

What works in delivering effective enhanced primary care support in care homes?

Published in October 2018

As an independent evaluator of seven NHS Vanguard projects, we have been exploring and sharing key findings relevant to new models of health and social care.

There were six enhanced health in care home (EHCH) vanguards across England, working to improve the quality of life, healthcare and health planning for residents through the provision of in-reach primary, secondary and community services and support.

Here we outline the key elements to effective practice in delivering enhanced primary care and support in care homes, based on our review of the evidence¹. We outline key supportive features as well as barriers and limitations to delivering enhanced primary care in care homes. We also explore three case studies to shine a spotlight on three different models to delivering enhanced primary care in care homes.

Please get in touch with our Head of Research, [Dr Stephen Boxford](#), for more detail or to continue the conversation.

1 Context

1.1 About enhanced primary care

Enhanced primary care services are primary medical care purchased in addition to the standard GP service provided under the General Medical Services (GMS) contract between GPs and the NHS. This happens for two key reasons ([SCIE 2013](#)):

- the activity concerned is not part of standard GMS services (such as scheduled, rather than request, visits) or because it increases the frequency of an existing activity (like medication reviews); or
- to buy in specialist GP input.

¹ If you would like details on the methodology used for the literature review, or a full bibliography, please feel free to get in touch with the Cordis Bright research team: info@cordisbright.co.uk.

While there is no standard enhanced service model, SCIE states that a local enhanced service agreement for residents of a care home typically requires the general practice to provide ([SCIE 2013](#)):

- a named clinician;
- a set number of sessions a week, including commitment to a weekly visit and a weekly follow-up session; and
- appropriate clinical administrative work.

1.2 Why enhanced primary care in care homes?

There is an increasing emphasis in policy and practice on enhanced primary care services being delivered in care homes. This is driven by a number of factors, which we outline below.

1.2.1 Ageing population and care home use

It is estimated that around 325,000 older people live in care homes in England, representing around 4% of the population aged 65 and over ([Smith et al. 2015](#)). As the population ages, the care home population may increase in size and come to represent a higher proportion of the population aged 65 and over.

1.2.2 Complex health needs of care home residents

Residents in care homes, particularly those in homes for older people, often have complex health needs, including multiple co-morbid medical conditions and profound physical dependency ([Bowman et al. 2004](#); [Gordon 2015](#)).

1.2.3 High primary and secondary care service use

There is growing recognition that providing healthcare to care home residents is often more challenging than providing it to those living in their own homes. Care home residents use primary and secondary care more and tend to have longer lengths of stay in hospital compared to a similar population living in the community outside of long term care ([Gordon 2015](#)).

1.2.4 Variable quality of primary care support for care homes

The literature suggests significant variation in quantity and quality of primary care support for care home residents ([O'Dea et al. 2000](#); [Gordon et al. 2014](#)). A systematic review and survey of the effectiveness of integrated working between primary care and care homes highlights that care home residents do not have universally high levels of primary care support, and that care home residents' access to NHS services is "erratic" ([Davies et al. 2011](#)). Likewise, a literature review by the Joseph Rowntree Foundation found evidence of variable quality in access to primary care from care homes: the review identified trends in unmet healthcare need amongst older people with dementia, poor quality of life, and inappropriate use of psychotropic drugs for care home residents ([Szczepura et al. 2008](#)).

One of the factors contributing to this variation may be the complexity of medical needs among care home residents and difficulties negotiating complex care over multiple organisational boundaries including health and social, primary and secondary, public and private care ([Gordon 2015](#)).

A lack of formalised and standardised relationships between the NHS and care homes may also be a contributing factor. Iliffe et al.'s review found that working relationships between the NHS and care homes lacked structure and purpose, and that most had evolved locally, resulting in wide inequalities in access to generalist and specialist primary healthcare services in care homes ([Iliffe et al. 2015](#)).

Variability is also evident in the approaches to commissioning and organising primary care support and services to care homes. These range, for example, from the payment of incentives to GPs to visit care homes, to the creation of outreach services run by geriatricians ([Goodman et al. 2014](#)).

1.2.5 The potential to result in improved outcomes

The enhanced primary care interventions that have been evaluated are often found to have had mixed effects, e.g. for there to be improvement against one outcome but no change or a negative change against another outcome, or for there to have been no significant impact when compared to GP care as usual ([Davies et al. 2011](#); [SCIE 2013](#)).

That said, the existing literature indicates that enhanced primary care has the potential to bring about a range of positive outcomes, as summarised in Figure 1 below.

Figure 1: Outcomes associated with enhanced primary care for care homes

Outcomes associated with enhanced primary care for care homes	
Resident and care quality outcomes	Improved staff and resident satisfaction (Briggs and Bright 2011).
	Better quality care (Briggs and Bright 2011 ; Jacobs 2003).
	High-quality prescribing, resulting in increased use of beneficial drugs and reduced use of unnecessary or harmful drugs (Registered Nursing Home Association 2013 ; Fahey et al. 2003).
	Streamlined or more efficient service delivery and better access to services (Briggs and Bright 2011).
	Better continuity of care in GP practices for residents (Briggs and Bright 2011).
	Improved quality or greater availability of palliative care (Briggs and Bright 2011 ; Donald et al. 2008).
	Improved management of patients at the end-of-life (Hockley et al. 2010).
Impact on secondary care and community services	Reduction in emergency hospital admissions or fewer deaths in hospital (Briggs and Bright 2011 ; British Geriatrics Society (BGS) 2011 ; NHS West Midlands 2011 ; Donald et al. 2008 ; JRF 2008).
	Reduction in Accident and Emergency (A&E) attendances (BGS 2011).
	Reduced use of emergency care practitioners (BGS 2011).

Outcomes associated with enhanced primary care for care homes	
	Reduced hospital admissions or crisis care (Briggs and Bright 2011 ; Donald et al. 2008).
Integration and partnership working	An improved relationship between care homes and GPs (BGS 2011 ; Briggs and Bright 2011 ; Donald et al. 2008).
	An improved relationship between primary and secondary services and improved referrals (Briggs and Bright 2011 ; Donald et al. 2008).
	Improved judgements of care home managers in identifying a need for a GP and in ordering repeat prescriptions (NHS West Midlands 2011).
	Streamlined medication and prescribing procedures (Briggs and Bright 2011).
	Better knowledge of care home staff and GPs about residents' health (BGS 2011 ; Briggs and Bright 2011).
	Increased use of preventative measures through regular monitoring and check-ups (Briggs and Bright 2011).
Cost benefits	Savings in prescribing costs, associated with more efficient medicines management. For example, one study estimated reductions in prescribing costs ranging from £10 to more than £550 per resident, with an average of £135 per resident (Crotty 2007).
	Cost savings and reduced resource use as a result of reductions in hospital admissions or deaths in hospital (Gladman 2011). For example, studies have estimated cost benefits due to reduced hospital admissions and deaths to range from £145,000 (gross saving) per annum for a small-scale pilot in Sheffield involving the delivery of GP Locally Enhanced Services (GP LES) to 500 care home beds (BGS 2011) to £18,000 (gross saving) per annum for one care home (net saving £3,000, taking into account cost of extended services) (Briggs and Bright 2011).

1.3 National policy context

1.3.1 Increased integration of health and social care

In recent years there has been an increasing emphasis on policy initiatives intended to promote and secure more integrated working between NHS and adult social care services. It is within this context that initiatives have been developed to increase cooperation between care homes and primary care so as to address the care home specific issues identified in the section above ([SCIE 2013](#)). Primary care in care homes has also been the focus of specific attention, most notably in NHS England's *Five Year Forward View*, which highlighted the failure of existing models in meeting care home residents' needs ([NHSE 2014](#)).

1.3.2 NHS new care models

NHS England announced a range of new care models in the *Five Year Forward View* ([NHSE 2014](#)). The *enhanced health in care homes* (EHCH) model in particular is intended to offer residents of care and nursing homes better and more joined up health, care and rehabilitation services via a range of in-reach services ([NHSE 2015](#)). In addition to

considering enhanced input from primary care in the care home, the EHCH model encompasses input from secondary and community health care services as well.

1.3.3 New care model vanguards

In 2015, NHS England and its national partners announced the first of 29 new care model vanguard sites, which would later increase to 50 sites. The vanguard sites were selected and funded to take a lead on the development of five of these new care models, to implement them at pace and sector-wide across the locality, thereby creating blueprints for the NHS moving forward and inspiration to the rest of the health and care system. The five new care models are summarised in Figure 2 below.

Six of the vanguard sites are EHCH sites, which sought to work with the care home sector to develop and implement the model. The EHCH vanguard sites are: Wakefield, Sutton, Nottingham, Newcastle and Gateshead, East and North Hertfordshire, and Airedale ([NHSE 2015](#)).

Figure 2: The five new care models developed via the NHS new care models vanguard programme



2 Effective practice in delivering enhanced primary care in care homes

2.1 National evidence-based standards

Enhanced primary care in care homes services should reflect several key national evidence-based national standards, including:

- National Institute for Health and Care Excellence (NICE) (2013). [Guidance QS50](#) 'Mental Wellbeing of Older People in Care Homes'.
- NICE (2014). [Guidance SC1](#) 'Managing Medicines in Care Homes'.
- NHSE (2015-16) '[Proactive Case Finding and Patient Review for Vulnerable People](#)'.
- [Care Quality Commission](#) (CQC) (2015) 'Regulations for Service Providers and Managers'.
- Social Care Institute for Excellence (SCIE) (2013). [Guide 52](#) 'GP Services for Older People: A Guide for Care Home Managers'.

2.2 Features of effective primary care involvement in care homes

In Figure 3 below we outline the key features identified by our evidence review as supporting effective delivery of primary care in care homes².

Figure 3: Features of effective primary care involvement in care homes

Type of factor	Specific features
Overarching factors	Governance arrangements that include contractual and financial incentives in order to specify a minimum service provision (Goodman et al. 2015).
	A strategic approach to partnership working and integration that fosters continuity and shared learning between NHS primary care and care home staff (Goodman et al. 2015).
Organisational factors	Professional and expert management and leadership across primary care organisations involved in delivering services to care homes (Smith et al. 2013).
	Data and performance management including information about the quality and outcomes of care (Smith et al. 2013).
	Information systems (including electronic patient records and electronic communications technology) (Smith et al. 2013).

² Please get in touch with us at info@cordisbright.co.uk if you would like access to the more detailed version of our analysis – we will be happy to share it.

Type of factor	Specific features
	Recognition of residents' and relatives' 'voice' in influencing medical and end of life care (SCIE 2013).
Human resources factors	A primary care workforce with a specific interest and experience in primary care support for the care home resident cohort (Donald et al. 2008).
	A manageable workload for primary care and care home staff (Donald et al. 2008).
	Provision of specialist primary care training to care home staff (JRF 2008).
Service factors	Enhanced provision of accessible age-appropriate clinical services (Goodman et al. 2015).
	A service tailored to the individual needs of residents (Goodman et al. 2015 ; Smith et al. 2013).
	Scope to enable proactive and preventive interventions (JRF 2008).
	Detailed minimum service specification including expected frequency and nature of attendance by primary care professionals at the care home (Smith et al. 2013).

2.3 Barriers to effective primary care involvement in care homes

As well as factors associated with effective primary care involvement in care homes, the evidence review highlighted a number of potential barriers to delivering effective primary care in care homes. These are outlined in Figure 4.

Figure 4: A summary of the barriers to effective primary care involvement in care homes identified in the literature

Barriers	Detail
Lack of integration	The complexities of collaborating across different sectors (such as private and public, health and social care, general and mental health) mean that integration of primary care and care provided by care homes at a strategic level can be difficult (liffe et al. 2015). In addition, several research studies suggest that high care home staff turnover and a failure of primary care staff to acknowledge the expertise of care home staff, can act as barriers to collaborative working at an individual level (Davies et al. 2011).
Lack of shared organisational models of care	'NHS services favour models of care that focus on diagnosis, treatment and episodic involvement, whilst care home providers prioritise on-going support and relationships which foster a continuous review of care' (Goodman et al. 2013 : 13). This means it can be difficult to develop shared organisational outcomes to support systematic integration of health and social care services.
Unclear roles and responsibilities	The legislation around the responsibility for healthcare in care homes is unclear meaning care home and primary care staff are often uncertain about their specific role. Consequently, there can be duplication of activity or a

Barriers	Detail
	neglect of important issues due to a lack of knowledge around who is responsible (Robbins et al. 2013). This is why clear service specifications, governance frameworks and effective leadership are important.
Reactivity vs proactivity	Robbins et al. (2013) found that both primary care staff and care home staff reported being uncertain about the correct balance between pro-active comprehensive assessment and responding to acute crises in a way that maximises limited human resources.
Complexity of care home residents	Residents' healthcare needs are complex and often include multiple long-term conditions and co-morbidity. This means clinical trajectories are unpredictable and it can be difficult to identify sudden acute decline (Robbins et al. 2013).
Lack of time	Conducting detailed assessments and reviews of complex residents is time consuming. This is often not recognised in existing job planning for GPs or in the staffing structure of care homes (Robbins et al. 2013) which are predominantly shaped around the need to deliver healthcare to individual residents. Instead working patterns should be adjusted to facilitate 'care delivery, review and discussion of residents' priorities' (Goodman et al. 2013: 13).
Insufficient training	Through interviews with staff from both primary care and care homes, Robbins et al. (2013) found that they felt they did not have the specialised training required to manage patients with multiple co-existing long-term conditions, polypharmacy, physical dependency and cognitive or behavioural symptoms. Therefore, the development of an appropriate training infrastructure is important.
Lack of a single representative body for care homes	The lack of an identifiable entity that is able to represent the care home sector means that 'there is no one place for NHS commissioners and managers to go to engage with the sector or establish contracts for more than an individual or group of care homes' (Goodman et al. 2013: 13).

2.4 Potential limitations of primary care services for care homes

Evidence from the literature also points to some potential limitations of models of enhanced primary care services in care homes. These are outlined in **Error! Reference source not found.**

Figure 5: A summary of potential limitations of enhanced service models as identified in the literature

Potential limitation	Detail
Enhanced services not being provided despite additional payment being made	In some cases, there is evidence that making payments does not guarantee that enhanced services are received. This is one reason why in the SCIE practice survey, care home respondents did not universally support enhanced services schemes (SCIE 2013). For example, Jacobs (2003) found that in one care home although £4,000 per year was paid to one practice for weekly scheduled visits, these did not always take place.

Potential limitation	Detail
Loss of continuity of care	Enhanced service models have the potential to improve the continuity of care for residents predominantly through enhanced primary care by one named GP, meaning secondary care referrals and hospital admissions may be avoided. However, both care homes and GPs report the possibility of a loss in continuity of care and knowledge of long-term medical histories when GPs are allocated through extended service arrangements (without the resident being given a choice of GP) instead of the resident continuing to be seen by their pre-admission GP (SCIE 2013).
Additional workload	As well as an existing workload being a barrier to delivering effective enhanced primary care services to care homes, GPs also highlight the potential for additional workload resulting from their enhanced provision to care homes. The reported reasons include home visiting with travel, being called out inappropriately, and the complexity of residents' health and illnesses (SCIE 2013). However, some GPs believe that payments can recognise extra workload in looking after care home residents (Jacobs 2003).

2.5 Which models of enhanced primary care support for care homes are currently in operation?

Local context is important in determining the most suitable model for delivering enhanced primary care services to care homes ([Smith et al. 2013](#)). Nevertheless, our review of the literature identified three broad models of enhanced primary care support:

- a nurse-led model
- a GP-led model, and
- a multi-disciplinary team model.

The literature also refers to a 'preferred practice model'. This involves the alignment of individual GP practices with care homes, but it does not necessarily entail delivery of enhanced services. This has not been included as a stand-alone model because it is difficult to identify any consistent features beyond the alignment itself.

This section describes each of the three models and their key features, providing a case study example for each.

2.5.1 Nurse-led model

This model involves nurses and nurse-led teams (for example, nurse clinicians, advanced nurse practitioners, Macmillan nurses and community matrons) taking a lead role in care homes, working in partnership with GPs to different degrees ([Gladman 2010](#)). This often comprises nurses and nurse-led teams mediating the relationship between care homes and GPs, pharmacists and specialist services ([BGS 2011](#)). This includes operating a 'nurse triage system' to regulate GPs' workload, for example leading on end-of-life care documentation, informally advocating for the care home in communications with GPs, or attending requested visits when judged as appropriate by GPs ([SCIE 2013](#)). Nurses can

also provide training to and work with care home staff to implement new protocols ([Ryden et al. 2000](#)).

Case study: nurse-led enhanced service

Hockley et al ([2010](#)) conducted research on an end-of-life care project in seven care homes in Scotland. An experienced palliative care nurse was assigned to facilitate the programme and two key champions, responsible for co-ordinating and embedding changes, were appointed in each care home. GPs were also informed about the project. The key champions attended training by the facilitator in order to implement the [Gold Standards Framework](#) and the [Liverpool Care Pathway for the Dying](#). Monthly discussions were held with each permanent resident around advanced care planning, Do Not Attempt Resuscitation (DNAR) status, and symptom assessment and control to which GPs were invited. The facilitator also visited each home every ten to 14 days.

From a review of residents' notes, a staff audit and interviews with bereaved relatives pre- and post-implementation, they found that there was a highly statistically significant increase in use of DNAR documentation, advanced care planning and use of the Liverpool Care Pathway for the Dying. There was also a reduction in unnecessary hospital admissions and a reduction in hospital deaths from 15% pre-study to 8% post-study.

*Source: Hockley, J., Watson, J., Oxenham, D., & Murray, S. A. (2010). [The integrated implementation of two end-of-life care tools in nursing care homes in the UK: an in-depth evaluation](#). *Palliative medicine*, 24(8), 828-838.*

2.5.2 GP-led model

The GP-led model seeks to provide enhanced services to care home residents, often with additional payment to GP practices. This usually involves a lead GP practice attached to a care home as in the preferred practice model. For example, in Leeds GPs and care homes have agreed to provide a locally enhanced service, which includes weekly visits to the care home, anticipatory care and regular reviews ([Donald et al. 2008](#)). For some homes this model has been enhanced by further support from community matrons and by a community geriatrician visiting complex cases every six weeks ([Donald et al. 2008](#)). In most cases, residents have the choice of moving to the linked GP or retaining their own ([Donald et al. 2008](#)).

This model is also referred to in the literature as enhanced medical care with lead practice or attached primary care with enhanced service ([Donald et al. 2008](#)).

Case study: GP-led enhanced service

Briggs and Bright (2011) conducted a review of the existing practices of the GP Local Enhanced Services (GP LES) across one borough's care homes through interviews with care home professionals, GPs, care home residents and their family members. In the GP LES model reviewed the service specified that GPs attended their allocated care homes on a weekly basis, conducted regular health checks and carried out medication reviews for care home residents every three to six months. The GP provider received a fixed payment of £15,000 per year to deliver GP LES services in the selected care homes.

The review found the following service improvements as a result of GP LES: the development of good working relationships; the promotion of resident continuity of care; streamlined service delivery, particularly in terms of medication and prescribing procedures; and a reduction in the number of referrals to hospital and deaths in hospital.

The review also calculated cost-effectiveness based on the number of registered deaths of residents in hospital. In 2009 one care home registered 35 deaths, 20 of which occurred in hospital, potentially costing £60,000. In comparison, in 2010 the same care home registered 36 deaths, only 14 of which occurred in hospital, costing £42,000. This is based on the assumption that the average cost per hospital visit by frail elder populations is £3,000. The care home therefore potentially saved £18,000 through reducing the number of deaths of residents in hospital following the introduction of GP LES. Balancing the reduction in death-related hospital costs against the cost of the GP LES service, an estimated £3,000 was saved in one care home in the borough.

Source: Briggs, D and Bright, L. (2011) [Reducing hospital admissions from care homes: considering the role of a local enhanced service from GPs](#), *Working with Older People*, Vol. 15 Issue 1, pp: 4 – 12

2.5.3 Multi-disciplinary team model

This model involves the establishment of a dedicated multi-disciplinary primary care specialist service to deliver primary healthcare to care homes. For example, in Durham a small practice was created by the Primary Care Trust to provide primary medical care to 14 care homes, two intermediate care units and a hospice (Donald et al. 2008). The team comprised a nurse practitioner, community matron, part-time GP specialist in geriatrics and additional GP sessions. The service included weekly visits by the nurse in a proactive style. Other interventions included: falls prevention, osteoporosis, end-of-life planning for people with a palliative care diagnosis and the use of nutritional screening tools (Donald et al. 2008). The service also provided training for the staff in care homes around falls, palliative care, syringe drivers and catheters (Donald et al. 2008).

Case study: multi-disciplinary team

In Manchester, an advanced practitioner nurse, GP and sessions of consultant time have been brought together to form a multi-disciplinary team that networks with other community services, physiotherapy and palliative care to deliver primary care to over 400 residents in nine care homes ([Donald et al. 2008](#)). The team has provided routine reviews of all residents; anticipatory care focussed on the management of sepsis; hydration and nutrition; discussion of the value and wish for future hospitalisation; embedded the Liverpool Care Pathway for terminally ill patients; and provided links to the out-of-hours service. The team has regularly met with the management teams in each home to develop the partnership and pursue opportunities for training. An audit has identified a number of significant improvements in outcomes. These include a 35% reduction in emergency admissions to hospital; 68% reduction in emergency bed days; and 56% reduction in the length of stay for those admitted over a 6-month period of intervention ([Donald et al. 2008](#)).

Source: Donald, I.P, Gladman, J, Conroy, S, Vernon, M, Kendrick, E and Burns, E (2008) [Care home medicine in the UK—in from the cold](#), *Age and Ageing*, Volume 37, Issue 6, pp: 618-620