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The Enfield Care Home Assessment Team – Improving the lives and deaths of residents in care homes across Enfield.

The Long Term Plan sets out clear recommendations and new investment to fund integrated care for an ageing population and expanded community multidisciplinary teams (MDTs) aligned with new Primary Care Networks (PCNs) these will comprise of a range of staff such as GPs, pharmacists, district nurses, community geriatricians, dementia workers and AHPs such as physiotherapists and podiatrists/chiropodists, joined by social care and the voluntary sector. This is an approach that the Care Home Assessment Team (CHAT) exemplifies and we'd encourage all CCGs to explore.

CHAT is a system wide partnership; an integrated multi-disciplinary mental and physical health team with strong links with primary care, specialist pathways such as frailty all underpinned by strong support from local Geriatricians and Consultant Psychiatrist. Through this partnership we have been able to improve the lives and deaths of residents in care homes across Enfield.

By commissioning an enhanced integrated care homes service we have seen clinically significant improvements in patient outcomes and commissioning outcomes including a reduction in A&E attendances and non-elective admissions leading to substanial cost savings.

These relationships and successes have taken time and energy to build and requires commitment from all partners and strong leadership to fully realise the benefits of a CHAT model. We'd like to thank Melanie Pettitt the CHAT manager for her commitment and vision, as well as all the Care Homes who are part of the CHAT team and the entire multi-disciplinary team, without whom the service would not be possible.

We are excited about the next chapter, moving ahead together and continuing to improve the lives and deaths of residents in care homes across Enfield.

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Executive Summary

NHS England identified North Central London (NCL) as one of three areas in England achieving good outcomes and demonstrating exemplar support for patients with dementia. In the London borough of Enfield, within North Central London, an integrated community mental and physical health care team supported by Geriatricians and a Consultant Psychiatrist have been commissioned to provide training and guidance to care homes. Older people in care homes are amongst the most frail, vulnerable and dependent populations in Enfield. As well as multiple complex physical health conditions, approximately 80% of people living in care homes have dementia[1] and people with dementia have worse outcomes when admitted to hospital[2]. This co-ordinated and integrated approach to supporting care homes have led to improvements in the quality of care to residents and enabled more people to be able to die in their preferred place of death. They have reduced the need for; acute emergency care and hospital admissions, the number of GP visits required, the amount of medications prescribed and the number of falls in care homes needing hospital admission, through supporting, training and improving the competence and confidence of care home staff.

The NHS Long Term Plan[3] published in January 2019 sets clear recommendations that a multi-disciplinary team approach, involving integrated care networks and services should be adopted to achieve maximum benefits for our patients' quality of life. The Enhanced Health in Care Homes (EHCH)[4] framework details the range of services a good integrated model of support for care homes should offer, CHAT exhibits these offers of support including integrated multi-disciplinary physical and mental health team support to care homes, enhancing end of life care, dementia care and primary care support.

The Enfield Care Home Assessment Team (CHAT) consists of an integrated mental and physical health team including Community Matrons, Geriatricians, a Consultant Psychiatrist and Mental Health Nurses, occupational therapy, a phlebotomist, pharmacists and work closely with primary care, frailty networks and a tissue viability service. CHAT started as a pilot project in 4 homes in 2011 and currently supports 39 care homes across Enfield. They provide emergency rapid response to deteriorating patients, medically supporting residents to not be admitted to hospital, where possible. CHAT undertakes a holistic geriatric assessment with the care homes, signposting to or delivering the identified support needed. They provide education and follow up on the job training to care homes to be able to manage their resident's needs safely and holistically.

The Outcomes

- **There was 35% reduction (-2,118) in the total number of A&E attendances and non-elective admissions, compared to a 23% increase in Enfield's 65+ year old non care home population.**
- **This equated to a 9% reduction in costs (-£598,671). Against a 34% increase in costs for the general population aged 65+ (+£7,113,284).**
- **Falls leading to hospital attendance or admission were reduced by 7%.**
- **99% of residents died in their preferred place**
- **39% of residents have had their medication reduced or stopped**
- **8,409 hospital attendances and 8,109 GP call outs have been avoided**
- **7,606 care home staff and managers attended training on 59 subjects**

Given the amount of positive qualitative and quantitative evidence this report seeks to add to the national conversation through the Enhanced Health in Care Homes (EHCH)[5] NHS workstream about best practice care for patients in care homes with mental health conditions and how to improve a residents quality of life and death. alongside other areas across England who are also achieving good outcomes in supporting care homes, (join the EHCH forum here[6]) to inform and support other areas across England to benefit from the experience and outcomes we have achieved in Enfield.

This Supporting Older People's Mental Health - Enfield's Care Home Assessment Team report sets out the need and local context of why resources should be targeted at supporting older people in care homes. It describes the model of care from its early pilot stage, through its development and adaptations, and shows the wide variety of benefits this service has had both physically and mentally for care home residents.

(Endnotes)

1 Dementia – the true cost: Fixing the care crisis. https://www.alzheimers.org.uk/sites/default/files/2018-05/Dementia%20the%20true%20cost%20-%20Alzheimers%20Society%20report.pdf. Alzheimer's Society, 2018.

2 Fix Dementia Care – Hospitals. https://www.alzheimers.org.uk/sites/default/files/migrate/downloads/fix_dementia_care_-_hospitals.pdf. Alzheimer's Society, 2016.

3 NHSE Long term plan. https://www.england.nhs.uk/long-term-plan/. NHS England, 2019.

4 NHS England new care models. https://www.england.nhs.uk/new-care-models/about/care-homes-sites/. NHS England, 2016.

5 NHS England new care models. https://www.england.nhs.uk/new-care-models/about/care-homes-sites/. NHS England, 2016.

6 NHS England Enhanced Health in care Homes Forum. https://future.nhs.uk/connect.ti/system/login?nextURL=%2Fconnect%2Eti%2Fcarehomes%2Fgrouphome. NHS England, 2016.