It just happens". Care home residents' experiences and expectations of accessing GP care

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ABSTRACT

Background: Care homes provide personal care and support for older people who can no longer be supported in the community. As part of a larger study of integrated working between the NHS and care homes we asked older people how they accessed health care services. Our aim was to understand how older people resident in care homes access health services using the Andersen model of health care access.

Methods: Case studies were conducted in six care homes with different socio-economic characteristics, size and ownership in three study sites. Residents in all care homes with capacity to participate were eligible for the study. Interviews explored how residents accessed NHS professionals. The Andersen model of health seeking behaviour was our analytic framework.

Findings: Thirty-five participants were interviewed with an average of 4 different conditions. Expectations of their health and the effectiveness of services to mitigate their problems were low. Enabling factors were the use of intermediaries (usually staff, but also relatives) to seek access. Residents expected that care home staff would monitor changes in their health and seek appropriate help unprompted.

Conclusions: Care home residents may normalise their health care needs and frame services as unable to remediate these which may combine to disincline older care home residents to seek care. Care access was enabled using intermediaries -either staff or relatives-and the expectation that staff would proactively seek care when they observed new/changed needs. Residents may over-estimate the health-related knowledge of care home staff and their ability to initiate referrals to NHS professionals.

1. Introduction

There is a range of provision in England for those older people who can no longer be supported in their own homes because of the complexity of their needs which includes supported and extra care housing to care homes with (and without) on-site nursing and nursing homes where registered nursing staff are on duty at all times (CQC, 2015). The context for our research is care homes which deliver personal care and support to older people but who do not have on-site nursing care. Residents in these types of care homes rely on visiting doctors (both primary care practitioners and specialists), community nurses and therapists for access to health care and referral to specialist and secondary care services. General practitioners (GPs) are especially important in the care of older people as in addition to their role in the assessment, diagnosis and treatment of illness they provide the link into other community and hospital-based health and social care services.

Access to primary care is a major policy interest of the successive UK administration's as it is a mechanism to reduce hospital/emergency department admissions. Difficulties in accessing a GP are linked with visits to emergency departments and the creation of the 7 Enhanced Health in Care Homes Vanguards in England recognises these problems. Problems of access to general practitioners and other services for care home residents remain a source of concern as do issues of quality of care and levels of provision (Iliffe et al., 2016; Goodman et al., 2013a; Gleeson et al., 2014). The regulatory body (Care Quality Commission standards 1 and 2) require care homes to facilitate access for residents

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to the health services they need (CQC, 2015). Achieving this objective is perceived as problematic from the perspectives of both care homes and;1; general practices as there are a range of ways that this may happen. Residents may remain with their 'own' GP, the one they were registered with before relocation to a care home or register with locally designated practices (British Geriatrics Society Failing the Frail, 2012; NHS England, 2016). As such, most care homes, 85%, work with more than one practice (Gage et al., 2012). Similarly, there are a range of service delivery models whereby General Practitioners, discharge their responsibilities for providing primary medical care to care home residents. These may include visiting specific residents in the home on request as they would provide a home visit for someone living in their own home or the provision of regular clinics in care homes which residents attend as appropriate.

It is recognised that there is a lack of integration between care homes and other components of the health and social carescape. There is a body of research with a focus upon developing models of care delivery and working that integrated all the elements of primary, secondary and social care services with care homes. Evidence from a review of effective provision of health care for older care home residents highlighted key elements in the successful provision of NHS services to this population. Two of these elements focussed on contractual and service delivery expectations. These focused upon the specification and delivery of age -appropriate services and the development of financial and contractual mechanisms to specify a minimum service that care homes could expect to receive. However, the third component emphasised support to develop relationships between staff working across the different sectors via activities such as shared learning between NHS and care home staff. These elements are not mutually exclusive but interlinked and are also highlighted in studies that have focussed upon specific issues in the care home context such as end of life care, continence, falls and prescribing. (Gleeson et al., 2014; Goodman et al., 2013a, 2016). The 7 Enhanced Health in Care Homes vanguards recognises the lack of integration across sectors and focuses upon addressing care, financial and organisation barriers to the delivery of effective health care to residents (NHS, 2016).

Access to primary care for older people remains an issue of concern for older people regardless their place of residence (Elias & Lowton, 2014; Evans & Evans, 2012; Ford et al., 2016; Glendenning et al., 2002; Iliffe et al., 2016; Shah et al., 2011; Veazie, 2014). Older people are one of the groups identified as having poorer access to health care with research emphasising the barriers to access as organisational, geographical and socio-cultural. The model developed by Andersen (Andersen et al., 2015) is one approach to understanding the decision-making underpinning the decision to consult a with health care professionals/services. The most recent manifestation of the model proposes that the decision to seek help from a GP or other health or social care service is the outcome of three sets of factors: precipitating, enabling and need at both the contextual and individual level. At the individual level need for health care includes perceptions of health status, illness/symptom severity and diagnosed conditions. Predisposing factors include socio-demographic characteristics that can also include social factors such as networks and relationships which can support (or inhibit) access to care. Enabling factors include the organisational arrangements for health care (free at the point of delivery like the NHS) and the characteristics of the locality where the individual lives (eg urban or rural, deprived or not deprived).

In debates about service provision and access to primary care the voice of the older person is largely absent, even more so for those living in care homes. There are remarkably few studies that are focussed on life in care homes (Backhouse et al., 2016). A review of living well in care homes identified 29 studies of which only 3 were from the UK and none reported on residents' experiences of accessing health and care services (Milte et al., 2016). Notions of 'home' among nursing home residents were evaluated in a systematic review of 17 studies across 7 countries (not including the UK). Although autonomy and control emerged as an important theme in the review this did not relate to service access decisions. The authors do not dwell on how comparable the definition of nursing homes was across studies (Rijnaard et al., 2016). A study of 4 nursing homes in The Netherlands examined the concept of home from the perspectives of residents, relatives and care workers. Facilitating care access was raised by staff and relatives but not residents (Van Hoof et al., 2016).

How does the context of living in care home relate to access to GP services by older people? Although there have been a range of care delivery based intervention studies based in care homes the actual process whereby residents access general health care services have been little studied. Condelius and Andersson Condelius and Andersson (2015) applied the Andersen and Newman behavioural model of health care access (Andersen & Newman, 1973) model in a qualitative study examining the e views of next of kin on health care access for relatives who had died in care. The Andersen and Newman model conceptualises use of health care as the outcome of the interplay between three sets of factors: need, predisposing and enabling. Need factors relate to physical or mental health problems or illnesses; predisposing factors relate to demographic type factors (age, gender, marital status) while enabling factors relate to things which facilitate service access (e.g.. income)

The use of Andersen and Newman conceptual model in a qualitative study is rare as the model is most often used in a quantitative paradigm. Condelius and Andersson (2015) focussed upon enabling factors in their study and highlighted the facilitative role of the next of kin in both supporting access to care but also for monitoring the quality of care provided. These authors argue that for vulnerable elders the next of kin can be a powerful factor in enabling access to good quality care. They also demonstrated the importance of how care was organised within homes in terms of named care staff for residents, levels of staffing and the routine of the home as important enablers of care access. As part of the APPROACH (Analysis and Perspectives of integrated working in Primary Care Organisations And Care Homes) study (Goodman et al., 2013b, Gage et al., 2012) this paper explores care home residents' experiences of accessing GP services using the Andersen and Newman (Andersen and Newman (1973) model by the reanalysis of interview data collected initially to investigate their experiences of integrated care.

2. Methods

The APPROACH study explored how care homes worked with the NHS, and how different ways of organising the delivery of health care affected the experience of residents (and staff) in terms of health care access (Gage et al., 2012, Goodman et al., 2013b). It was a longitudinal mixed-methods study which included a quantitative survey of service provision to care homes and case studies of six care homes in three different study sites. The homes were selected because they exhibited different models of working with the NHS and presented social and geographical variation: a deprived inner city area in the South East; a suburban town; and a mixed urban-rural coastal area with pockets of affluence and deprivation. Three of the care homes had both residential and nursing beds which were separate in two homes (on different floors) but mixed in the third. In these homes our focus was upon the residents who were not in the nursing part of the facility, and associated staff and procedures. The size of the care homes ranged from 29 to 87 beds; none had safeguarding problems, and all had been assessed by the regulator (Care Quality Commission) as providing average or above average care (the terminology for inspection has changed since the study was completed). Three of the care homes were run by large care home organisations, two by not-for-profit groups and one was privately owned.

The case studies included interviews with residents, staff and relatives as well as a review of residents' care home notes to capture service use. Our data is derived from the semi-structured interviews with residents, conducted at baseline and at 4 and 8 months, about their perceptions of their health care needs, their access to services and their views about how NHS and care home staff worked together. Interviews