# GPs' involvement to improve care quality in care homes in the UK: a realist review

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**Declared competing interests of authors:** As a practising general practitioner, Christopher Williams is employed by a general practice that is paid by a standard NHS contract to provide general medical services care and enhanced services to care homes. In addition, Christopher Williams has supported training of care home staff as part of his university role, but has not received specific consultancy payment for this activity. Claire Goodman leads the Ageing and Multimorbidity theme for the Applied Research Collaboration – East of England and this project is an Applied Research Collaboration-endorsed study and is funded 0.2 full-time equivalent of her time. In addition, Claire Goodman is a National Institute for Research Health (NIHR) senior investigator and receives a £20,000 per annum award that recognises her research with older populations and those in long-term care settings. Claire Goodman is also the lead investigator for the Developing research resources And minimum data set for Care Homes' Adoption (DACHA) study (NIHR Health Services and Delivery Research programme NIHR127234).

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## Scientific summary

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# Scientific summary

## Background

Enhanced Health in Care Homes, led by NHS England, is an example of a national improvement initiative aimed at improving health care in care homes. Similar policy initiatives have been undertaken across all four UK nations and in other countries internationally. National policies largely do not specify which professional group should lead or be involved in service development, but there is usually an explicit or implicit role for the doctors responsible for the primary care of residents, which, in the UK nations, means general practitioners (GPs). There is a gap in the literature about GP engagement in service development and quality improvement (QI) in care homes. We aimed to describe the ways in which GPs have been involved in improvement in care homes to help inform how such initiatives are designed.

## Methods and analysis

Following reporting standards [i.e. the Realist And Meta-narrative Evidence Syntheses: Evolving Standards (RAMESES)], we conducted a realist review to develop theories of how GPs work with care homes to bring about improvements in care quality. We also attempted to identify when improvements in processes or outcomes did not occur and why this may be the case. The first stage included interviews with GPs to gather their experiences around improvement in care homes. Interviews enabled the development of initial theories and gave direction for the literature searches. In the second stage, we used iterative literature searches to add depth and context to the early theories. The databases used were MEDLINE, EMBASE™ (Elsevier, Amsterdam, the Netherlands), Cumulative Index to Nursing and Allied Health Literature (CINAHL), Psycinfo® (American Psychological Association, Washington, DC, USA), Web of Science™ (Clarivate Analytics, Philadelphia, PA, USA) and Cochrane Collaboration. In the third stage, evidence that was judged as rigorous and relevant was used to develop the initial theories and refine these theory statements. In the final stage, we synthesised findings and provided recommendations for practice and policy-making.

During the review we held meetings of a Context Expert Group, which had expertise in current trends in the UK primary care and care home sectors, to reflect on our findings.

## Results

### *Step 1: locating theories*

Theory-gleaning interviews revealed a diversity of ways of working between GPs and care homes, determined, in part, by differing contractual arrangements and, in part, by differing interests, experiences and skills mix. The contexts of GP working include the relationship between GPs and care home organisations (as opposed to individual residents and staff), which was affected by organisational and policy structures within the NHS and care home providers. The limited experience and infrastructure for QI among primary care teams was another element of context. Health care in care homes requires specialist knowledge in care of older people and holistic and generalist skills. The scoping literature developed these topics by exemplifying different models of primary care working with care homes, and the topics and areas of interest that had been covered by improvement programmes in care homes.

At the end of this step, we developed ‘if/then’ statements to focus and guide data extraction. These were ‘If the GP reviews prescriptions together with a pharmacist, then they may find opportunities to alter prescription or regimens to reduce the “burden” of medication and adverse outcomes, thus improving

the quality of care' (i.e. polypharmacy); 'If GPs are involved in documenting and implementing advance care plans, then it will ensure that all those involved in providing and receiving care will be able to review medical diagnoses in a way that reflects residents' priorities and inform care provision and ongoing decision-making' (i.e. end-of-life care); and 'If support, training or professional networks are available . . . then GPs may develop special interests and expertise in care homes leading to fuller engagement with quality improvement and resident outcomes' (i.e. extended GP role).

### *Step 2: conduct literature search*

From step 1, a search strategy was designed to yield examples of GPs working around improvement in care homes and specific examples around medication management and end-of-life care, which our evidence suggested would comprise useful case studies where previous improvement work had been significantly involved GPs.

Our primary and secondary searches yielded 73 articles. Forty-three articles were excluded (28 because they did not describe improvement initiatives and 15 because they did not describe the role of GPs). Thirty articles were collated into intervention categories and appraised for relevance, rigour and richness of evidence.

### *Steps 3 and 4: extracting and organising data, synthesising evidence and drawing conclusions*

We developed two overarching programme theories.

#### Programme theory 1: negotiated working with general practitioners around local improvement initiatives

According to programme theory 1, most initiatives for improvement in care homes come from professionals other than general practice professionals, and often from those outside the immediate care home team. GPs are, however, integral to many aspects of health-care delivery. To realise improvements in the care home setting, negotiation is required to recognise and plan for the unique contribution of GPs and how they will interdigitate with other professionals, including care home staff, to deliver improved outcomes for residents. We described three case studies that provided evidence for this programme theory. The first related to de-prescribing in care homes, led by community pharmacists but facilitated when GPs were involved to support diagnosis, prognosis and communication. The second related to the role played by GPs in de-prescribing antipsychotics as part of a larger programmatic intervention focused on behavioural support for older people living with dementia in care homes, and was achieved through specific training co-designed by GPs and changes to care home routines that would prompt GP involvement. The third related to team-based initiatives, in which GPs and care homes worked to develop shared understanding of end-of-life care so that roles and responsibilities could be better delineated, reducing duplication and confusion in end-of-life decision-making.

#### Programme theory 2: role of general practitioners in supporting national improvement programmes

Programme theory 2 described a similar process of GPs responding to external stimuli to become involved in care home improvement, but, in this instance, the stimuli were nationally co-ordinated programmes with clearly expressed roles identified for GP participation. GPs participated through their role as primary care doctors and the focus was, again, on what they could uniquely provide that was different from other community-based health-care professionals. In both initiatives described, the Gold Standards Framework for Care Homes and the 'Difficult Conversations' initiative impetus came from high-profile national leaders who were also GPs. We could not find evidence on whether or not this professional identity was important to the success of the interventions, either in terms of enlisting the support of GPs or more generally, or, indeed, how the role played on the ground by GPs mirrored that included in project specifications.

## Discussion

Based on our findings, we recommend that for GPs to work as part of QI initiatives in care homes it is important to address from the outset their role in the initiatives and how they complement the work of other disciplines. Furthermore, opportunities should be defined for GPs to engage in approaches that support a care home focus (and not just individual patients) when working with care home staff. There is a persistent narrative of conflicting commitments and, because of this, and the nature of their largely medical expertise, GPs are not always the best-placed professional group to lead a QI initiative. GPs do, however, frequently lie on the critical path to success for QI initiatives undertaken in the sector and they are responsible for medical care and referral to other specialist services.

## Conclusions

General practitioners will be best able to contribute to improvement in care homes if they are consulted early about how and when they might contribute to QI, focusing on their role as medical practitioners. Their medical role offers specific contributions that can be made only by GPs and not by other community-based health-care professionals. In addition, the QI initiatives should recognise the continuum of expertise and interest in relation to care homes among GPs and optimise this within the team. GPs may require specialist training and their engagement with the improvement initiatives should be recognised and co-designed. Policies, procedures, documentations and schedules may require adaptation to make best use of GPs as part of an improvement initiative. Finally, it is recognised that GPs, care home staff and other professionals may need to train or work side by side for a period of time to develop the shared trust and understanding required to build confidence to deliver improvement outcomes. The impact of the initiative on GP working should be recognised, measured and reported.

## Ethics and dissemination

The study was approved by University of Nottingham Faculty of Medicine and Health Sciences Research Ethics Committee (reference 354-1907). Findings will be shared through stakeholder networks and submitted for peer-reviewed journal publication.

## Study registration

This study is registered as PROSPERO CRD42019137090.

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