Care homes provide the majority of long-term care to older people. They rely on primary care for access to medical support and referral to specialist services yet studies  [https://doi.org/10.1017/S146342361500025](https://doi.org/10.1017/S1463423615000250) consistently show that healthcare provision to residents in care homes across England is unpredictable and inequitable. People’s expectations are changing and the debate about social care and what good care looks like is not going away.

For the NHS, care homes are often a conundrum; they are responsible for the most vulnerable and frail in our society and provide care that used to be supplied by the NHS, but they are often perceived as providing poor care and generating avoidable demands on emergency and hospital services.

It isn’t that the NHS is ignoring care homes. There is a long history of local health care services setting up care home services, invariably as time limited projects. The recent investment in the six care home Vanguard sites demonstrates that there is an ongoing desire to improve how the NHS works with long term care providers <https://www.england.nhs.uk/ourwork/new-care-models/vanguards/care-models/care-homes-sites/> . The question is what needs to be in place for effective cross organisational working to be sustained delivering long term and predictable benefit to care home residents?

To paraphrase Susan Sontag’s “Kingdoms of the Sick”, <http://www.susansontag.com/SusanSontag/books/illnessAsMetaphor.shtml> care homes have been characterised as “Islands of the old”. High quality healthcare provision to care homes can only be achieved if close collaboration between the NHS and care homes becomes part of the everyday landscape of care. It is important that care homes are not seen as set apart and “other”. It is time for the NHS to see care homes as partners not problems.

The recently completed OPTIMAL study involving seven UK universities, theorised that it was unlikely that there would be one “right” way for the NHS to work with care homes. [file:///C:/Users/rpcqcg/Downloads/3010367%20(1).pdf](file:///C%3A/Users/rpcqcg/Downloads/3010367%20%281%29.pdf). Instead it argued that there were likely to be key elements or activities within different models of service delivery that contributed to effective working and improved health related outcomes for residents and staff. It reviewed the evidence of what works when and in what circumstances <https://doi.org/10.1186/s12913-016-1493-4> It then looked at how NHS services work with, and for, care homes across England and studied in depth different patterns of care provision in three geographically disparate sites, tracking the care 232 residents received over 12 months.

OPTIMAL found that when NHS commissioners and healthcare professionals see care homes as an integral and important part of the health and social care system and take time to learn how to work together, there is an improvement in appropriate access to, and use of, health care. Supporting (incentivising) the right mix of people to be involved in the design of health care provision to care homes enabled alignment of health care provision with the goals of care home staff and developing a shared view about what needs to be done.

Single care home teams or nurse and therapist specialists can make a difference to residents’ experience of health care. However, by working apart from other services they risk being isolated, unable to sustain their service or access the relevant expertise they need to address the multiple needs of residents. As the majority of care home residents live and die with dementia, understanding symptom and behaviours that arise from living with dementia is core to working with and for care homes. The OPTIMAL study found that access to dedicated specialist dementia care benefits residents and improves the confidence and skills of NHS and care home staff.

When NHS provision was in response to GP callouts on a resident by resident basis rather than working with the care home as a whole, or was designed as short-term, time limited interventions focusing on care home staff shortcomings in specific areas of care. The study found there could be unintended consequences, most notably, mutual mistrust and a belief that the desired improvements in health care were not being achieved because NHS or care home staff had not done what was required. Not considering the priorities of the care homes and what affected staff’s ability to benefit from additional visits or training was observed to work against developing working relationships between NHS and care home staff.

A perfect service delivery model for the NHS to use when working with care homes does not exist. The heterogeneity of care homes in terms of size, approach to care, local history resident characteristics, staff experience, availability and proximity to other services and uncertainty around funding, means it will always be context specific.

That is not an excuse for the provision of ad hoc and inequitable health care by the NHS. There are certain characteristics that are more likely to support effective working and continuity of provision. Ongoing investment in resources and services dedicated to care homes and links with different services located around the care home supports patterns of working that can accommodate the different priorities of health and social care staff. This is most obvious in situations where commissioners and NHS and care home staff have learnt how to work together, having gone through several iterations of service provision to accommodate their different priorities and interests. Health care professionals should not be expected to fit their care home work within existing caseloads. They need protected time that permits them to develop experience and expertise when working with social care.

To date, most of the research has been driven by a health care agenda. This may not be the starting point for residents and their families interested in the not unrelated issues of quality of life and quality of care. The OPTIMAL study has demonstrated the benefits of finding common ground between health and social care, more work is needed ensuring care homes and their staff have an equal say on what matters for the health care of their residents.

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