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Long-Term Care Around the Globe

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

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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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 survey[3] 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