

Addressing the problems associated with general practitioners' workload in nursing and residential homes: findings from a qualitative study

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SUMMARY

Background: Caring for older people in residential and nursing homes makes major demands on general practitioners (GPs).

Aim: To investigate the perceptions and experiences of home managers and GPs of the provision of general medical services for older residents.

Design of study: In-depth qualitative study.

Setting: Forty-two nursing and residential homes in five locations in England, interviewing home managers and eight of their residents' GPs.

Method: Semi-structured face-to-face and telephone interviews.

Results: Most homes endorse principles of continuity of care and patient choice. Although many homes therefore deal with a large number of GPs, with the inherent difficulties of coordinating care and duplication of GP effort, limitations in residents' choice of GP result in the majority of residents in many homes being registered with only one or two practices. Contracts between homes and GPs may provide opportunities for improving medical care but do not guarantee additional services and have implications for patient choice and residents' fees. Visits on request form the bulk of GPs' workload in homes but can be hard to obtain for residents and may not be appropriate. Regular weekly surgeries are preferred by many homes but may have additional workload implications for GPs.

Conclusion: The assumption that patient choice and continuity in medical care are paramount for older people in nursing and residential homes is questioned. While recognition of the additional workload for GPs working in these settings is necessary, this should be accompanied by additional NHS remuneration. Further research is urgently required to identify which models of GP provision would most benefit both residents and GPs.

Keywords: elderly patients; GP workload; health services accessibility; nursing homes.

Introduction

THERE is now good evidence that the impact of providing medical services to older residents of institutional care on GPs' workload is greater than that of caring for older people living in their own homes.¹⁻⁴ The closure of long-stay NHS geriatric wards, the increasing dependency of care home residents,⁵ and earlier hospital discharge of older people are placing considerable demands on GPs.⁶ Indeed, the British Medical Association (BMA) have long since called for the removal of this group of patients from GPs' core responsibilities.⁷ Appeals have been made for adequate remuneration for GPs and also for a reorganisation of medical care.^{4,8} Others claim that universal access to free medical care for older people in residential settings is at risk.^{9,10} Yet current UK government policy in this area is underpinned by the National Service Framework (NSF) for Older People,¹¹ which clearly states in its leading standard that 'NHS services will be provided, regardless of age, on the basis of clinical need alone' (page 16).

In a national survey of home managers,¹² we have already demonstrated that 33% of nursing homes in England (8% of homes overall) paid GPs for medical services. We also demonstrated that, in a minority of homes, GP visits on request were not available to residents. However, information was unavailable about the link between increasing demands on GPs and access to medical care for residents. We therefore undertook a second phase of this study to investigate in depth the perceptions and experiences of home managers and GPs of the provision of general medical services (GMS) to older residents.

The aims of this paper are twofold: (a) to provide a qualitative description of the organisation and delivery of existing GMS to nursing and residential homes in England; and (b) to discuss, in this context, the options for GP remuneration and restructuring of general medical cover for nursing and residential homes.

Method

The qualitative study reported here followed a national cross-sectional telephone survey of the owners, managers or matrons of 570 nursing, residential and dual registered homes in England,^{12,13} and used a subsample of responders to that survey. First, five of the original 72 Primary Care Group/Trust (PCG/T) localities covered by the survey were purposively selected to include a range of geographical and socioeconomic settings, but allowing for a sufficient number of subjects (10 or more) in each location. Responders from

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HOW THIS FITS IN*What do we know?*

There is now good evidence that caring for older people in nursing and residential homes has significant workload implications for GPs. We have previously demonstrated in a national survey of nursing and residential homes that there are wide variations in arrangements for access to general medical services for older people both within and between homes.

*What does this paper add?*

This qualitative follow-up study provides insight into the views and experiences of home managers and GPs of the provision of medical services to older residents. These data suggest ways in which the problems associated with GPs' workload in homes may be addressed.

each of these areas were then purposively selected to obtain an even distribution of home registration type (nursing, residential, and dual registered homes) and home size. From 59 homes contacted, 42 interviews (15 in residential homes, ten in dual registered homes and 17 in nursing homes; between six and ten homes in each area) were obtained. Only five refused to take part; others were unavailable for the duration of the study or were unsuitable owing to recent changes in personnel.

Home interviewees were each asked to supply contact details for up to three health professionals who provided services to their older residents. Of 16 GPs contacted, eight interviews were obtained. Only four refused outright; others were unable either to set or to keep an interview date for the duration of the study; in a small number of cases, it proved impossible to speak directly to the GP to try to arrange an interview.

In-depth qualitative interviews were conducted between June and August 2000 by the author and two trained freelance interviewers. Interviews followed semi-structured interview guides, specific to the category of interviewee, which covered such topics as GP registration of new residents, contracts between homes and GPs, and provision of GP services. Interviews with home responders were conducted face-to-face and lasted one to one-and-a-half hours. Interviews with GPs were conducted by telephone and lasted between 30 minutes and one hour. Interviews were audiotape recorded and fully transcribed. The transcripts were thematically analysed using grounded theory techniques.¹⁴ The themes that emerged during this analysis were tested for their own internal consistency¹⁵ and then adapted and refined in the light of evidence from the quantitative study. The data were organised and interrogated using the QSR NUD*IST software package.¹⁶

Results*Continuity of care*

Most home interviewees stated that, wherever possible, new residents retained their existing GP. The importance of continuity of medical care was stressed:

'Well, I think if they've known the resident for twenty, thirty years, they should continue that. I don't see any point in changing, because they know them best. They've dealt with all their illnesses for the last X number of years. So, we wouldn't, you know, we wouldn't change, unless we were forced to for some reason.' (Home D, Area 5.)

Barriers to continuity in medical care usually related to residents moving out of their existing GP's catchment area. This was a particular problem in rural areas, where there were few practices in the vicinity of homes:

'Well, with this home being in the middle of nowhere, as you can appreciate now you've been here, there's no local village surgery, so it's either X or Y [names of two towns nearby] and it is a problem because nobody likes to come out to Z [name of village].' (Home C, Area 2.)

However, homes in urban areas also faced this problem. Here, some GPs maintained strict practice boundaries:

'It depends solely on the practice. We have people from here whose actual practices are five or six miles away and they will consider us as part of their catchment area. We have got some that are three or four miles away and we're not part of their catchment area, so it's solely down to the individual practice.' (Home G, Area 1.)

This was particularly irksome when residents were placed for short-term stays:

'I mean I've got one gentleman from X [name of town], and I, I've had awful problems with that surgery ... but he, he came here and the surgery's only in X, and this end of X, so it's only three miles away. I went in there, "Oh we can't keep prescribing to this man because he's out of our area". "No the doctor won't come and see him you need to re-register", because at the time he was only here for respite care. I tried to explain, I said, "Well he may only be here for three or four months, it's just a, a trial period, so rather than change GPs could you just keep him on?" "No", it was quite adamant, "And we won't be doing the GP prescriptions any more".' (Home F, Area 1.)

There were some exceptions where home interviewees felt that GPs had gone out of their way to ensure continuity:

A: *'I've had one recently came. Now her GP in fact doesn't want to change. He said he'll come and see her, he's the only one and he's out of the area.'*

Q: *'But he's prepared to travel over?'*

A: *'Yes, because she's over ninety and he's, she's always been under him and he said, "There's no way, I'll come to keep an eye on her, I would like to come".'* (Home D, Area 4.)

GPs similarly stressed the importance of maintaining strict practice boundaries but some were prepared to travel out of these areas for terminally ill patients or those unable to re-register. In these situations, the likely duration of this arrangement was also considered. That GPs would always retain patients moving into homes *within* their catchment area was not inevitable. Decisions in these situations were made on the basis of GPs' judgements of the quality of care offered by a home, in particular whether they were known to 'create a lot of workload' for GPs, and whether GPs had other patients there. Thus, a GP's judgement of the overall workload involved in retaining a patient either within or outside their catchment area was a key determinant of continuity of care:

'This problem came up last week. Chap who has a terminal illness, he's admitted to hospital, diagnosed as being terminal, been sent from a rest home to a full-time sort of nursing home outside of the area. Would we like to keep him? We sat down and discussed that, what the prognosis was, what the home is like, in terms of have we had any problems with them before? Do we know that they're competently run? And we got back to them and said that we would be happy to take him on, but if he's going to, if it looks as if he's going to be going for more than a month or two, we're probably not happy to ... We understand that he's got a terminal illness, but if it's not within the foreseeable, next couple of months, it's probably wisest if a local doctor took it, and got to know him.' (GP, Area 1.)

Patient's choice of new GP

When a resident had to register with a new GP, many home interviewees stressed the importance of patient choice. Often, however, they would suggest a local GP on the basis of the existing relationship between the home and that surgery:

'We don't actually have a retained GP here as such, so they would, I mean, there are a couple of surgeries that are quite local so they're sort of like the surgeries probably of choice. But you know what I mean, at the end of the day it would be down to the resident to choose, wherever they wanted to have a GP, wherever they wanted to register.' (Home D, Area 2.)

Moreover, restrictions placed on registering new patients by local GPs often dictated which GP the resident registered with:

'If they have a real preference, you know, if relatives are with that GP they usually take them. But they tend to take them in rotation. You know, we have to go round to the GPs and say well, "Yeah we'll take this one but leave it for a bit", you know. So it just depends if there's vacancies or if they're prepared to take them so it's really down to the GPs not the residents which GP they get.' (Home C, Area 5.)

Full lists and quota systems operating in some practices were the most common reasons cited by home interviewees having difficulties registering residents with GPs. However, some homes had experienced GPs' unwillingness to register patients with high needs or those who would be expensive for the practice. These reasons were corroborated by GPs who also took into account past experience of working with particular homes in an effort to manage their workload. One only took new patients from a limited list of homes. Another 'trimmed' his list when the workload created by a particular home became 'intolerable'. Thus, the true extent of patient choice was somewhat limited.

Many GPs per home or the 'home GP'

The emphases placed by homes on continuity of care and patient choice explain why many nursing and residential homes in England reported in our survey that they deal with a large number of GPs and practices.¹² We have now been able to ask home managers and GPs about the advantages and disadvantages of this arrangement. The most common view held by home managers was that it posed no problems overall. Indeed, a small number of managers preferred to have the input of more than one GP or practice. Where difficulties arose, these related to coordinating different systems for ordering repeat prescriptions and requesting home visits:

Q: 'Tell me about the kind of little niggly things that you said happen between your different practices.'

A: 'Well some like us to ring after 10.00 am for prescriptions, some it's after 12.00 pm, some say afternoon, some have up until 3 o'clock, and it just varies so much that it's hard to remember which is which.' (Home B, Area 3.)

Another disadvantage was that some residents chose to be registered with a GP who was disliked by the home or was seen to offer poorer quality care:

'Well very often it can be, they can register with a GP that the home or if you like, myself or one of my trained nurses is not particularly popular, it's not a popular choice. It's somebody that we'd rather not work alongside but there again that is the patient's choice.' (Home G, Area 1.)

Although, on paper, many homes dealt with a large number of GPs, sometimes the restrictions on patient choice described above meant that most residents were in fact registered with just one or two practices. Apart from easing administrative difficulties, these homes were able to build up good working relationships with those GPs who often became known as the 'home GP(s)':

'I suppose if you've only got one resident registered with a GP then you don't have as much contact with them, whereas if you've got half a dozen, you know, if they're round the corner, say, so you do tend to build up relationships with local GPs that you use regularly. Whereas if it's a GP you only called out once in a year then there's no real relationship.' (Home D, Area 2.)

From some GPs' perspectives, having only one GP per home was a more efficient way of organising medical care and presented an opportunity to improve the quality of service they could offer:

'I certainly think the care could be improved, now whether it's with some, probably a contract to look after them all, is a better idea than just going in when they call. I don't feel that we give the optimum care to the patient. It's like emergency cover we provide really. So probably if somebody regular looked after them then it would improve.' (GP, Area 5.)

GP contracts/payments

In our survey, we had demonstrated that in 33% of nursing homes (8% of homes overall), payments were made to GPs for medical services, usually by way of a formal contract.¹² In a small number of homes in the qualitative study, the 'home GP' was so designated by this type of contract. Generally, payments to GPs were for weekly or fortnightly visits to residents. Some also covered the occupational health of home staff. Payments, however, did not guarantee a particular level of service. In one home, although £4000 per year was paid to one practice for weekly surgeries, these were not always provided:

'They will if there's enough people. If there's one or two we have to take, send them to the practice, which can be very difficult and expensive and incur staff travelling time, hiring vehicles, etc.' (Home A, Area 4.)

In two cases, although payments were made, GPs did not provide any services over and above the visits on request normally expected by homes.

Homes with experience of paying GPs were divided over whether or not such arrangements were beneficial. Some felt that payments were a way of ensuring that residents got the medical care they required and that the medical care offered was of a particular standard. Other home managers felt forced into paying for GP care and that the contracts impinged upon patient choice:

'If they were scattered about the place they'd have to be making home visits, here at least they've got all our facilities, and a trained nurse to go round with them to carry out, to follow up their decisions, so we can't, I don't think that it's, it's extra work, but we're over a barrel, we have no alternative.' (Home A, Area 2.)

GPs were also divided over the desirability of contracts. Some felt that the extra workload involved in caring for home residents should be recognised in this way and that they would be able to offer better quality care. However, others believed that any additional remuneration should be coming from the NHS. These GPs considered that contracts with homes had the potential to alter the doctor-patient relationship, 'because really the contract's between you and the patient, not you and the home' (GP, Area 3), or could create additional workload or inflexibilities.

Visits on request

A large number of home interviewees felt that they had no problems overall with obtaining visits on request from GPs:

'We never seem to have a problem and I think this has been built up by the relationship with the surgeries. Very rarely have we called a GP out and it's not been needed. We do, particularly our permanent people, we do know them, we do recognise changes, although we're not medically trained, so we're very quick on picking up urine infections. [So we] phone up and say, "Can we send up a urine sample?" and nine times out of ten it is an infection. So we never get refused or have any problems having a GP out.' (Home J, Area 1.)

Where difficulties arose, these could be classified as problems relating to access (from the homes' perspective) and problems relating to workload (from the GPs' perspective).

Practices were sometimes perceived by homes as being inflexible with the times they allowed requests to be made:

'We do have problems. Especially if you don't ring up, you know, if you have somebody like for example whose conditions deteriorated in the afternoon, or after the ten o'clock deadline where they want you to ring for that day.' (Home I, Area 5.)

Other homes had experienced problems with GPs' reluctance to make home visits. This could entail arguments with receptionists, who were perceived as a major barrier to access, arguments with the GP, delays in getting an appointment or, in a small minority of cases, a refusal by the GP to visit at all:

'I don't have any problems with the two GPs that come regular, I phone, they come out. I can phone other GPs and I've got a process of probably half the morning arguing with receptionists before I actually get the GP and then arguing with the GP. I've had a GP in this morning who I requested on Monday, we're now Friday, who I had quite strong words with on the phone with on Monday.' (Home G, Area 5.)

Disagreement between homes and GPs over the necessity of visits was a common theme in both home and GP interviews. Home interviewees generally felt that they were in the best position to know if a resident's health had deteriorated:

'If we say that we want a visit they know that that person needs a visit. I mean we have worked in the health service a number of years and like I said we wouldn't call them out just for something that's trivial you know.' (Home A, Area 1.)

GPs, on the other hand, often felt that they were called out for trivial reasons, sometimes as a way for homes to cover their backs:

'There's a lot of sort of time expenditure on fairly straight-

forward stuff, and a fair amount, it has to be said, that seems to serve the paranoia and the interest of the rest home proprietors rather than of the patient.' (GP, Area 4.)

The quality of care offered by homes, in particular the skills, qualifications and turnover of home staff, was frequently identified by GPs as contributing to their overall workload. This was a particular problem with residential homes and was thought to influence both the appropriateness of requests for visits and the frequency of visits, sometimes to a greater degree than the dependency of residents:

'The practice has a lost a number of homes that used to give us an almighty amount of work, so these were often homes that were providing less than fantastic quality care. So we've got a, you know, sort of paradoxical increase in dependency but on the other hand we've lost some of the homes that actually used to give us quite a lot of work for not terribly dependent patients.' (GP, Area 4.)

To minimise the workload implications of caring for nursing and residential home residents, GPs employed a number of different strategies. Firstly, most GPs sometimes used the telephone for giving advice or producing a prescription where they felt that they knew enough about a particular patient and their condition. Home interviewees were generally happy with this and found it a useful service:

'Sometimes if they've got a urine infection — because we're able to test here and we can usually tell if they're symptomatic — and then we'll probably contact them and say, "We've done the urinalysis, it showed bla di bla, we've sent a specimen off to the hospital" and they'll tend to just say, "Oh all right, I'll write you a prescription for antibiotics, can you come and collect it?" Because they trust us.' (Home E, Area 2.)

However, some had concerns about telephone prescribing:

'This doctor in particular, he does prescribe over the phone. He'll have the notes in front of him or up on the screen in front of him, but he doesn't come and actually see, he's taking our word for it. So we could tell him the biggest load of twaddle and he'd prescribe something completely different, and he's quite happy to do that over the phone.' (Home E, Area 3.)

Secondly, for other requests, GPs would send a nurse where this was deemed more appropriate. Nurses also took a role in regulating GPs' workload in practices where a nurse triage system operated.

A third strategy employed by GPs was to maximise the use of their time while they were at a home. Often, when GPs were called out to see one patient, they were asked to see other residents. GPs perceived some advantages to this, instead of making additional journeys. However, there were disadvantages also, particularly the fact that these patients' notes would not be available to them. One GP overcame this by allowing residents' medical notes to be kept securely in

the home itself. In another instance, the GP held regular surgeries in the home.

Regular surgeries

Regular (weekly, fortnightly or monthly) GP surgeries are held by one or more GPs in over one-third of homes nationally.¹² Most of the GPs interviewed in the qualitative study had past experience of providing regular surgeries to homes. The majority, however, had perceived no significant advantage to running these surgeries in terms of reducing their overall workload. Indeed, in some cases, they created more work:

'There were a couple of homes that I used to visit every week without fail but I have to admit, I've stopped doing that now, 'cos they still ring up in between, so there's no advantage.' (GP, Area 3.)

Only one GP interviewed currently offered regular surgeries. From that GP's perspective, regular surgeries could not only cut down on travelling to and from homes, but also enabled clinical problems to be identified earlier and ongoing problems monitored.

These were also cited as benefits by home interviewees. In particular, homes saw regular visits as an opportunity to consult GPs over minor health problems that would not necessarily merit a callout:

'Sometimes, if there's something little and niggling it's not always worth calling a GP for, and you feel it isn't, you feel you are being finicky and things like that, whereas if they are coming anyway it can be discussed and, just their general state of health as well, and especially elderly if anything happens like a sudden death, it's very important that they've been seen.' (Home A, Area 3.)

Homes also recognised the benefit for residents of knowing that they would regularly have the opportunity to speak directly to the GP. These perceived benefits had led other homes to request regular surgeries from GPs. In most cases, however, they had either been refused or, if regular surgeries had been instigated, they were not maintained.

Discussion

The strengths and weaknesses of this study

By taking a two-stage approach to this investigation of access to general medical care in nursing and residential homes, we have been able to build up a comprehensive picture of current arrangements. In particular, we have been able to compare and contrast the views and experiences of home managers with those of GPs. Moreover, these findings can be placed in the national context of access to services reported previously.¹²

There are some limitations to this study. Firstly, the number of GP interviews obtained was small. The reasons for this were three-fold: this was part of a larger study looking more widely at access to health care in homes and the GP interviews were only a portion of total number of health professional interviews conducted; the researchers

experienced unexpected and time-consuming difficulties setting up interviews with GPs in particular; the researchers were working to a very strict deadline. While this shortfall could not be helped, it does mean that we may not have been able to present the full range of GPs' views. A second major limitation of this study was that the views of older residents themselves were not sought. Thus issues such as the importance of patient choice and continuity of medical care cannot entirely be disentangled. Lastly, this study did not aim to measure the effectiveness or costs of different models of service organisation and delivery. Clearly, this is one area where further research is urgently needed. However, this qualitative study has provided some important indications of where more systematic measures might appropriately be used.

Discussion of main findings

Most homes in this study endorsed the assumptions that continuity of medical care and patient choice were paramount. However, it is also clear that in many cases these principles were either unworkable, owing to restrictions imposed by GPs, or were not, in fact, adhered to. In light of the well-publicised increases in GPs' workload, restrictions placed by GPs on both their list sizes and the number of workload-intensive patients on those lists is understandable, given the need to balance the needs of all their registered patients. Indeed, homes admitted that the best medical care might not necessarily come from residents' long-standing GPs, but from other GPs who took a particular interest in caring for the residents of that home. From the GP's perspective, the workload involved in caring for all residents in one or two homes was more manageable, and presented more opportunities for providing a better service, than caring for many individuals spread over a number of different locations. There have been debates recently over the importance of personal and clinical continuity in general practice.¹⁷⁻²⁰ Furthermore, there have been anecdotal reports of salaried GPs offering regular monitoring to all nursing home residents in one location, drastically reducing the workload of those residents' registered GPs.²¹ Research is needed to determine whether, in the particular instance of older people moving into long-term residential or nursing care, the benefits of medical continuity outweigh the potential benefits of having dedicated GPs serving these communities.

Regular surgeries were viewed by most home managers as preferable to just visits on request in terms of the benefits to their residents' wellbeing. Although suggestions were made that weekly surgeries could cut down on visits in between, or callouts for minor ailments, most GPs we spoke to refuted these claims. The practice of holding GP surgeries in homes may be compared with that of specialist outreach clinics in primary care. These have been shown to improve access to services for patients and also to improve the quality of health care received. However, they also cost the NHS more for relatively little health gain.²² Again, this is an area where research is needed to provide evidence of the costs and outcomes of regular GP surgeries in care homes, both in terms of residents' health and GPs' workload. Consideration would need to be given to systems of remuneration for this service should there be health benefits but

no, or negative, implications for GPs' workload.

Practice and policy implications

Whether the additional workload involved in caring for nursing and residential home residents is recognised by contractual arrangements with homes or by remuneration from the NHS is of crucial importance. Currently, General Practitioners Committee guidance states that 'A GP is entitled to receive fees from nursing homes for services which are of a general nature and/or are outwith GMS'²³ However, our study has shown that contracts are sometimes entered into reluctantly by nursing homes and may not secure more than visits on request from GPs. As small businesses, homes may be forced to recoup the costs of GP payments in fees to residents. A revised weighted capitation system of GP funding by the NHS that takes into account, not only the age of patients, but also the additional workload involved for GPs visiting care homes would surely be a more equitable resolution to this problem. It remains to be seen whether the imperatives outlined in the NSF¹¹ for 'rooting out age discrimination' make any impact on this particularly insidious form of inequity.

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