The interface between primary care and care homes: General Practitioner experiences of working in care homes for older people.

Abstract

Supporting residents in care homes for older people is an important, though little studied, aspect of the General Practitioner (GP) role. This study explored GPs' experiences of working to support older people living in care homes, and the challenges and facilitators to providing effective care in this unique practice environment. A qualitative online survey was shared with GPs in England via Twitter and through Named Doctor for Safeguarding networks. This was available from October 2019 – March 2020 and was completed by 58 GPs. Responses were analysed using inductive Thematic Analysis. Participants highlighted the complexity of care home residents' health, with multiple long-term conditions frequently reported. Furthermore, dementia and communication difficulties meant the GPs were often reliant on communication with others (staff and families). GPs had to navigate multiple relationships within care homes, including with residents, staff/managers, families and other healthcare practitioners, all of whom could have competing perspectives and priorities. Gaining access to information about resident health could be challenging, and was affected by staff continuity/discontinuity; lack of Wi-Fi access was also common. Care home organisation of and support for the visit was important. We conclude that care home work requires GP skills to meet resident healthcare needs, as well as to navigate multiple relationships. GPs are often reliant on others; this has important implications, both risking marginalising the resident voice, and in respect of recognising and reporting abuse.

Key words

General practice; care homes; older people; adult safeguarding; qualitative research

What is known about this topic

- GPs are among the most frequent practitioner visitors to care homes.
- However, there has been limited research in respect of their roles in care homes, especially from their own perspectives.
- Care home residents frequently have cognitive impairments, complicating the management of long-term conditions.

What this paper adds

- Relationships between GPs and staff are important; but the risk of collusion with the staff perspective was noted.
- GPs are reliant on staff for information and communication; with a risk that the resident voice is marginalised.
- GPs' may observe signs of abuse and neglect when in care homes, and their safeguarding role is worthy of further research.

Introduction

While the majority of consultations are within the surgery, support to older people living in care homes (CHs) is also an important element of the General Practitioner (GP) role. Recent UK health policy has underscored the importance of primary care in delivering 'Enhanced Health in Care Homes', emphasising the importance of proactive care for residents and collaborative working between CHs and the NHS (National Health Service) (NHS England 2019, NHS England and NHS Improvement 2020), with a clear role for GPs in supporting this enhanced delivery. The CH represents a unique and distinct environment, in contrast to the practice setting. However, despite the importance of the GP role within CHs, there appears to have been little research exploring GPs' experience of delivering healthcare in this context (British Society of Geriatricians, 2011). The existing literature, often focusing on collaborative working during end-of-life care, gives limited voice to the perspectives of GPs, often recording others' perceptions of their practice. However, if GPs are

to deliver enhanced support to care homes, a greater understanding of their experiences in such settings, and the facilitators and barriers to supporting resident health, are required.

This study formed part of a wider study which aimed to explore GP experiences of safeguarding residents living in CHs. Safeguarding is an important CH role for GPs alongside their support for resident health. This first stage of the study was intended to help contextualise the subsequent findings in respect of GP experiences of safeguarding, the decisions and actions undertaken in this context, and the facilitators and barriers to identifying and acting on concerns, as well as providing insights into the GP experience of working in CHs more broadly.

The abuse and neglect of older people in CHs is an ongoing and concerning issue (Manthorpe & Martineau, 2016, 2017), which appears to account for a significant proportion of adult safeguarding activity (Milne et al, 2013; NHS Digital, 2020). Residents may not be easily able to report experiences of abuse and neglect (Manthorpe & Martineau, 2017), and may require others in their support network to recognise abuse and take action on their behalves. CH visitors, including visiting practitioners (Marsland et al, 2012), can provide an important outside perspective and appear well placed to identify signs of abuse and harm, and report these appropriately. GPs provide a universal service, and are among the most frequent visiting professionals to CHs (Handley et al, 2014; Kinley et al., 2014, Victor et al, 2018); they may therefore have valuable opportunities to identify signs of abuse, raise alerts and report concerns. However, while the contribution of General Practice to safeguarding has been highlighted, it has been subject to little research (Gibson et al, 2016). GPs report encountering poor care and abuse in CHs (Gleeson et al, 2014; Gibson et al, 2016) and have identified abuse in these settings as a significant concern; however, they reported that elder abuse was difficult to address in comparison to child safeguarding and domestic violence, and a lack of confidence was indicated (O'Brien et al, 2014). This suggests that consideration of GPs' roles in safeguarding in CH contexts is an area requiring further exploration.

The aim of this stage of the research was to explore GP experiences of working in care homes, the challenges and facilitators of their work in these settings, as well as to collect some early information about safeguarding experiences.

Method

An online survey was employed. Surveys can be a valuable source of in-depth qualitative data, enabling researchers to access a large and geographically diverse sample and to capture a range of perspectives, especially useful in under-explored areas (Braun et al., 2020). The survey was designed by the researchers, one of whom is a GP, and Named Doctor for Safeguarding Adults, the other a University researcher with a background in CH research and social work. Professional background may influence the ways in which data is collected and analysed (Richards & Emslie, 2000); therefore, the involvement of researchers with different professional contexts, knowledge and assumptions was important in designing effective questions and providing a broad perspective on the data during analysis.

Recruitment

A volunteer sample of participants was recruited using Twitter (@GPsafeguarding), in which regular Tweets were posted, providing information about the study and links to the survey site, as well as through regional and national Named Doctor for Safeguarding networks in England. Leads for the Named Doctor networks were contacted and provided with information about the study, which they were asked to forward to GPs in their Clinical Commissioning Groups (CCG).

GPs were eligible to participate if they were:

- A GP working in England, at the time of the survey or during the previous year, and
- Their role included visiting and supporting residents and staff in CHs, or had included this role during the previous year.

Data collection

The survey sought demographic information, and included open questions to capture qualitative data about:

- Key differences between consultations in the surgery and those in CHs
- Challenges and facilitators to GPs' work in CHs
- How CH staff and managers support or hinder GP practice
- Whether there are any aspects of CH organisation which facilitates or makes their role difficult
- Whether there are any resident characteristics which present challenges or require additional skills
- How much contact GPs have with residents' families, whether this supports good care, as well as any challenges associated with family communication.

Participants were also asked whether they had ever observed clear signs of abuse/neglect, or less clear signs which gave rise to concerns about the possibility that residents were being abused or neglected, and to give examples of these. If they had identified clear or more ambiguous signs they were asked how they responded, and whether they experienced any dilemmas in reporting these signs. Data on signs observed, actions and dilemmas provided was brief and therefore not included in the analysis, but was used to inform subsequent stages of the research.

Prior to completing the survey, participants were asked to read an information page. This provided information about the research, identifying it as the first stage in our study, and including information about the overall scope of the study. Information was also provided about what participants should do if they had any concerns about resident abuse or neglect, and signposted to sources of advice and support. GPs were asked to complete the survey anonymously. Written consent was not sought, in order to maintain confidentiality, and survey completion implied consent. Permission was sought for the use of anonymised quotes.

The survey was conducted between October 2019 and March 2020. CH staff and residents have been profoundly impacted by the COVID-19 pandemic (Gordon et al, 2020, Salcher-Konrad et al.,

2020), and GP visits to CHs decreased during this time (Devi et al., 2020), however, data collection ceased immediately prior to the UK lockdown and issues associated with COVID-19 were not therefore reflected in the responses.

The study was reviewed and given a favourable opinion by the Faculty of Health Sciences Research Ethics Committee, at the University of Hull.

Data analysis

Thematic analysis was used to analyse the data; this provides a 'rich, detailed, yet complex account of data' (Braun & Clarke, 2006, 78). Both researchers developed initial codes inductively, through a process of open coding, following a close reading of the survey responses. The codes developed were agreed by both researchers, and one researcher then created tables for each code into which all relevant data was entered, to give a detailed view of each code. The codes were then developed and grouped by one researcher to outline the key themes which described the data; these were discussed and refined by both researchers to develop the final themes, bringing a GP and social work perspective on the data. A narrative of the data was then developed.

Findings

Participant data

58 responses were received. Participant data is reported in Table 1. No data was captured about any surveys started, but not submitted.

Table One – Participant data

Participants' experiences of noting concerns in CHs are outlined in Table 2.

Table Two – Participant experiences of safeguarding concerns

The thematic analysis identified four key themes within the data: resident health and care needs; professional relationships; communication and accessing information; organisation and conduct during the GP visit.

Theme 1 – Resident health and care needs

Residents were widely identified by GPs as experiencing 'complex' health issues; these included residents with multiple long-term conditions (and consequently complex medication regimes), residents who were considered frail, and those at end-of-life. Restricted mobility was reported, making moving to a private place for examination difficult. Further, residents were frequently identified as having dementia or other cognitive impairments, and were often reported to have difficulties in respect of communication and capacity. This meant that GPs often relied on others, communicating with paid staff or family, rather than directly with residents, although family members were not always present during the visit:

Usually care home residents are elderly with several co-morbidities and likely to have communication difficulties - though this is sometimes mitigated by staff, however the quality of this is variable (GP56).

Patients in care homes may not have requested GP input themselves. They may have impaired cognition and lack autonomy. They are rarely seen alone and rarely have the opportunity to ask to be seen independently. There may not be family present to offer support or other testimony. Most of my contact at the home and away from the home is done through the care home staff (GP48).

The resident needs identified highlight the need for skilled support from healthcare practitioners and, along with the frequent reliance on communication with others, form important starting points for understanding the context of GPs' CH work, which are further developed in subsequent themes.

Theme 2 - Professional relationships

GPs form multiple professional relationships when working in CHs. Key relationships within CHs are with residents, staff and managers. However, they also have important working relationships with other visiting professionals caring for residents, such as pharmacists; Occupational Therapists; Physiotherapists; Medicine for the Elderly consultants; other primary care staff. They therefore have

to navigate multiple relationships and communicate with a wide network of people, all of whom may have distinct backgrounds, perspectives and expectations. Accordingly, GPs described different:

Expectations of care home staff vs relatives. Both supportive elements, but also unrealistic asks, fuelled by CQC [Care Quality Commission – independent health and care regulator in England] fears rather than health outcomes (GP31).

Accordingly, they highlighted the need to *'balance the needs and wants of the relatives, patient and care home staff which are not aligned (GP55),* and they therefore have to manage questions about what information can legitimately be shared, and with whom.

Building relationships with these multiple agents required time, and was facilitated by continuity; where there was a high turnover of CH staff, managers and residents this was experienced as more challenging.

GPs often recognised the importance of families (although not all residents have family members), in which *'contact equates with good care' (GP3).* However, family members were generally not present during GP visits; this reflects the times of visits and families not being made aware by the home of GP visits. As a result, GPs either needed to invest time in contacting families, or relied upon staff to do so. It was reported that the involvement of families:

Sometimes facilitates good care; depends on expectations of relatives. As they are not present often difficult to involve in minor decisions, rely on staff passing on message. I ring if I need to discuss a major decision (GP7).

The potential for conflict if there were diverse views was however also highlighted:

Family involvement can be helpful (they often know the patient best) or the reverse if they have differing views about treatment to us / the patient / the staff (GP49).

The findings also highlighted the importance of the quality of the relationship between CH staff and residents, which could support GPs in their role; the value of staff who knew residents well and understood their needs was emphasised. Such staff were recognised to be *'the constant eyes and*

ears' (GP1) with the ability to *'see decline and change' (GP40),* and were able to *'demonstrate care and warmth, comfort and encourage patients when I am making an assessment' (GP47),* as well as advocating for residents. Thus, it was apparent that staff represented an important bridge between GPs and residents, and that the relationship CH staff have with residents is an important element of individuals' health care, ensuring that if they are unable to communicate their needs and preferences clearly or independently, they receive knowledgeable support to do so. Where staff have the skills, knowledge and time to enact this bridging role, this supports both residents and GPs; conversely, a lack of knowledge of residents was perceived as unhelpful.

While the importance of relationships with CH staff and other practitioners was apparent, it was also acknowledged that there is a consequent risk that residents' voices may be marginalised, especially as a result of reliance on staff and the need to build effective professional relationships with them:

Care home staff often become a patient's family and our relationship is often with them rather than the patient or their family (GP48).

A GP noted the potential tension between '*being [the] patient/relative advocate whilst also maintaining good relationships with staff. Being the "go between" - not often, but does happen' (GP36).*

The data suggested difficulties for GPs and staff in appreciating one another's roles and the boundaries and limitations of these. GPs did not always appear to understand care staff roles and the limits of their training and expertise: '*often communication is poor and my instructions for care aren't followed' (GP4).* They also reported difficulties in '*explaining things to staff who are not highly trained' (GP52).* Further, they perceived that care staff often had unrealistic expectations about possible outcomes for residents and that they did not '*understand the boundaries of a GP's remit' (GP23).*

These factors, and difficulties in understanding the boundaries and limits of respective roles and training, highlight the potential for tensions between GPs and carers.

Theme 3 – Communication and accessing information

A critical aspect of the GP visit is accessing information about residents' health, and especially any recent changes. GPs are frequently reliant on staff or managers to provide an accurate and balanced account on behalf of residents. In this GPs depend on '*the quality of care staff and their documentation/insight' (GP46).* Further, they identified that it is '*difficult to get information due to lack of continuity of care staff and poor notation which is not always contemporaneous' (GP28),* and that it can be difficult to obtain a '*clear account of concerns in patients with advanced dementia - often staff read out concerns from care record and don't know details' (GP47).*

Their reliance on staff meant that GPs could be at risk of being led by staff views:

Care homes - always get collateral history - sometimes useful, sometimes easy to be led by care home staff opinion (GP36).

The quality of communication and record keeping within the home appeared to impact on the ease with which information was available to GPs. GPs require staff on duty to have a sufficiently detailed understanding of residents' health and any changes, and the reason the visit has been requested. However, they reported that:

Poor communication in care homes is common, [it is] not uncommon for no one to know why you have been called (GP45).

In addition to the quality of communication and information sharing, GPs also highlighted the importance of the CH infrastructure in enabling them to access patient records remotely. In contrast to work in the surgery, GPs often lacked access to computerised records; access to laptops and Wi-Fi facilitated their work in CHs, but were not always available. This lack of access to records may compromise residents' care and safety, especially in respect of prescribing.

Theme 4 – Organisation and conduct during the GP visit.

Both the way in which the GP visit was organised and what happened during the visit impacted on GPs' CH work.

Some GPs expressed frustration about the ways in which the need for a visit was identified (and sometimes whether such visits were required, or could have taken place at the surgery). They also perceived that CHs can have 'low thresholds' for requesting visits. GPs and CH staff appeared to have different levels of confidence in respect of residents' health, needs and safety. GPs appeared to perceive staff as risk averse and fearful of criticism; in contrast, GPs appeared more confident that residents were being monitored and had ongoing support, when compared to their patients living at home:

I am more confident with patients in care homes as they will have 'eyes' on them to alert me if our plan is not working or the patient is deteriorating. Patients living at home especially alone cause me more concern (GP17).

Patients in care homes already have a level of support. Isolated patients at home and even couples at home don't (GP29).

These different perspectives may cause tension and lead to discordant views about the urgency of residents' needs for GP attention. GPs also perceived that requests for visits were often made reactively, while proactive identification of concerns and needs was preferred.

Good preparation by the CH for the GP visit was identified as important, ensuring that the visit was anticipated and its purpose understood by the staff on duty. GPs perceived that some visits were poorly organised, such that the staff were not aware that the visit had been requested, had little information and were not available to support the GP:

Lack of continuity between whoever has requested a visit and the person who is present when the visit occurs, e.g. night staff requesting visit before going off shift, but daytime staff who have just come on being present (GP27).

In contrast, staff awareness that the visit was occurring and understanding the reasons for this facilitated GPs' work. Furthermore, managers ensuring that they or staff were available to meet with the GP and support the visit was consistently noted as helpful:

It's useful having a nurse who gives a good but brief history of events prior to seeing the patient. It's very good also having them in the room with us, so that information can be passed onto relatives, or indeed to the patient if they don't immediately understand (GP30).

The importance of good organisation during the visit was important, especially in the context of the high workload and time demands frequently reported by GPs, who noted that visits, relationship building with staff, communication with families and examination of patients all required time:

The amount of time it takes to see a patient. Sometimes an hour, when at the surgery we can have seen 6 patients (GP30).

Discussion

Supporting residents in CHs is an important element of the GP role, however to date it has been little studied, especially from the perspective of GPs themselves. The study findings position the CH as a unique environment for the delivery of primary care, one in which there are distinct challenges in contrast to those within the surgery, and in which GPs work away from practice colleagues and IT systems, providing support to a population with high levels of medical need, and who frequently need assistance from others to facilitate communication and decision making. The complexity of resident needs, and the multiple relationships encountered, indicate that this is an area of primary care practice which requires a high level of medical and interprofessional skill.

As identified in previous studies, CH residents typically experience multiple health conditions, underpinned by polypharmacy, physical frailty and cognitive impairments; these factors contribute to a context in which decision making and treatment may be complex (Robbins et al., 2013; Gordon et al., 2014, Finucane et al., 2017). Our findings suggest that GPs are often reliant on others to act as a bridge, supporting communication and interaction with residents, and providing information and medical updates on their behalves, as well as liaising with family members. However, this reliance on others risks marginalising the resident voice. Participant accounts indicate that discussion and decision-making about residents' medical care is frequently carried out by others, with a consequent risk that other people's views and perspectives dominate, and that residents may have limited

power and voice in these decisions. There is therefore a risk, as highlighted by participating GPs, of colluding with other people's views about what residents need or want. Some residents may wish for others to lead on their healthcare decisions, however others have clear preferences in respect of future treatment and care (Mathie et al, 2011; Victor et al., 2018) which should receive attention. Our findings highlight that, in addition to good clinical skills, GPs working in the CH context require good communication skills, and knowledge and understanding of dementia. Furthermore, although little mentioned by participants, GPs also require a clear understanding of Mental Capacity legislation and how to support individuals to make decisions where possible, as well as how to support Best Interests decision making where necessary, ensuring that individuals' past and present views are central to decision making processes.

Previous research has concluded that relationships are 'pivotal in the delivery of all aspects of healthcare' within CHs (Badger et al., 2012; British Geriatrics Society, 2011; Robbins et al., 2013, 3; Pearson et al., 2021). Within the CH context GPs have to navigate a complex array of relationships and interact with many players, over and beyond residents themselves (British Geriatric Society, 2011; Gordon et al, 2018), and are reliant on the skills, knowledge and availability of staff and managers. Relationships between staff, managers and GPs were also found within this study to be important. The development of such relationships requires time, stability and continuity (see also Goodman et al., 2015); however, high levels of staff turnover, often encountered in CHs (Care Quality Commission, 2020), militated against this. Further factors which may impact on the quality of relationships include staff perceptions that practitioners do not recognise and value their skills (Bamford et al., 2018, Kupeli et al., 2018) and apparent differences in confidence among staff and GPs (as also highlighted by British Society of Geriatricians 2011; Robbins et al., 2013) which we conclude may lead to different perceptions of the urgency of visits, with the potential to contribute to tension between CHs and GPs. The development of relationships with managers and staff was reported by participants to require time. However, GPs, CH staff and managers work within considerable time pressures and experience demanding workloads (Croxson et al., 2017; Vandrevala et al., 2017; Kupeli et al., 2018), which may militate against this. These time constraints may also

impact on the organisation of the GP visit, including whether staff or managers are available to enact the bridging role highlighted as important, and may impact on Best Interests decision making and the extent to which the resident voice is heard. Relationships and communication with families was also an important element of CH work; this required additional work and investment of time from GPs as family were not always able to be present during visits, due to the times of these, and geographic separation, as it is not unusual for families to live at a distance from their relatives (Powell et al., 2018; White et al., 2020).

Organisation of visits, in which staff were aware the GP was visiting and were available to provide support, and proactive, rather than reactive, identification of health needs were identified as important. The Framework for Enhanced Health in Care Homes (NHS England/NHS Improvement, 2020), which mandates that all CHs are aligned with named PCNs (Primary Care Networks), and that a clinician led, weekly multi-disciplinary 'home round' is conducted, is anticipated to help to address these issues.

This was the first stage of a study exploring GP experiences of safeguarding in CH settings. Survey responses indicated that a significant proportion (approximately 40%) of GPs reported that they had witnessed signs which they believed to be clear or possible signs of abuse or neglect during CH visits. This suggests that they are well placed to identify residents at risk, and that further research in respect of their safeguarding roles in this currently under-explored area is warranted. Our findings on GP experiences of CH work provide some valuable insights which have implications for the detection of abuse and neglect, and for safeguarding in this context. In this study the importance of relationships with managers and staff, and GPs' dependence on these to facilitate their CH role, were highlighted. However, the importance of relationships, and the observed risk of collusion with the CH perspective, suggests an important paradox in the context of care homes and adult safeguarding, in which working to develop and maintain relationships risks shifting the focus of practitioner attention from residents to staff and managers, meaning that their views and needs may be privileged. Visiting practitioners may be required to navigate vexed questions about what to

do when they are unhappy about resident care or see things that concern them. This is well illustrated by research with psychologists working in CHs (Stenfert Kroese and Smith, 2018). Their research highlighted the importance for psychologists of relationships and collaborative working with staff; these facilitated their work and the implementation of their recommendations, supporting positive outcomes for residents. Psychologists therefore sought to maintain collaborative working, and adopted careful approaches to questioning and challenging staff practice. This need for caution was reinforced by the observation that when safeguarding reports were made, the relationship between the visiting practitioner and the CH was negatively affected. These findings suggest that practitioners may make finely tuned judgements when deciding how to balance the need to highlight or report concerns, against the potential damage to working relationships and therefore to the care of residents. How GPs navigate the need to preserve relationships while ensuring that concerns are raised and resolved, and resident wellbeing and safety is pursued, are important questions to be explored within the next stage of the research.

Although outside of the scope of this study, it is notable that among the protective measures employed during the COVID-19 pandemic, there has been an increased use of remote consultations, including those for CH residents (Murphy et al 2021). These may assist GPs in addressing the time challenges within CH work. However, in such consultations there is a risk that non-verbal cues may be missed (Murphy et al, 2021); further such consultations may not help foster the relationships which are identified as a critical element of CH work, or enable GPs to see the wider environment, which may help to identify signs of poor care or abuse. The use and role of virtual consultations in CHs beyond the pandemic therefore appears an important area for reflection and future research.

Strengths and Limitations

The use of the online survey enabled the inclusion of the views of a significant number of GPs throughout England. The survey could be completed at participants' convenience, reducing the demands on a busy practitioner group; however, in comparison to interview or focus group methods, it did not allow for probing of participant responses or enable clarification to be sought.

This study focused solely on the experiences of GPs. The views of residents, families and of CH staff and managers, who have previously highlighted both positive and negative experiences of working with GPs, (Robbins et al., 2013; Bamford et al., 2018) were not sought. The inclusion of such perspectives would enable a fuller understanding of health provision in the CH context, the needs of different participant groups, and how practitioners and CHs can work together to promote good resident care, effective communication with residents and families, and promotion of resident wellbeing and safety.

The majority of participants were situated within the north of England. While this represents a large and diverse area, a greater geographic spread, in which all regions of England were well represented, would have better highlighted any potential regional differences in experience and perceptions.

The survey was part of a wider study of GP experiences of CH safeguarding, and the overall research focus on safeguarding was evident in recruitment materials (although it was not a requirement for participants to have safeguarding experience in the CH setting), and the recruitment methods relied on safeguarding networks and a Twitter page developed for the wider study; these factors may have encouraged participation from GPs with an interest in safeguarding. Had the survey been more clearly separated from the overall study and focussed solely on experience of working in CH settings, the participant group may have been larger and reflective of a more diverse range of experiences and perceptions.

Conclusion

The findings highlight the complexities of the GP role within CHs, indicating that GPs need good clinical and communication skills when working in this setting. They also highlight the importance of GPs' relationships with CHs, managers and staff; however, risks of collusion with CH colleagues and the marginalisation of the resident voice were noted, limiting GP opportunities to gain a perspective on how residents perceive and experience their own care and support, and any related concerns. Further, these findings raise important questions about how GPs navigate the tension between

maintaining vital working relationships and acting on concerns when they have questions or concerns about resident care or wellbeing. Given GPs' potential role, as frequent visitors to CHs, in identifying signs of abuse, neglect and poor practice, this is an important consideration and area for further research.

Conflict of Interest Statement

The authors report no conflicts of interest.

Acknowledgements

The authors wish to thank all GPs who participated in the research.

References

Badger, F., Plumridge, G., Hewison, A., Shaw, K. L., Thomas, K. & Clifford, C. (2012). An evaluation of the impact of the Gold Standards Framework on collaboration in end-of-life care in nursing homes. A qualitative and quantitative evaluation. *International Journal of Nursing Studies, 49*(6), 586-595. https://doi.org/10.1016/j.ijnurstu.2011.10.021

Bamford, C., Lee, R., McLellan, E., Poole, M., Harrison-Denining, K., Hughes, J., Robinson, L., & Exley, C. (2018). What enables good end of life care for people with dementia? A multi-method qualitative study with key stakeholders. *BMC Geriatrics,* 18:302. https://doi.org/10.1186/s12877-018-0983-0

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77-101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., Clarke, V., Boulton, E., Davey, L & McEvoy, C. (2020). The online survey as a qualitative research tool. *International Journal of Social Research Methodology, 0*(0), 1-14. DOI: 10.1080/13645579.2020.1805550

British Geriatrics Society (2011). *Quest for quality. An inquiry into the quality of healthcare support for older people in care homes: A call for leadership, partnership and improvement.* London: British Geriatrics Society. https://www.bgs.org.uk/sites/default/files/content/attachment/2019-08-27/quest_quality_care_homes.pdf

Care Quality Commission (2020). *The state of health care and social care in England*. Newcastle upon Tyne: Care Quality Commission. https://www.cqc.org.uk/sites/default/files/20201016_stateofcare1920_fullreport.pdf

Croxson, C. H. D., Ashdown, H. F. & Hobbs, F. D. R. (2016). GPs' perceptions of workload in England: a qualitative interview study. *British Journal of General Prac*tice, *67*(655): e138-e147. DOI: https://doi.org/10.3399/bjgp17X688849

Devi, R., Hinsliff-Smith, K., Goodman, C. & Gordon, A. (2020). Editorial. The COVID-19 pandemic in UK care homes – Revealing the cracks in the system. *The Journal of Nursing Home Research Science*, *6,* 58-60. http://dx.doi.org/10.14283/jnhrs.2020.17

Finucane, A.M., Stevenson, B. & Murray, S. A. (2017). Gradual physical decline characterises the illness trajectories of care home residents. *International Journal of Palliative Nursing*, *23*(9), 457-461. https://doi.org/10.12968/ijpn.2017.23.9.457

Gibson, J. C., Nicol, B., Ronayne, E. & Grant, M. (2016). The role of the general practice surgery in safeguarding adults. *The Journal of Adult Protection*, *18*(5), 288-298. https://doi.org/10.1108/JAP-04-2016-0006

Gleeson ,L. E., Jenings, S., Gavin, R., McConaghy, D. & Collinds, D. R. (2014). Primary care in nursing homes revisited: Survey of the experiences of primary care physicians. *Irish Medical Journal, 107*(8), 234-236. PMID: 25282960.

Goodman, C., Davies, S. L., Gordon, A.L., Meyer, J., Dening, T., Gladman, J. R. F., Iliffe, S., Zubair, M., Bowman, C., Victor, C. & Martin, F. C. (2015). Relationships, expertise, incentives, and governance: Supporting care home residents' access to health care. an interview study from England. *Journal of the American Medical Directors Association, 16*(5), 427-432. https://doi.org/10.1016/j.jamda.2015.01.072

Gordon, A.L., Goodman, C., Achterburg, W., Barker, R. O., Burns, E., Hanratty, B., Martin, F. C., Meyer, J., O'Neill, D., Schols, J. & Spilsbury, K. (2020). Commentary: COVID in care homes—challenges and dilemmas in healthcare delivery. *Age and Ageing*, *49*(5), 701-705. doi: 10.1093/ageing/afaa113

Gordon, A. L., Franklin, M., Bradshaw, L., Logan, P., Elliott, R. & Gladman, J. R. F. (2014). Health status of UK care home residents: a cohort study. *Age and Ageing, 43*(1), 97-103. https://doi.org/10.1093/ageing/aft077

Gordon, A. L., Goodman, C., Davies, S. L., Dening, T. & Gage H. (2018). Optimal healthcare delivery to care homes in the UK: a realist evaluation of what supports effective working to improve healthcare outcomes. *Age and Ageing*, *47*(4), 595-603. https://doi.org/10.1093/ageing/afx195

Handley, M., Goodman, C., Froggatt, K., Mathie, E. & Gage, H. (2014) Living and dying: responsibility for end-of-life care in care homes without on-site nursing provision - a prospective study. *Health and Social Care in the Community*, *22*(1), 22-29. https://doi.org/10.1111/hsc.12055

Kinley, J., Hockley, J., Stone, L., Dewey, M., Hansford, P., Stewart, R., McCrone, P., Begum, A. & Sykes, N. (2014). The provision of care for residents dying in UK nursing care homes. *Age and Ageing*, *43*(3), 375-379. https://doi.org/10.1093/ageing/aft158

Kupeli, N., Leavey, G., Harrington, J., Lord, K., King, M., Nazareth, I., Moore, K., Sampson, E.L. & Jones, L. (2018). What are the barriers to care integration for those at the advanced stages of dementia living in care homes in the UK? Health care professional perspective. *Dementia*, *17*(2), 164-179. https://doi.org/10.1177%2F1471301216636302

Manthorpe, J. & Martineau, S. (2016). Serious Case Reviews into Dementia Care: An Analysis of Context and Content. *British Journal of Social Work*, *46*(2), 514-531. https://doi.org/10.1093/bjsw/bcu135

Manthorpe, J. & Martineau, S. (2017). Engaging with the new system of safeguarding adults reviews concerning care homes for older people. *British Journal of Social Work, 47(*7), 2086-2099. https://doi.org/10.1093/bjsw/bcw102

Marsland, D., Oakes, P. & White, C. (2015). Abuse in care? A research project to identify early indicators of concern in residential and nursing homes for older people. *The Journal of Adult Protection*, *17*(2), 111-125. https://doi.org/10.1108/JAP-08-2014-0027

Mathie, E., Goodman, C., Crang, C., Froggatt, K., Iliffe, S., Manthorpe, J. & Barclay, S. (2011). An uncertain future: The unchanging views of care home residents about living and dying. *Palliative Medicine, 26*(5), 734-743. DOI: 10.1177/0269216311412233

Milne, A., Cambridge, P., Beadle-Brown, J., Mansell, J. & Whelton, B. (2013). The characteristics and management of elder abuse: evidence and lessons from a UK case study. *European Journal of Social Work*, *16*(4), 489-505. DOI:10.1080/13691457.2012.722983

Murphy, M., Scott, L. J., Salisbury, C., Turner, A., Denholm, R., Lewis, R., Iyer, G., Macleod, J. & Horwood, J. (2021). Implementation of remote consulting in UK primary care following the COVID-19 pandemic: a mixed-methods longitudinal study. *British Journal of General Practice*, *71*(704): e166-e177. DOI: https://doi.org/10.3399/BJGP.2020.0948

NHS Digital (2020). *Safeguarding Adults England, 2019-20.* https://digital.nhs.uk/data-and-information/publications/statistical/safeguarding-adults/2019-20#resources

NHS England (2019). *The NHS Long Term Plan.* https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf

NHS England and NHS Improvement (2020). *The Framework for Enhanced Health in Care Homes Version 2.* https://www.england.nhs.uk/wp-content/uploads/2020/03/the-framework-for-enhanced-health-in-care-homes-v2-0.pdf

O'Brien, J. G., Riain, A. N., Collins, C., Long, V. & O'Neill, D. (2014). Elder abuse and neglect: a survey of Irish General Practitioners*. Journal of Elder Abuse and Neglect, 26*(3), 291-299. https://doi.org/10.1080/08946566.2013.827955

Pearson, R., Mullan, J., Dijkmans-Hadley, B., Halcomb, E. & Bonney, A. (2021). Medical care in Australian residential aged care: Perspectives of residents, family, nurses and general

practitioners. *Health and Social Care in the Community, 39*(6), e279 – e287. https://doi.org/10.1111/hsc.13352

Powell, C., Blighe, A., Froggatt, K., McCormack, B., Woodward, B., Young, J., Robinson, L. & Downs, M. (2018). Family involvement in timely detection of changes in health of nursing homes residents: A qualitative exploratory study. *Journal of Clinical Nursing, 27*(1-2), 317–327. https://doi.org/10.1111/jocn.13906

Richards, H. & Emslie, C. (2000). The 'doctor' or the 'girl from the University'? Considering the influence of professional roles on qualitative interviewing. *Family Practice, 17*(1), 71-75. https://doi.org/10.1093/fampra/17.1.71

Robbins, I., Gordon, A., Dyas, J., Logan, P. & Gladman, J. (2013). Explaining the barriers to and tensions in delivering effective healthcare in UK care homes: a qualitative study. *BMJ Open*, 3:e003178. doi:10.1136/bmjopen-2013-003178

Salcher-Konrad, M., Jhass, A., Naci, H., Tan, M., El-Tawil, Y. & Comas-Herrera, A. (2020). COVID-19 related mortality and spread of disease in long-term care: first findings from a living systematic review of emerging evidence. *medRxiv*. https://doi.org/10.1101/2020.06.09.20125237.

Stenfert-Kroese, B. & Smith, N. (2018). How do psychologists experience work with staff in residential care settings for people with an intellectual disability? *International Journal of Developmental Disabilities, 64*(3), 144-157. https://doi.org/10.1080/20473869.2018.1439818

Vandrevala, T., Samsi, K., Rose, C., Adenrele, C., Barnes, C. & Manthorpe, J. (2017). Perceived needs for support among care home staff providing end of life care for people with dementia: a qualitative study. *International Journal of Geriatric Psychiatry*, *32*(2), 155-163. https://doi.org/10.1002/gps.4451

Victor, C., Davies, S., Dickinson, A., Morbey, H., Gage, H., Froggatt, K., Iliffe, S. & Goodman C. (2018). "It just happens". Care home residents' experiences and expectations of accessing GP care. *Archives of Gerontology and Geriatrics, 79*, 97-103. https://doi.org/10.1016/j.archger.2018.08.002

White, C., Wray, J. & Whitfield, C. (2020). 'A fifty mile round trip to change a lightbulb': An exploratory study of carers' experiences of providing help, care and support to families and friends from a distance. *Health and Social Care in the Community,* 28*(5),* 1632-1642. https://doi.org/10.1111/hsc.12988

Table One – Participant data

Gender	n	%
Male	24	41.4
Female	33	56.9
Prefer not to say	1	1.7
Geographic area of current practice		
North East England	16	27.6
North West England	8	13.8
Yorkshire and Humber	24	41.4
The Midlands	1	1.7
London	2	3.4
South East England	2	3.4
South West England	4	6.9
Missing data	1	1.7
Role *		
GP partner	41	68.3
Salaried doctor	8	13.3
Locum	7	11.7
Other	4	6.7

**Participants could select more than one answer*

Table Two – Participant experiences of safeguarding concerns

When working in care homes, have you ever seen clear signs that residents have been abused or neglected?	Yes – 39.6% (n = 19) No – 60.4% (n = 29)
When working in care homes, have you ever seen or heard things that made you concerned that residents might be experiencing abuse or neglect (or were at serious risk)	Yes – 42.6% (n = 20) No – 57.4% (n = 27)