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## Supporting Older People's Mental Health: Enfield's Care Home Assessment Team



Barnet, Enfield and Haringey

Mental Health NHS Trust

A University Teaching Trust



# 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/chiropractors, 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 substantial 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<sup>1</sup> and people with dementia have worse outcomes when admitted to hospital<sup>2</sup>. 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<sup>3</sup> 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)<sup>4</sup> 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 with 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)<sup>5</sup> 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<sup>6</sup>) 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.

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## 1 | INTRODUCTION

Older people in care homes are amongst the most frail, vulnerable and dependent populations in Enfield. More than half of care home residents die within eighteen months of admission<sup>7</sup>. As well as physical health conditions, 80% of people living in care homes have dementia<sup>8</sup> and people with dementia have worse outcomes when admitted to hospital<sup>9</sup>. An estimated 60% have 'poor mental health', approximately 40% with depression and anxiety prevalence varied from 6% to 30%<sup>10</sup> within care homes. Future projections show an increase in life expectancy in Enfield's population, and an increase in the number of years older people will live with a limiting long-term illness (either physical or mental illness), and therefore there will be an increased demand for support to manage medical conditions and daily living for our elderly residents. Due to developments in creating wider housing options and more wrap around support in a person's own home, advances in treatments, new expectations around end of life care and earlier discharge from hospital as a system, the complexity of the residents entering care homes are far more complex than was previously the case.

Whilst the primary goal of health and social care services in Enfield is to support people to live in their own home for as long as possible, if this is no longer possible, we must ensure that the best possible care is provided to those needing care home placements. Care homes house a large proportion of our most dependent populations, therefore they contribute significant costs to the health and social care economy. In Enfield, like other areas, care homes are owned by a range of providers, including private businesses, charities and one by a local authority trading arm in Enfield. As an outer London Authority Enfield has a large number of homes and beds and a range of commissioners from Enfield and surrounding Local Authorities and CCGs fund placements in Enfield (circa 40% of beds). Therefore optimal support for care homes will not only increase a patient's quality of life and death but will have a significant impact on costs. This support needs to include integrated physical and mental health provision due to the prevalence of these conditions in residents in care homes. In Enfield, a Care Home Assessment Team (CHAT) was commissioned, providing a real world example of an integrated physical and mental health support for care homes. The CHATs aim was to improve quality of life and death for its residents. To provide tailored interventions to care homes to ensure care home residents have access to high quality, pro-active and co-

ordinated health care that reduces the need for acute and reactive care. This model brings to life some of the best practice adopted in the Enhanced Health in Care Home Vanguards<sup>11</sup> which designed models of care based on a suite of evidence-based interventions, designed to make the biggest difference to the health and happiness of residents. This report seeks to add to the evidence base of effective interventions and support local commissioners and health care professionals to adopt some of the principles of the model that will work for their local populations, to improve their physical and mental health support to care homes.

## 2 | LOCAL CONTEXT

### Enfield Population

Enfield have a population of 333,000 residents, 12.8% (42,624) of whom are aged over 65 (2017)<sup>12</sup>. Population projections suggest that the population in Enfield will rise to 356,943 residents by 2025, and that 14.2% (50,536) will be aged over 65. Alongside this increase in the number of older adults is an increase in life expectancy.

The male life expectancy at birth is 80.7 (2012-14) which has increased by 0.9 years from 79.8 years over 5 years (2009-11). The female life expectancy at birth is 84.1 (2012-14) which has increased by only 0.2 years from 83.9 years (2009-11)<sup>13</sup>. However, the average number of years a person is predicted to live disability free is only 64.2 years for men and 62.9 years for women<sup>14</sup>. Predicting that men and women will live 16.5 and 21.2 years respectively with a limiting long-term illness. One of those limiting long-term illnesses is dementia.

### Dementia Diagnosis Rates

There was a policy drive called the prime minister's challenge<sup>15</sup> for dementia which included a commitment to identify more people who have dementia. The rationale being that a timely diagnosis enables people living with dementia, their carers and healthcare professionals to plan accordingly and work together to improve health and care outcomes for them. Enfield has an estimated Diagnosis Rate of those 65+ year old with dementia of 72.2% (2018) equating to 2,000 people, which has increased from 71.8% (2017).

Projections suggest that the number of people aged 65+ living with dementia in Enfield by 2035 may reach 5,369<sup>16</sup>. As risk increases with age, it is predicted that 73% of the total number of people with dementia will be 80+ years old. Women have a higher risk of dementia, 66.2%

of women over the age of 80 have dementia compared with 54.8% of men. The Alzheimer's Society suggest that at least 80% of people living in care homes have dementia. And that 80% of people with dementia have another physical or mental co-morbid health condition such as heart disease, stroke or depression<sup>17</sup>. In Enfield, two-thirds of people with advanced dementia live in residential/nursing care or in supported accommodation, particularly as they develop significant problems in daily living (2011)<sup>18</sup>.

### A&E attendances and hospital admissions by people with dementia

In Enfield, between 2014 and 2017, there has been an 18% increase in the number of A&E attendances or hospital admissions from people aged 65+ with dementia (from 4,623 to 5,469). This is compared with a 6% decrease in the number of A&E attendances or hospital admissions from people aged 65+ without dementia (from 36,530 to 34,453). On average 66% of people with dementia attended a hospital at least once between 2014 and 2017, compared with 28% in the general population without dementia aged 65+. However this data should be interpreted with caution as dementia is largely under diagnosed in the population and there is poor coding of dementia patients in hospitals<sup>19</sup>. The Alzheimer's Society (2016)<sup>20</sup> stated at least a quarter of hospital beds are occupied by an older person with dementia at any one time (this can be as much as 50%). On average, people with dementia in hospital stay more than twice as long as their counterparts without dementia aged over 65. People with dementia make up a quarter of delayed discharges and 10% of re-admissions within 30 days and of those who are admitted to hospital from their homes, over a half are then discharged into residential care.

In Enfield, the average MFF adjusted cost per A&E attendance or hospital admission for patients aged 65+ with dementia, equated to £2,720.14, compared with £1,284.42 for patients aged 65+ without dementia, an average cost ratio of 2.12 cost of a dementia versus non dementia A&E attendance or hospital admission<sup>21</sup>.

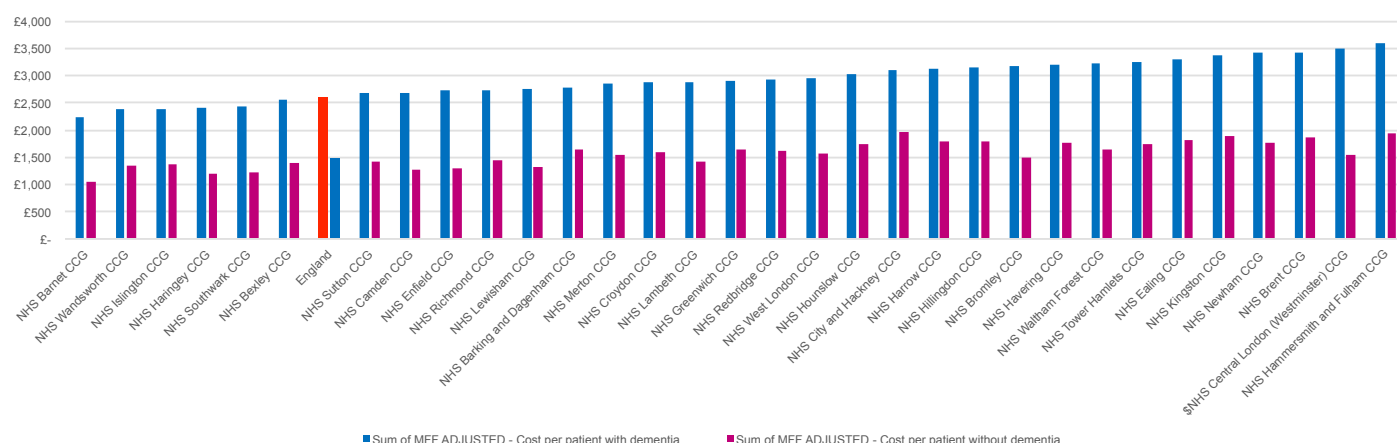
The total cost of A&E attendance or hospital admission for patients aged 65+ with dementia, equated to £440,246,431 in London, compared with a total cost for patients aged 65+ without dementia of £1,253,179,160 between 2009 – 2017. The total cost of Dementia A&E attendance or hospital admissions accounted for 26% of the total cost of A&E attendance or hospital admissions. With dementia prevalence predicted to increase a system wide approach is needed to support people with dementia and their carers and to manage these escalating costs<sup>22</sup>.

### Functional mental health

Functional mental health conditions such as stress, anxiety and depression are often not recognised in care homes. It is thought that 60% of those living in residential institutions are reported to have 'poor mental health' and that the prevalence of depression within care homes has been estimated at 40%, the prevalence of anxiety varied from 6% to 30%<sup>23</sup>. Care workers often don't have specialist training in mental health to recognise the symptoms of these mental health conditions, and access to specialist support to diagnose and treat mental health conditions is often limited in care homes. Support is needed to develop effective care plans and upskill care home staff with the skills to manage these conditions within a care home.

### Graph 1: The Cost of Dementia

Cost (MFF adjusted) per hospital incidents for dementia compared to control in London, 2009 - 2017



Source: Alzheimer's Research UK dataset, extracted from Hospital Episode Statistics (HES) datasets, 2009 – 2017.

### 3 | CARE HOMES IN ENFIELD



Resident of Autumn Gardens Care Home

Enfield have the second highest number of care home beds in NCL. There are around 230 homes and nearly 6,100 beds in North Central London, broken down into 2,761 nursing and 3,308 residential beds. The majority of the homes are located in Barnet and Enfield and the majority of homes are focused around the care needs of older adults. London wide analysis highlights that there are fewer nursing beds in NCL compared with other areas, which will have an impact on residential care homes.

Across NCL Local Authorities are trying to develop wider housing options and more wrap around support in a person's own home, there is a challenge to provide more care in the community, but increasing support in the community has lead to the complexity of need within care homes rising significantly.

**Table 1: Number of Care Home beds in North Central London**

No of Care Home beds	Barnet	Camden	Enfield	Haringey	Islington	Total
Nursing	1104	282	<b>761</b>	149	465	2761
Residential	1454	175	<b>1114</b>	450	115	3308
Sum of care homes beds	2558	457	<b>1875</b>	599	580	6069

Source: Care Quality Commission, March 2018.

## 4 | THE CHALLENGE



### How best do we support care home residents and reduce emergency admissions?

To be able to improve the lives and deaths of residents in care homes across Enfield, the specific difficulties facing care homes had to be addressed which were;

- ▶ Lack of capacity of existing community health services to deliver care and support in care homes (e.g. primary care and district nursing capacity).
- ▶ Primary care support varied. Care homes were often the responsibility of multiple primary care practices but with no responsible GP attending.
- ▶ Care home staff were not able to consistently and effectively manage long-term conditions, co-morbidities and end-of-life care for their residents which resulted in adverse health outcomes, including avoidable hospitalisation. In particular, care home staff's confidence to manage exacerbation of a known condition in patients who have a complex multi pathology varied considerably across homes.
- ▶ There were concerns regarding variation in standards of care, amounts of training and capability of staff varied considerably, the quality of basic nursing care is highly variable but the complexity of co-morbidities and pressure on nursing requirements is increasing. Staff reported not understanding some training and preferred on the job real life training.
- ▶ Lack of knowledge and awareness of how to refer to community support services, and those services varied across the borough.
- ▶ Some care homes suffered from high staff turnover and vacancies, pay for these jobs do not change much between less and more experienced workers<sup>24</sup>.
- ▶ Just over 80% of care homes in Enfield were rated 'Good' by the CQC, which is in line with London and the National Average<sup>25</sup>. However, some care homes displayed examples of poor leadership competence, varying responsiveness, engagement and proactivity in supporting their residents which can result in inadequate preventative measures to manage the health and wellbeing and safeguarding concerns.

### The financial burden

- ▶ Analysis undertaken in 2010/11, indicated that admissions from care homes were costing NHS Enfield in excess of £3m with 64% of these admissions attributed to 16 care homes (£1,360,722) equating to 1104 admissions. For issues that it is felt might be manageable within the care home environment with appropriate support, e.g. having appropriately trained, skilled staff who have confidence in managing end of life pathways and have easy access to healthcare services when needed.

## 5 | THE INTERVENTION



### How were these concerns addressed? – The pilot

To address these issues, a pilot model of support to care homes was proposed at the joint protected learning time session for primary care. In order to establish a Geriatrician and Community Matron led service model, with support from GPs, to establish a relationship with 4 care homes. Over a 2 month period when the team first started, there was a 52% reduction in admissions, equating to a £48,768 reduction in cost.

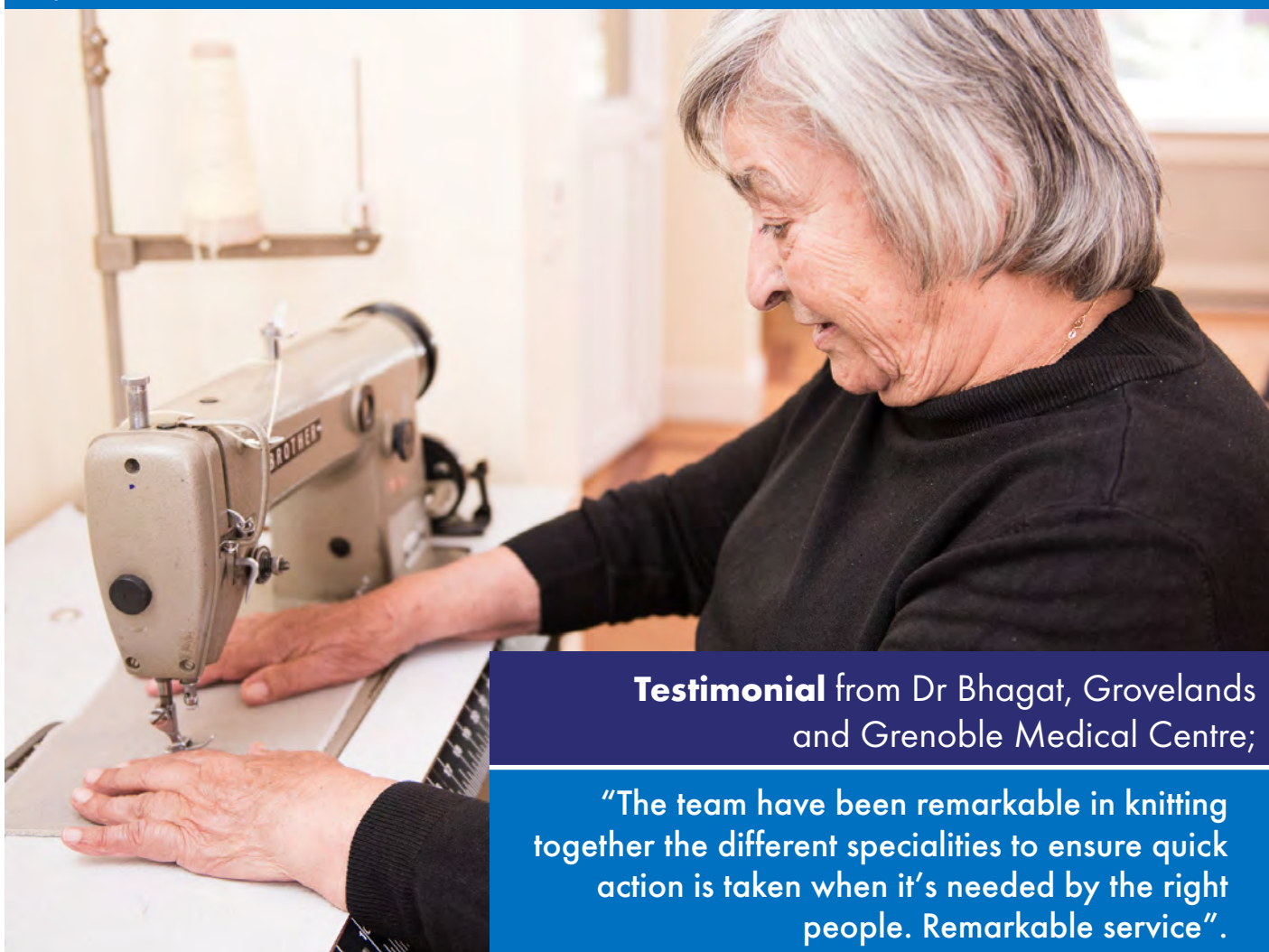
Based on the pilot Enfield CCG (integrated care team) commissioned the model to expand to a further 13 registered nursing and residential homes that had the highest number of non-elective hospital admissions. A specialist Care Homes Assessment Team (CHAT) was commissioned in 2012 to provide a specialist and multi-disciplinary approach to care to cover the 17 care homes, cost £330,000. The Consultant Geriatricians are contracted as part of the Older People Assessment Unit acute trust budget. Funding originally came from monies removed from acute contracts to be re-invested in community services to prevent admissions and reduce 30 day re-admissions.

**Table 2: Initial pilot results from 4 care homes over 2 months.**

	2010/11		2011/12	
Care Home Name	Admissions	Cost + MFF	Admissions	Cost + MFF
Elizabeth Lodge Nursing Home	11	£44,417	1	£4,857
Nairn House	7	£20,579	9	£30,444
Springview	7	£18,809	5	£20,767
Parkside Residential Home	8	£21,992	1	£960
Grand Total	33	£105,797	16	£57,029

Source: Enfield Clinical Commissioning Group, March 2012.

## 6 | THE CHAT MULTI-DISCIPLINARY TEAM



**Testimonial** from Dr Bhagat, Grovelands and Grenoble Medical Centre;

**“The team have been remarkable in knitting together the different specialities to ensure quick action is taken when it’s needed by the right people. Remarkable service”.**

### **CHAT would have two functions;**

1. Reduce the need for acute emergency and reactive care, by improving the direct management of individual patients in care homes, improving the knowledge, skills and confidence of care home staff.
2. Improve end of life care, increasing the number of residents who die in their preferred place.

Since the inception, the CHAT team have expanded in a phased approach to cover 39 care homes. Similarly the skills, integrated partnership work and developed relationships have increased over time as the CHAT service has become embedded as a care home support team. Table 3, seeks to describe each member’s role within the multi-disciplinary team, the journey and associated benefits of the development of the CHAT service over time.

When commissioners are thinking about which type of models of care home support best suit their population it is imperative to note that these benefits evolve over time, and the relationships between the medical staff and the care homes develop and strengthen over time, and so do the outcomes. The cost of the Geriatricians and the Consultant Psychiatrists leaving the wards in hospitals and delivering care in the community maybe perceived as expensive however this model seeks to highlight the benefits of specialist input, the legacy of this input and how the need for the specialists decreased overtime. The Community Matrons shadowed the Geriatricians and were trained by them to work to the top of their skill set and skill mix, so that the specialists are no longer required for less complex patients. Subsequently, the matrons train the care home staff to be able to deliver the best possible care. The Consultant Psychiatrists train the mental health nurses and care home staff directly.



**Testimonial** from Ms Bowler (resident);

“I avoided a hospital admission and instead got to see a consultant in my care home and had tests as an outpatient. I am thankful they supported me to have a voice”.

**Table 3:** Functional composition of the integrated CHAT team – providing an integrated care network for care homes in Enfield.

Who	RESPONSIBILITIES - Initial function	RESPONSIBILITIES - Function now – In addition to the initial functions of CHAT, there have been improvements over time, which include;
Consultant Geriatrician	<p>16 hours per week of Geriatricians time from the local hospital in the south of the borough (North Middlesex University Hospital) were commissioned to provide enhanced out of hospital support for residents in Care Homes. Geriatrician support was not utilised from Barnet and Chase Farm Hospital, in the North of the borough, because fewer residents attend that hospital.</p> <p>The CHAT Geriatrician Consultants provide specialist geriatric care and treatment to residents. Residents can see a Geriatrician in their care home rather than attending hospital. They undertook Comprehensive Geriatric Assessments (CGA – see appendix) with each resident (inpatient and care home resident) completing Advanced Care plans (ACPs) and/or Do Not Attempt Resuscitation (DNAR) orders as required. The findings from the CGA and the resulting care plan are shared with relevant agencies in the integrated care network, with the residents’ consent (or their representatives’), most notably their GP.</p> <p>Residents admitted to hospital were highlighted to the Geriatricians. This provided continuity of care for patients who consequently needed acute care or who had recently been discharged. They also notified the community matrons of an unplanned admission of patients from care homes. All discharges from hospital had their CGA updated and care plans altered if appropriate, and matrons followed up all patients discharged from hospital in the care home; within 24 hours if palliative, within 5 days if complex or within 2 weeks if routine.</p> <p>All care homes called the community matron if they were concerned about a deteriorating resident, the matron clinically triaged that patient and assessed them using the CGA and if the geriatrician was needed the community matron will contact them directly via a hot phone for advice. This relationship also provided easier access to diagnostics and treatment for residents.</p> <p><b>Falls:</b> Targeted falls clinics were set up, led by geriatricians, these clinics were held monthly within those care homes recorded as having the highest falls. Depending on the falls data they tailored the falls training with the aim to reduce the risk of falls by; reviewing unnecessary polypharmacy, stabilising long-term conditions, encouraging exercise, and reviewing the living environment.</p>	<p>The Geriatricians trained the community matron’s overtime and taught them how to complete an Comprehensive Geriatric Assessment. The Geriatricians enabled the matrons to be able to work at the top of their skill set and skill mix, ensuring they are supported with regular contact via the hot phone. This meant that over time, the required input from the Geriatricians is needed less in the community. The Geriatricians are now able to improve processes internally within the hospital, improving care planning processes for CHAT care home resident’s admitted under different specialties, e.g. Surgery, Oncology not just the Older Persons Assessment Unit (OPAU).</p> <p>Due to less time being needed to support the matrons the allocated CCG time can now be used to review the internal hospital processes to support patients with dementia. The admission clerking pro forma now includes a cognitive screening test that helps clinicians determine if patients who are confused might be delirious, have dementia or have both dementia and delirium. Dementia is diagnosed, recorded and a referral to the memory service for post diagnostic support is made, if appropriate. Dementia patients are recognised by marking their bed with a Forget Me Not flower*, 10 Important Things About Me* are completed with the patients and carers to try and support patients better and reduce behavioural disturbances. Food passports* are completed detailing the patient’s likes and dislikes, helping to provide better care and satisfaction, support and information for carers is delivered via a Carers Passport* (*see appendix).</p> <p>CHAT have created a register of all patients who are identified as high risk of unplanned hospital admission due to deteriorating health. This register, includes frequent admissions and other unplanned attendances. Due to the development of the relationships within the MDT these regular discussions are often held by doing a virtual ward round of these patients, video calling, a quick phone call or email. This relationship development has led to improving access to wards and speeding up waiting times to see a consultant where needed.</p> <p><b>Falls:</b> The Bone Health specialist and Fracture Liaison Nurse service is now integrated within the Community Falls Prevention Team who work as part of the MDT with CHAT, proactively identifying and assessing patients who at risk of falling, conducting bone health and fracture liaison reviews in care homes to promote recovery and prevent re-admissions, co-ordinating with primary care, A&amp;E and fracture clinics. CHAT have developed a falls folder so less individual clinics are needed (see appendix).</p> <p>Historically some falls have had inadequate investigation, due to poor completion of incident reporting forms. CHAT now train care home staff on incidence investigations.</p>

Who	RESPONSIBILITIES - Initial function	RESPONSIBILITIES - Function now – In addition to the initial functions of CHAT, there have been improvements over time, which include;
<p><b>Community Matrons</b></p>	<p><b>The Community Matrons provide 3 main functions;</b></p> <p><b>1. Rapid Response</b></p> <ul style="list-style-type: none"> <li>▶ Ensure that residents that need urgent care get the right advice, in the right place, first time.</li> <li>▶ CHAT urgently respond to a deteriorating resident at risk of hospital admission within 4 hours. Through relationships with the Geriatricians, CHAT can directly access acute settings for tests, investigations and reviews, without the resident needing a hospital admission where possible.</li> <li>▶ Providing clinical triage and support to care homes to prevent avoidable calls to the London Ambulance Service (LAS) and unwarranted admission/re-admission to acute settings.</li> <li>▶ If a hospital stay is necessary, the team coordinates a planned admission to a named consultant, helping to reduce A&amp;E attendances as well as length of stay. They provide the CGA and other key information at the point of urgent planned transfer between care home and acute setting to reduce the length of stay and re-admission.</li> <li>▶ Where admission has been unavoidable, community matrons work with social workers and GPs to develop packages of care to facilitate early discharge and to avoid crisis leading to re-admission.</li> <li>▶ They undertake post-discharge patient reviews in the care homes to help prevent re-admission, within two weeks.</li> <li>▶ CHAT receive urgent referrals from GPs and other care professionals to provide unplanned care. CHAT deliver unscheduled and unplanned care to care homes, providing crisis management and clinical triage e.g. when falls and emergencies occur.</li> <li>▶ Provide appropriate case management of residents health needs, ensuring that patients receive appropriate clinical outcomes by undertaking assessments, developing care plans, advising on and co-ordinating treatment, delivering care for residents with respect to their preferences. E.g. they review residents post fall, support / deliver care for physical health conditions such as suspected infection, pain, bowel care, skin care, palliative care, management or monitoring of long term conditions, they deliver same day phlebotomy.</li> </ul> <p><b>2. Hold a Caseload</b></p> <ul style="list-style-type: none"> <li>▶ CHAT sees all new residents for a holistic geriatric assessment within two weeks. They then leave a simplified plan with actions for the care home staff to follow up e.g. refer to Speech and Language.</li> <li>▶ CHAT has scheduled rolling reviews. Every time a resident is seen in a care home the CHAT team update their care plan and record the outcomes of the review.</li> <li>▶ Undertake a medication review for each resident looking at issues such as polypharmacy, use of unnecessary antipsychotics, need for different formulations e.g. syrups for residents with difficulty swallowing tablets.</li> <li>▶ CHAT undertake end of life care planning meetings with residents, families and carers making DNAR/ ACPs decisions and reviews.</li> </ul> <p><b>3. Provide Support / Training to Staff</b></p> <p>They provide planned training courses, 1-2-1 and small group training sessions on mental and physical health topics. Provide training to develop the care home workforce to have the confidence, skills and abilities to proactively manage patients. Give staff the knowledge of community services and referral pathways to access additional appropriately skilled clinicians.</p> <p>The CHAT team are the CCG representative on the NCL Care Homes Quality Improvements Forum. They attend Adult Social Care Safeguarding meetings and support care homes CQC inspection processes.</p>	<p>A key stakeholder’s feedback day was organised to help inform the development of the CHAT model. Representatives from NHS Acute Trusts, the CCG, primary care, the Local Authority, the voluntary sector, patient groups and care homes attended. It was identified that many hospital admissions were not due to a physical medical issues but issues of safeguarding or problems due to care home staff turnover and skills. Based on the views shared, a renewed model was created, consequently it moved from a consultant led service to a nurse-led one. It retained the proactive elements and regular visits to care homes, but strengthened the rapid response element based on risk stratification for quicker call outs and made stronger links with the Local Authority. At the same time due to the success of the service and more and more care homes requesting CHAT support, the service was extended to cover 39 care homes in the borough.</p> <p><b>1. Rapid response</b></p> <ul style="list-style-type: none"> <li>▶ Each care home has a named CHAT matron to build a therapeutic relationship and respond to urgent requests. This reduces the times a care home / resident has to repeat their story.</li> <li>▶ CHAT now urgently responds to a deteriorating resident at risk of hospital admission within 2 hours (previously 4 hours).</li> <li>▶ CHAT identify and record all hospital attendances, they review the case and assess whether the attendance was warranted and what (if anything) could have done to prevent the attendance.</li> <li>▶ CHAT work with care homes to avoid placement break downs and ensure residents are accepted back to their care home. Their mental health support nurses work with patients in a crisis and presenting challenging behaviour to prevent an admission. They train care home staff and develop care plans for placements at risk of breakdown. They conduct physical and/or mental health best interest meetings with clinicians, residents and families.</li> <li>▶ CHAT see all discharges from hospital within 5 days (previously two weeks)</li> <li>▶ In 2013, CHAT recruited a phlebotomist who undertakes blood tests with those that have complex, challenging behaviour or frail skin. The complex residents in care homes therefore do not have to be sent to wait in line at a hospital or GP appointment.</li> <li>▶ In 2013, CHAT forged strong links with the Tissue Viability Nurse (TVN) service, the TVN service decided to develop one of their nurses to be a care homes lead. The TVN prevents and treats pressure ulcers (Grade 3+ pressure sores, bed sores and decubitus ulcers) and supports care homes by providing education in: wound management, pressure ulcer prevention and management, leg ulcer assessment and management, skill development in compression bandaging, product selection, nurse prescribing, as well as responding to immediate needs via referrals. The TVN attends CHAT meetings and supports the data collection.</li> </ul> <p><b>Caseload</b></p> <p>CHAT see all new residents and conduct an assessment within 5 days (previously two weeks).</p> <p><b>Out-of-Hours support</b></p> <p>The Rapid Response function has a focus on time limited intermediate care, enablement and crisis response, delivering care at care homes if possible and supporting prevention of avoidable admissions or delayed transfers of care. CHAT ensures care / crisis plan information is provided to out-of-hours Rapid Response providers e.g. LAS and GP OOH with clear instruction of agreed care plans in the event of an emergency and follow up actions in hours where appropriate. In 2018-19 CHAT have now been sub-contracted to support GP OOH provision.</p> <p>Overtime the CHAT team have supported embedding or directly delivered national care home initiatives as and when they have been developed such as; significant seven training<sup>26</sup> including hydration and nutrition support, the red bag scheme<sup>27</sup>, trusted assessor<sup>28</sup>, ‘This is Me’ tool<sup>29</sup>, medicine optimisation, 111 *6 service support for care homes<sup>30</sup>, EHCH<sup>31</sup> and new ways of working recommendations<sup>32</sup>.</p>

Who	RESPONSIBILITIES - Initial function	RESPONSIBILITIES - Function now – In addition to the initial functions of CHAT, there have been improvements over time, which include;
Primary Care	<p><b>Integrated Primary Care / CHAT Frailty Management</b></p> <p>CHAT provide the frailty function in care homes. CHAT identify and assess frailty in care homes, they undertake care planning, rolling reviews, falls prevention planning, ACPs and DNARs. Residents are identified to GPs (as Lead Accountable Professional) and/or other relevant professionals operating within the integrated care network.</p>	<p>There has been improved integration between primary and secondary care. Multi-disciplinary Integrated Locality Teams (ILTs) are in place to support GPs in identifying, assessing and case managing the “top 2%” of patients aged 65+ with frailty who are most at risk of hospitalisation. The CHAT team provides specialist nursing and geriatric support to GPs through the ILTs. Residents may have been identified in primary care and referred to CHAT. GPs have easier access to advice from the Geriatricians and Community Matrons.</p> <p>Enfield CCG have commissioned an enhanced primary care out-of-hours service, 7 days a week, 8am – 8pm. This contract has been partly sub contracted to CHAT to increase the continuity of care due to GP availability.</p>
Partners	<p><b>Key interdependencies</b></p> <p>CHAT work closely with Local Authority Social Care teams which has strengthened the safeguarding of vulnerable adults.</p> <p>CHAT acts as a single point of contact and signposting / information source for care homes, residents, relatives, GPs, NHS organisations, the Local Authority and other healthcare professionals. Acting as a single point of contact ensures a more consistent level of care and improves patient experience by reducing the stress of multiple individuals being involved in a resident’s care. Through integration of secondary, primary, community, social care and statutory/non-statutory agencies (such as community specialist professionals), residents have better access to palliative care, physiotherapists, speech and language therapists, continence advisors, memory services and cognitive stimulation therapy.</p> <p>All external stakeholders including out of service delivery (e.g. GPs, district nursing, community rapid response etc) continue to provide care when relevant to care homes residents, CHAT provision does not replace the roles and responsibilities of other services.</p>	<p>Other CCGs have care home quality improvement nurses, CHAT provides the quality improvement nurse function with a large focus on safeguarding. CHAT has helped to reduce the barriers between primary and secondary care and health and social care.</p>

**Testimonial** from Reardon Court residential home;

We were pleased to have the opportunity to have the CHAT team coming in to Reardon Court. The benefits to the service include:

- ▶ Monitoring of service users with particular health concerns and complex cases.
- ▶ Supporting hospital discharge ensuring resources available to support the return.
- ▶ Supporting in end of life care and liaising with relatives who may have concerns.
- ▶ Following up on service users in hospital liaising with consultants and feeding back to us within a very short timescale.
- ▶ Advising on medication.
- ▶ Blood tests carried out that are asked for by G.Ps, to save the community Phlebotomist coming and avoid hospital admissions.
- ▶ I have had the benefit of attending a training course organised by the CHAT team on falls prevention and due to this attendance am putting into practice recommendations made on the training day.
- ▶ We are reassured to have CHAT involved. We have built up a good relationship with the team.

**Testimonial** from Rita Lynch - Social Worker;

Safeguarding Team Enfield: I have worked collaboratively with CHAT over the past 2 years, whilst undertaking complex Safeguarding Investigations. My experience has been an extremely positive one and often their input made the difference in reaching difficult conclusions. I visit residential and nursing homes on a regular basis and the feedback I have received regarding CHAT has been nothing less than excellent. Their input has made huge differences to the lives of elderly frail and vulnerable adults within Enfield and it has improved the relationships between the medical profession and we as social work practitioners.

## Mental Health Integration

In October 2016, CHAT became a fully integrated physical and mental health multi-disciplinary team. CHAT promotes the identification and diagnosis of functional mental health disorders (such as stress, anxiety and depression), cognitive disorders and mental health conditions such as dementia. CHAT co-ordinate management strategies for these patients, they provide training for care home staff to identify the signs and symptoms of mental health conditions and help to prevent placement breakdown due to behavioural challenges.

CHAT were a physical health team within Barnet, Enfield and Haringey Mental Health Trust, CHAT recognised the need for mental health expertise and specialism to support residents in care homes, so they transferred a band 7 senior CPN from the older people's Community Mental Health Team (CMHT) to CHAT. Following further investment from Enfield CCG a band 7 OT with specialism in dementia care was employed to address the physical environmental triggers in care homes and their impact on mental health, supported by a Consultant Psychiatrist. The mental health staff undertake individual assessments and

design care plans addressing resident's behaviours and make adaptations to the care home physical environment to promote wellbeing.

In April 2018, dedicated consultant psychiatrist time was allocated directly to Care Homes (16 hours a week). From April - September 2018, the team have assessed 730 residents face to face, 25% of total residents seen by CHAT in 6 months (2,893). The OT with dementia specialism undertook 392 assessments (54%), the CPN undertook 307 assessments (42%) and the Consultant Psychiatrist saw 31 patients (4%) of the total assessments, 15 of which were emergency rapid response referrals. They have reported to have prevented 53 hospital admissions, 7% of the total mental health assessments. They have admitted 1 patient under the Mental Health Act to a mental health ward. They have undertaken 730 mental health medication reviews, 25% of the total medications reviews undertaken by CHAT in 6 months (2,893). The number of medication reviews is an important outcome measure, residents with mental health conditions may not have been identified previously and therefore starting medication or an increase in medication maybe medically



### Testimonial from Avon Lodge residential home;

"Mental capacity assessments and the mental capacity act used to really confuse me; I know how important it is but the e-learning the home provided didn't make anything relatable. CHAT visited and gave me some insight into how I am already using the act when making assessments. I feel more confident if CQC visit that I know what and why the mental capacity act is important to know. Most importantly I feel able to use the mental capacity assessments to benefit the residents I work for.



## **Testimonial** from Resident and mental health service user from Murrayfields Nursing Home;

"CHAT always listen, I know I get anxious and worried but CHAT always hear my concerns. They try to help me manage my own anxiety and concerns but recently when it was all too much they got a psychiatrist in to see me and I was so thankful. Things are good for me now and if I am honest I really do look forward to their visits".

appropriate. Of the 730 medication reviews, 103 residents had their medication reduced (14%) and 10 were taken off antipsychotic drugs.

They have had 63 assessments transferred from CMHT, reducing the CMHT caseload. CMHTs provide limited emergency rapid response to care homes for mental health crisis nationally because care home residents are thought to be safe due to care home supervision, through CHAT residents can be seen the same day if needed within hours. They have discussed 149 patients as an MDT with the physical health nurses. They are now starting to record the number of placement breakdowns prevented, in 3 months they have prevented 18 placement breakdowns.

**Dementia** – The consultant psychiatrist diagnoses dementia if the patient is not able to leave the care home and signpost patients to the memory service for those that can. They are starting to use the DiaDem tool<sup>33</sup> for diagnosis.

**Functional mental health** - Although CHAT do not manage Mental Health registered care homes, the CHAT team refer residents with complex psychological unmet needs to the Consultant Psychiatrist, who assesses patients, diagnoses mental health conditions, co-produces care plans and helps manage symptoms.

### **Training**

Care home staff receive specific mental health training from the mental health specialists. The physical health CHAT matrons were able to deliver the basic training around dementia and its causes, but the Consultant Psychiatrist and CPNs are needed to provide more in depth work around behaviours that challenge training especially for residents with dementia, communication, environmental triggers, differences in identification of delirium and dementia, optimise treatment of behavioural disturbances, provide support for residents with unmet psychological needs and reduce the use of anti-psychotic drugs where appropriate. Across the physical and mental health nurses they have provided 1,384 care home staff with mental health training, 79% of mental health training was focused on dementia and behaviours that challenge.

<b>MENTAL HEALTH TRAINING TOPICS</b>	<b>2015-16 (Aug-Mar - 8 months)</b>	<b>2016-17</b>	<b>2017-18</b>	<b>2018-19 (Apr-Sept - 6 months)</b>	<b>Total number of staff members trained</b>
Dementia & Challenging Behaviour	21	227	509	342	1099
Mental Capacity Act/Assessment/DoL	29	44	68	37	178
Management of Depression	2	8	24	9	43
Delirium signs & symptoms	1	14	17	5	37
Psychology services in Enfield	5	3	5	14	27
<b>TOTAL MENTAL HEALTH</b>	<b>58</b>	<b>296</b>	<b>623</b>	<b>407</b>	<b>1384</b>



**Testimonial** from Elena Makrides - Operations Director, Autumn Gardens residential and nursing home;

"Their input has improved the quality of life for the residents. They have improved patient safety in a number of ways, including the falls clinics they offer and diabetes and insulin training.

CHAT is committed to moving the barriers between physical and mental health and now is a good example of an integrated physical and mental health care team (see mental health integration section\*).



**Testimonial** from Dr  
Fenn, Forest Road GP;

The CHAT team make a real difference to patient care. They are able to review patients promptly to prevent hospital admissions. They work successfully with care homes to improve their care of their clients. The approach is an integrated one working with patients, families and secondary care. There no longer seems to be a barrier between primary and secondary care. I can genuinely recommend them as the best example of integrated care that I have seen in my career.

**Table 4: Operational Delivery Model – staff changes over time**

YEAR	2012-13	13-14	2014-15	2015-16	2016-17	2017-18	2018-19
<b>No of Care Homes (beds)*</b>	4 (222 beds) increasing to 17 (749 beds).	17 (749 beds)	29 (1,247 beds)	38 (1,455 beds)	39 (1,491 beds)	38 (1,523 beds) (2 additional CHs in another borough)	36 (1,471 beds) 2 care homes in another borough
<b>Total staff for the year including investment</b>	16 hours/wk NMUH Geriatricians 0.6 wte psychologist 1 wte band 7 matron 0.6 wte band 3 admin	16 hours/wk NMUH Geriatricians 1 wte psychologist 2 wte band 7 matrons 0.6 wte band 3 admin.	16 hours/wk NMUH Geriatricians 4 wte band 7 matrons 1 wte band 3 HCA / phlebotomist 0.8 band 3 admin	16 hours/wk NMUH Geriatricians 1 wte band 8a manager / matron 4 wte band 7 matrons 1 band 4 assistant practitioner / phlebotomist 0.8 band 3 admin	16 hours/wk NMUH Geriatricians 1 wte band 8a manager / matron 4 wte band 7 matrons 1 wte band 7 specialist mental health nurse 1 wte band 4 assistant practitioner / phlebotomist 0.8 wte band 3 admin	16 hours/wk NMUH Geriatricians 1 wte band 8a manager / matron 4 wte band 7 matrons 2 wte band 7 specialist mental health nurse, one with OT specialism 1 wte band 4 assistant practitioner / phlebotomist 0.8 wte band 3 admin Pilot project in Haringey; 0.6 wte band 7 matron.	16 hours/wk NMUH Geriatricians 16 hours dedicated Consultant Psychiatry time 1 wte Band 8a manager / matron 4 wte band 7 matrons 2 wte band 7 specialist mental health nurse, one with OT specialism 1 wte band 4 assistant practitioner / phlebotomist 0.8 wte band 3 admin Pilot projects; 0.6 wte band 7 matron in Haringey. 3 wte band 7 matrons / trusted assessors 1 wte band 8a prescribing pharmacist 0.6 wte band 6 pharmacy technician.
<b>Additional investment in staffing</b>	Investment of 1.0 wte matron 1.0 wte geriatrician 0.4 wte psychologist		2 wte band 7 matrons 1 wte band 3 HCA 0.2 band 3 admin	1.0 wte band 7 matron with teaching experience (external funding by Health Education England) 1.0 wte band 3 HCA changed to 1.0 wte band 4 assistant practitioner	1 wte band 7 specialist mental health nurse	1 wte band 7 specialist mental health nurse with OT specialism Pilot 0.6 wte band 7 matron in Haringey	16 hours / week Consultant Psychiatry time Pilot 3 wte band 7 matrons / trusted assessors 1.6 wte pharmacy input

\* The number of care homes and beds vary, care homes have opened and closed and had extensions to include more beds through the years, numbers reflected in the table are reported by the CHAT service.

### Rapid Access telephone service.

There is a single point of contact, the Community Matrons triage the call and can provide telephone advice to GPs, other healthcare professionals, care home managers and staff. They will organise a CHAT team unplanned visit, a Consultant Geriatrician review, co-ordinate with any members of the integrated care network e.g. GP, physiotherapist depending on what is required. Referrals are made by phone, anyone can refer residents. They are a point of contact for residents and their carers if needed.

### CHAT team Days/Hours of operation:

The service operates **Monday – Friday 09.00 – 17.00** exclusive of bank holidays.

#### Resident inclusion / exclusion criteria

##### Inclusion criteria

All residents in the 39 registered nursing and residential care homes, including residents placed in Enfield care homes from outside the borough that provide care to older people with frailty, in particular those with physical disability and/or multiple long-term conditions, dementia and/or stress, anxiety or depression. Provide step down and increased support to;

- ▶ Patients over 65s with particular medical attention to frail patients >85s
- ▶ High risk patients >65
- ▶ Patients >65 years with a history of falls
- ▶ Patients >65 years at risk of re-admission

##### Exclusion Criteria

- ▶ Residents under 65\* (\*from 2014 all residents regardless of age were included)
- ▶ Patients with long term conditions already under the care of specialty/other community service
- ▶ Sheltered accommodation
- ▶ Mental health and Learning disability care homes. However, if CHAT covered care homes have Elderly Mentally Infirm and/or Dementia floors, residents on these sites will be included

##### Discharge

CHAT keep residents on their caseloads, residents are only discharged from the service if;

- ▶ Moved out of borough
- ▶ Moved back to a private residence
- ▶ Admission to hospice care
- ▶ Deceased

## 7 | THE OUTCOMES

As a result of implementing the model there have been significant improvements in health outcomes for residents:

**There was a significant reduction ( $P < 0.05$ ) in the total number of A&E attendances and non-elective admissions by 35% (-2,118) in all CHAT managed care homes, from 6,059 in 2013-14 to 3,941 in 2017-18, compared with 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).**

**A&E attendances reduced by 47%, (-1,834). Compared to a 23% increase in A&E attendances by the 65+ year old Enfield non care home population.**

**Non-elective admissions has decreased by 13%. Compared to a 24% increase in non-elective admissions by the 65+ year old Enfield non care home population.**

**There has been a 5% increase in the number of calls to LAS from CHAT managed care homes (from 1,519 in 2014-15 to 1,600 in 2017-18, 81 calls) across a 24 hour period.**

**Falls leading to hospital attendance or admission were reduced by 7%.**

**On average, 99% of residents died in their preferred place (10% of residents who died did not have their preferred place of death wished recorded).**

**1514 residents (39%) have had their medication reduced or stopped as result of CHAT input. Calculating one year's reduction in costs of prescribing equated to £7,506 of savings.**

**7,606 care home staff and managers attended training on 59 subjects.**

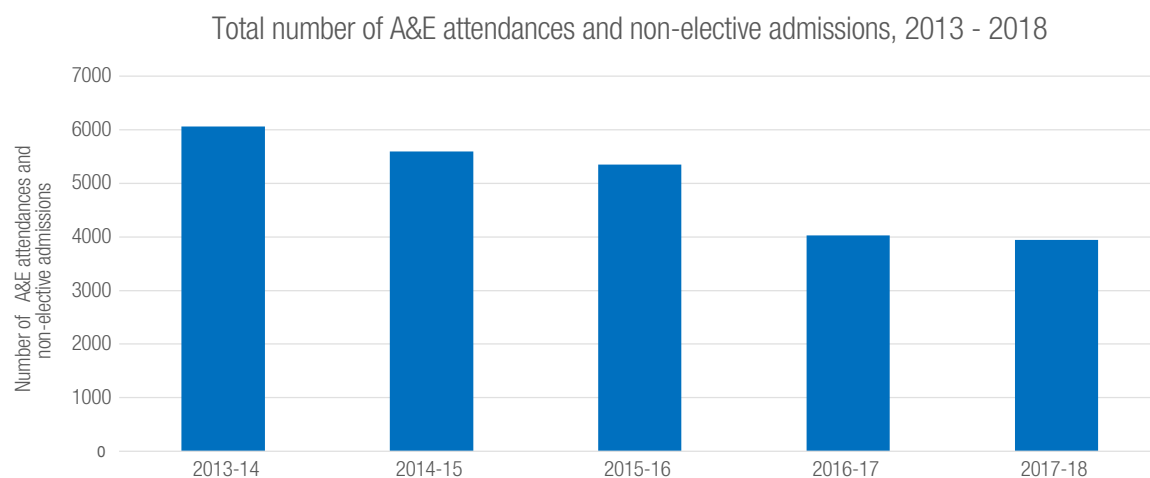
**There have been significant self-reported improvements in the quality of care outcomes for residents.**

**The CHAT team record the number of hospital attendances and GP visits they believe they have helped to prevent, which equated to 8,409 hospital attendances and 8,109 GP call outs between 2013 and 2018.**

This evaluation does not have matched comparators so it is not possible to attribute all changes to the CHAT intervention, other factors might also have been changed at the time and impacted these outcomes, e.g. national emphasis on prevention of falls, pressure sores, significant 7 training, etc. There are caveats and limitations to the data, please see Appendix 1.

In the next section A&E attendances and non-elective admissions are compared between the 65+ year old general population in Enfield compared with the 65+ year old population in care homes managed by the CHAT team. Data includes all A&E attendances and non-elective admissions within the CHAT team service hours and out-of-hours to reflect the total impact of care. Data compares all care homes CHAT support throughout the time period from 2013-14 to 2017-18. However, there was a phased approach to supporting Enfield care homes, this was addressed using service level data (see service level data section).

**Graph 2: Total A&E attendances and non-elective admissions, from 2013 – 2018.**

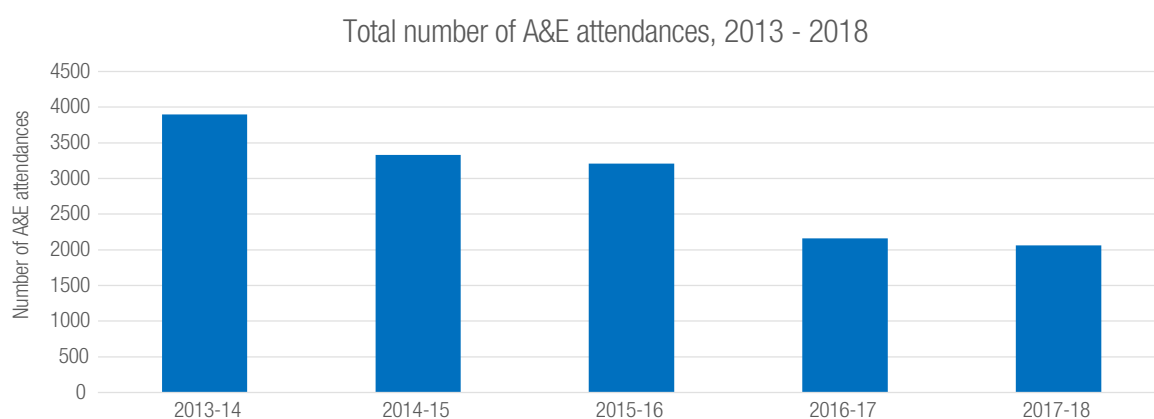


Source: North East London Commissioning Support Unit (NEL CSU) extracted from Secondary Uses Service data (SUS), 2013 - 2018.

The total number of A&E attendances and non-elective admissions has decreased by 35% (-2,118 A&E attendances and non-elective admissions) from all CHAT care homes, from 6,059 in 2013-14 to 3,941 in 2017-18, against a 23% increase by the 65+ year olds in Enfield's non care home population, from 23,185 in 2013-14 to 28,615 A&E attendances and non-elective admissions in 2017-18.

A paired sample t-test was applied to 37 care homes in 2013-14 and 2017-2018, there was a significant difference of  $P < 0.05$  between the number of hospital attendances when CHAT started in 2013 and when CHAT managed all care homes in 2018.

**Graph 3: Total number of A&E attendances, from 2013 – 2018.**

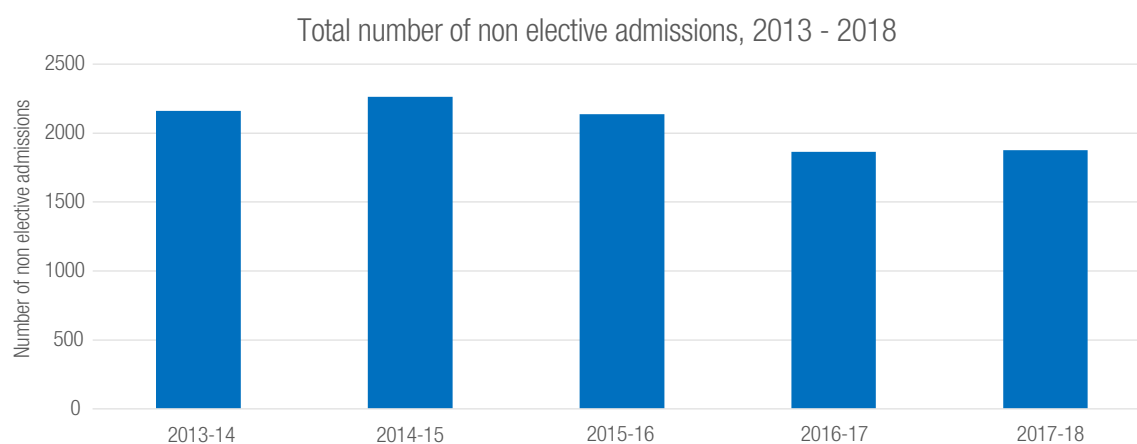


Source: North East London Commissioning Support Unit (NEL CSU) extracted from Secondary Uses Service data (SUS), 2013 - 2018.

The total number of A&E attendances has decreased by 47% from all CHAT care homes, from 3,898 in 2013-14 to 2,064 in 2017-18, (-1,834 A&E attendances across 5 years). Compared to a 23% increase in A&E attendances by the 65+ year old Enfield non care home population, from 16,674 in 2013-14 to 20,530 A&E attendances in 2017-18. Indicating that the CHAT team have helped to reduce unwarranted A&E attendances.



**Graph 4: Total number of non-elective admissions, from 2013 – 2018.**



Source: North East London Commissioning Support Unit (NEL CSU) extracted from Secondary Uses Service data (SUS), 2013 - 2018.

The total number of non-elective admissions has decreased by 13% from all CHAT care homes, from 2,161 in 2013-14 to 1,877 in 2017-18, (-284 non-elective admissions across 5 years). Compared to a 24% increase in non-elective admissions by the 65+ year old Enfield non care home population, from 6,511 in 2013-14 to 8,085 non-elective admissions in 2017-18. Indicating that the CHAT team have helped to reduce unwarranted non-elective admissions. The smaller percentage reductions in non-elective admissions compared with A&E attendances may indicate that the admissions are warranted, reflecting the complex co-morbidities of care home residents. As mentioned earlier, CHAT support will not be the only factor influencing the reductions in A&E attendances and non-elective admissions.

## COST SAVINGS

Due to the reductions in A&E attendances and Non-Elective Admissions in the CHAT supported Care Homes there have been associated reductions in costs.

**Table 5: Cost of A&E attendances and Non-Elective Admissions for the General 65+ year old population in Enfield and CHAT Care Homes, from 2013-2018.**

Year Type of Cost	2013-14	2014-15	2015-16	2016-17	2017-18	Change from 2013-14 to 2017-18	
						Cost	% change
<b>Total Cost A&amp;E attendances and NE Admissions Gen 65+ Pop</b>	20,916,798	20,899,367	20,124,012	21,449,968	28,030,082	7,113,284	+34%
<b>Cost A&amp;E attendances Gen 65+ Pop</b>	2,149,837	2,194,036	2,278,750	2,555,133	3,168,763	1,018,926	+47%
<b>Cost NE Admissions Gen 65+ Pop</b>	18,766,961	18,705,331	17,845,262	18,894,835	24,861,319	6,094,358	+32%
<b>Total Cost A&amp;E attendances and NE Admissions CHAT CHs</b>	6,775,215	6,420,469	5,883,809	5,464,218	6,176,544	-598,671	-9%
<b>Cost A&amp;E attendances CHAT CHs</b>	546,463	459,314	472,240	365,265	404,782	-141,681	-26%
<b>Cost NE Admissions CHAT CHs</b>	6,228,752	5,961,155	5,411,569	5,098,953	5,771,762	-456,990	-7%
<b>Total: Cost All A&amp;E attendances and NE Admissions each year</b>	27692013	27319836	26007821	26914186	34206626	6,514,613	+24%

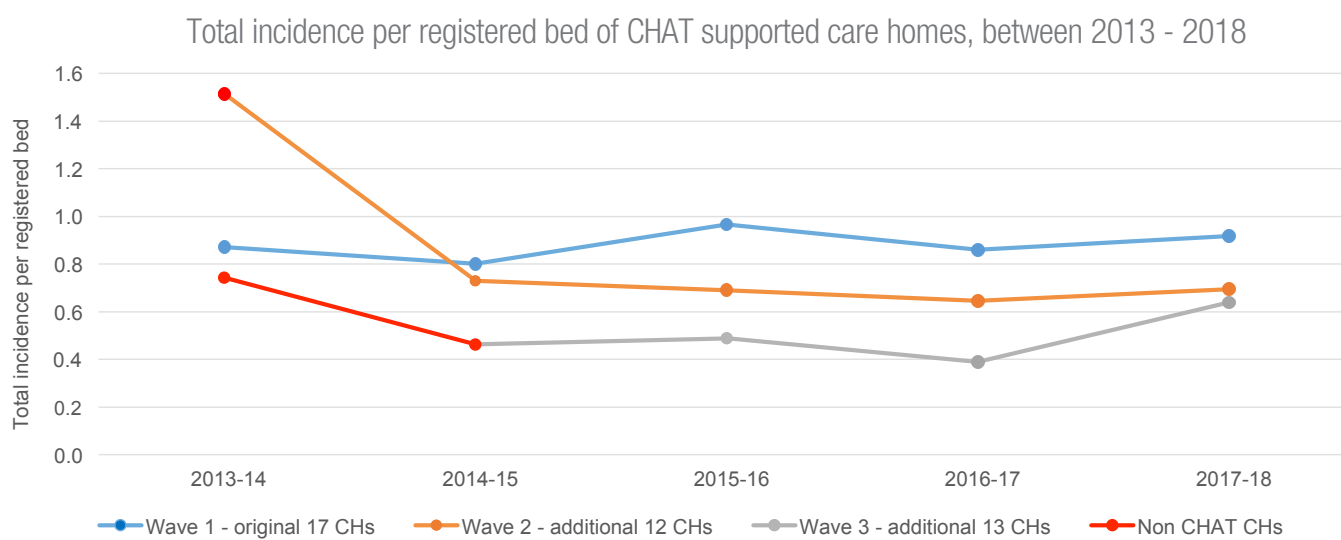
Source: North East London Commissioning Support Unit (NEL CSU) extracted from Secondary Uses Service data (SUS), 2013 - 2018.

There has been a 9% reduction in total A&E attendance and non-elective admission costs for CHAT supported care homes between 2013-14 and 2017-18, equating to a reduction in costs of £598,671 over 5 years. Resulting from of a 26% reduction in A&E attendance cost for CHAT supported care homes, equating to a reduction in costs of £141,681 and a 7% reduction in non-elective admission cost for CHAT supported care homes, equating to a reduction in costs of £456,990. Compared with a 34% increase in total A&E attendance and non-elective admission costs for the general population aged 65+ years old in Enfield, equating to a increase in costs of £7,113,284 over 5 years.

## Service Level data - The transitional journey of supporting care homes in Enfield.

There was a phased approach to supporting care home in Enfield. Graph 5, shows the total A&E attendances and non-elective admissions per registered bed, from 2013-14 when CHAT started to support 17 care homes with the highest conveyances to, called Wave 1. Continuing in a phased approach to support more care homes, throughout 2014-15 supporting an additional 12 care homes in Wave 2, and an additional 13 care homes in 2015-16 in Wave 3.

**Graph 5: Total A&E attendances and non-elective admissions per registered bed, from 2013 – 2018.**



Source: Enfield CHAT team service level data, 2013 – 2018.

**Table 6: Total A&E attendances and non-elective admissions per registered bed, from 2013 – 2018**

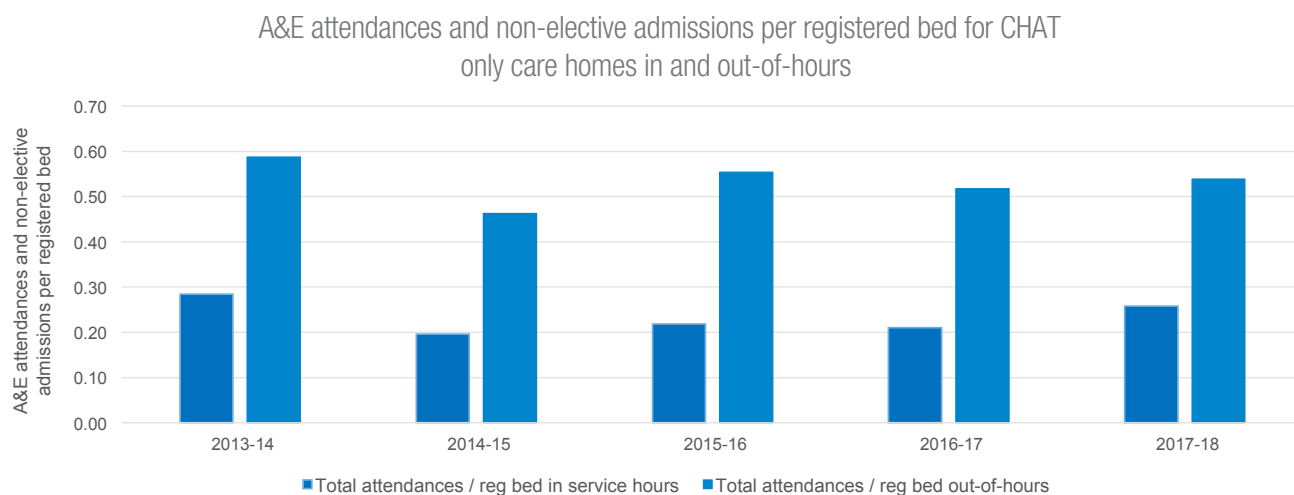
Years Care Homes	2013-14	2014-15	2015-16	2016-17	2017-18	Difference from 2013-14 to 2017-18
Wave 1 - original 17 CHs	0.87	0.80	0.97	0.86	0.92	0.05
Wave 2 - additional 12 CHs	1.51	0.73	0.69	0.64	0.69	-0.82
Wave 3 - additional 13 CHs	0.74	0.46	0.49	0.39	0.64	-0.10
Total incidence / reg bed	3.13	1.99	2.14	1.89	2.25	-0.88

Source: Enfield CHAT team service level data, 2013 – 2018.

There has been an overall reduction from 3.13 A&E attendances or hospital admissions per registered bed in 2013-14 to 2.25 in 2017-18, a reduction of 0.88 A&E attendances or hospital admissions per registered bed. Wave 2, the additional 12 care homes, have reduced their hospital attendance per registered bed by the greatest amount (-0.82). As a commissioner one might be tempted to only continue to support Wave 2 care homes which showed the greatest reductions in attendances to hospital, however the higher number of care homes supported produce greater economies of scale in staffing costs, the hospital attendances from the other care homes maybe warranted attendances and may have been higher had the CHAT team not been there to support them and arguably care home residents should have equal access to CHAT support.

Wave 1, the original 17 care homes on average have had the highest attendances to hospital, there has been an increase of 0.05 hospital attendances per registered bed from 2013 to 2018. Commissioners should be aware that starting with the most challenging care homes does not always lead to the greatest reductions in hospital attendances, some of the care homes with the highest number of hospital attendances often have the lowest amount of unwarranted attendances, their residents have the highest complexity of healthcare needs.

**Graph 6: A&E attendances and non-elective admissions per registered bed for CHAT managed care homes, in CHAT service hours and out-of-hours provisions.**



Source: Enfield CHAT team service level data, 2013 – 2018.

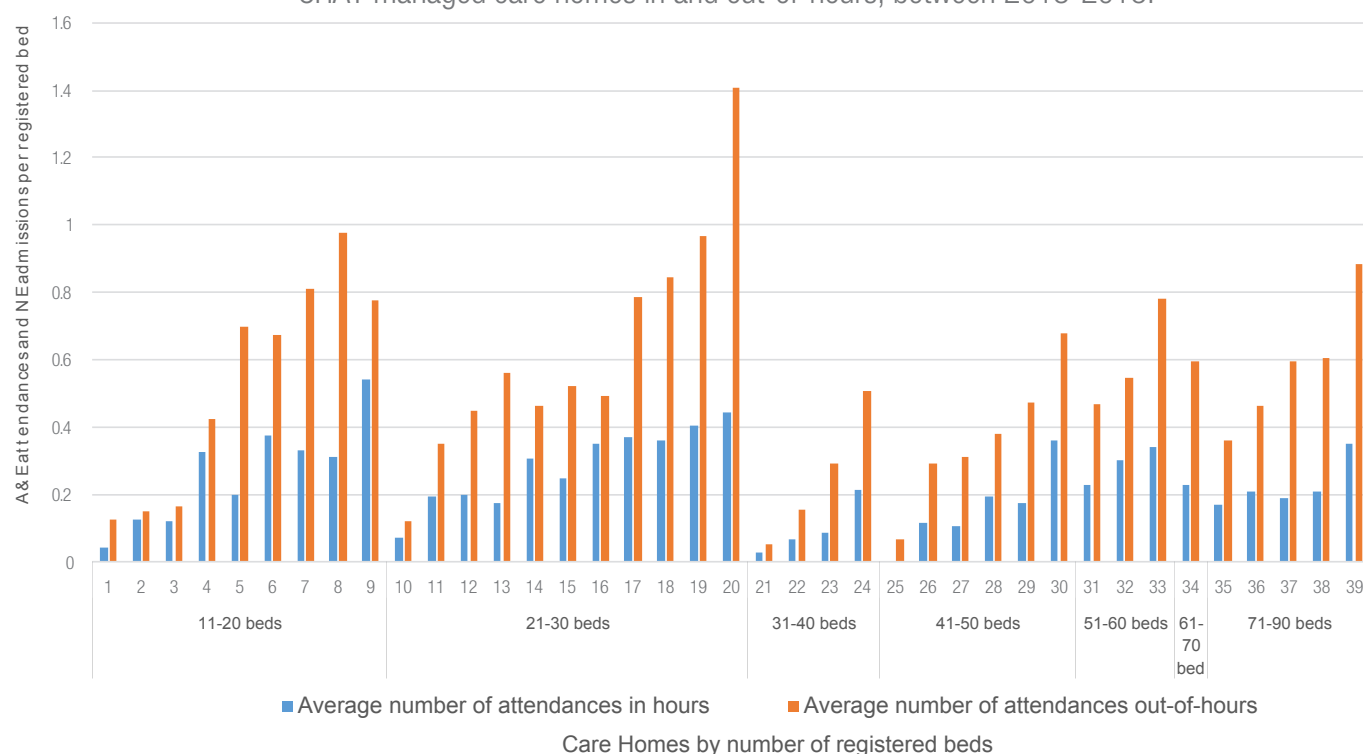
On average, 70% of hospital attendances were made out-of-hours (5pm – 9am), compared with 30% in hours (9am – 5pm) from 2013 – 2018. This would suggest CHAT is having a beneficial impact in hours, however there will also be other factors contributing to the reduced attendances to hospital in hours e.g. access to GPs, better access to other health services, etc. Incidents occurring out-of-hours are causing the highest number of residents to attend hospital.

### Testimonial from a relative;

You have been by far the most helpful, transparent, honest and knowledgeable health professional I have come into contact with in 5 years. You have been able to give me an oversight and holistic view of Dad's situation that I haven't found anywhere else. I am also extremely grateful for your guidance with the Advanced Care Plan, which was a very difficult process. You were tactful yet honest throughout. The combination of specialist nursing and doctor input has been so beneficial to managing Dad. Thank you.

**Graph 7: Average number of A&E attendances and non-elective admissions per registered bed in hours and out-of-hours grouped by size of care home.**

Average number of A&E attendances and non-elective admissions per registered bed for CHAT managed care homes in and out-of-hours, between 2013-2018.

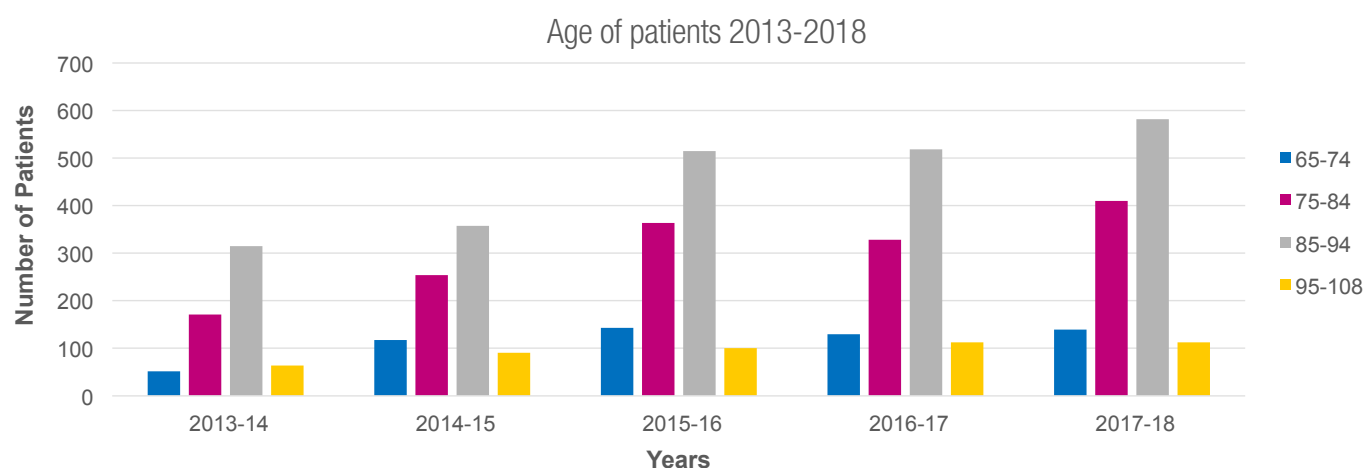


Source: Enfield CHAT team service level data, 2013 – 2018.

The average number of A&E attendances and non-elective admissions per registered bed by CHAT managed care homes between 2013 – 2018 was 0.75, this ranged from 0.07 to 1.85 A&E attendances and non-elective admissions per registered bed. It could be argued the higher the bed number per care home, or the type of care home (nursing vs residential) the higher the number of A&E attendances and admissions. However, there are large variances in the number of hospital attendances despite having similar bed numbers, for example, in the 71 – 80 bed sized care home, care home numbered 35 has 90 beds and had 0.53 A&E attendances or hospital admissions per registered bed, whereas care home numbered 39 who has fewer beds

(80 beds) had a higher number of A&E attendances or hospital admissions per registered bed at 1.23. Care homes could be grouped into quality improvement working groups, with similar size care homes with similar staffing ratios. For example, in the 21 – 30 bed care home category, care home 10 had a very low number of A&E attendances or hospital admissions, can we learn anything from that care home to replicate in the other 10 similar sized care homes to reduce hospital attendances. Further investigation is needed into the causes of hospital attendance variation between care homes, for example is it dependant on the type of care home, the different staffing levels, time of day or just the medical condition of the residents.

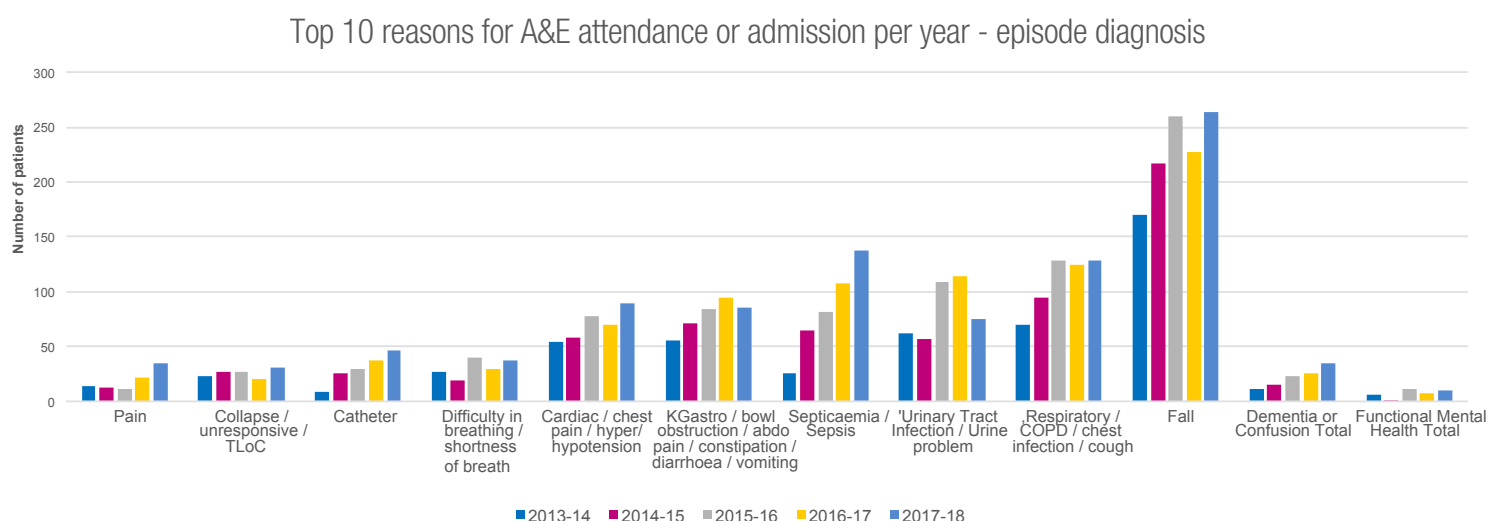
**Graph 8: Age of care home residents attending A&E or being admitted to hospital**



Source: Enfield CHAT team service level data, 2013 – 2018.

The mean age of care home residents from 2013-2018 was 85 years old. Between 2013 – 2018, 46% of residents were in the 85-94 age bracket. There was a 5% and 3% increase in the number of residents attending hospital in the 75-84 and 65-74 age bracket respectively. There was a 6% and 1% decrease in the number of residents attending hospital in the 85-94 and 95-108 age bracket attending hospital. Despite the number and complexity of co-morbidities increasing with age, its encouraging less older people are attending hospital and the care homes supported by CHAT are able to treat them in the care home.

**Graph 9: Top 10 reasons for A&E attendance or non-elective admission per year - episode diagnosis. Plus Functional Mental Health and Dementia or Confusion episode diagnosis.**



Source: Enfield CHAT team service level data, 2013 – 2018.

**Table 7: Number and percentage of patients per episode diagnosis per year.**

Episode Diagnosis	2013-14	2014-15	2015-16	2016-17	2017-18	Total	% of total
Total ALL Falls (breakdown of falls below)	170	217	260	228	264	1139	23%
Fall - pain	11	9	11	12	16	59	
Fall - laceration	16	17	20	17	20	90	
Fall	32	27	17	12	35	123	
Fall - injury	27	21	24	21	32	125	
Fall - fracture / dislocation	18	28	53	55	51	205	
Fall - soft tissue injury / contusion / epistaxis (nose bleed) / swelling / mass	39	39	65	46	45	234	
Fall - injury head	27	76	70	65	65	303	
Respiratory / COPD / chest infection / cough	70	95	128	124	129	546	11%
Urinary Tract Infection / Urine problem	62	57	109	114	75	417	8%
Septicaemia / Sepsis	25	65	81	107	137	415	8%
Gastro / bowel obstruction / abdo pain / constipation / diarrhoea / vomiting	56	71	84	95	86	392	8%
Cardiac / chest pain / hyper/hypotension	54	58	78	70	89	349	7%
Difficulty in breathing / shortness of breath	27	19	40	30	37	153	3%
Catheter	9	26	29	37	47	148	3%
Transient loss of consciousness (TLoC) / collapse / unresponsive	23	27	27	21	31	129	3%
Pain	14	13	11	22	35	95	2%
Diabetes / hypo / hyper	12	16	24	25	14	91	2%
Disorders of electrolyte and fluid balance - anaemia, hyper/hypo-kalaemia natremia	11	12	14	18	22	77	2%
Fitting / seizure	7	16	17	14	19	73	1%
Musculo-skeletal - including impaired mobility and abnormal gait	5	3	19	30	15	72	1%
Patient for medical take	8	9	19	13	22	71	1%
Missing data	7	3	15	3	42	70	1%
Unwell Adult	15	10	12	6	21	64	1%
Dehydration / not eating or drinking	5	15	11	7	13	51	1%
Infection / allergic reaction / rash / fever	9	7	16	11	7	50	1%
Total physical health - below 55 patients	48	66	94	79	97	384	8%
Dementia or Confusion Total	11	15	23	26	35	110	2%
Functional Mental Health Total	6	1	11	8	10	36	1%
<b>Total</b>	<b>654</b>	<b>821</b>	<b>1122</b>	<b>1088</b>	<b>1247</b>	<b>4932</b>	<b>100%</b>

Falls have been the reason that 23% of care home residents have attended hospital between 2013-2018 in CHAT managed care homes, 12% higher than any other reason for hospital attendance. In 2011, Enfield reported in their Joint Strategic Needs Assessment that around a third of people in care homes had musculoskeletal conditions and a further third had hypertension, which would contribute to the number of falls occurring. There were fewer older people admitted to care homes due to a stroke/TIA (17%), coronary heart disease (10%) or COPD (5%). The proportions suffering from diabetes (16%) or incontinence (15%) is likely to be an under-estimate due to poor recording or under-diagnosis of these conditions<sup>34</sup>. Which is in line with the reasons why care homes residents are attending hospital. However, there are a number of conditions where arguably a resident should be treated in their care home e.g. UTI infection, catheter problem, pain. The CHAT team have regular access to this data so they can implement action plans to try and reduce the incidence of the conditions causing the high hospital attendance rates and are aware of the types of conditions care home staff may need extra support and training on.

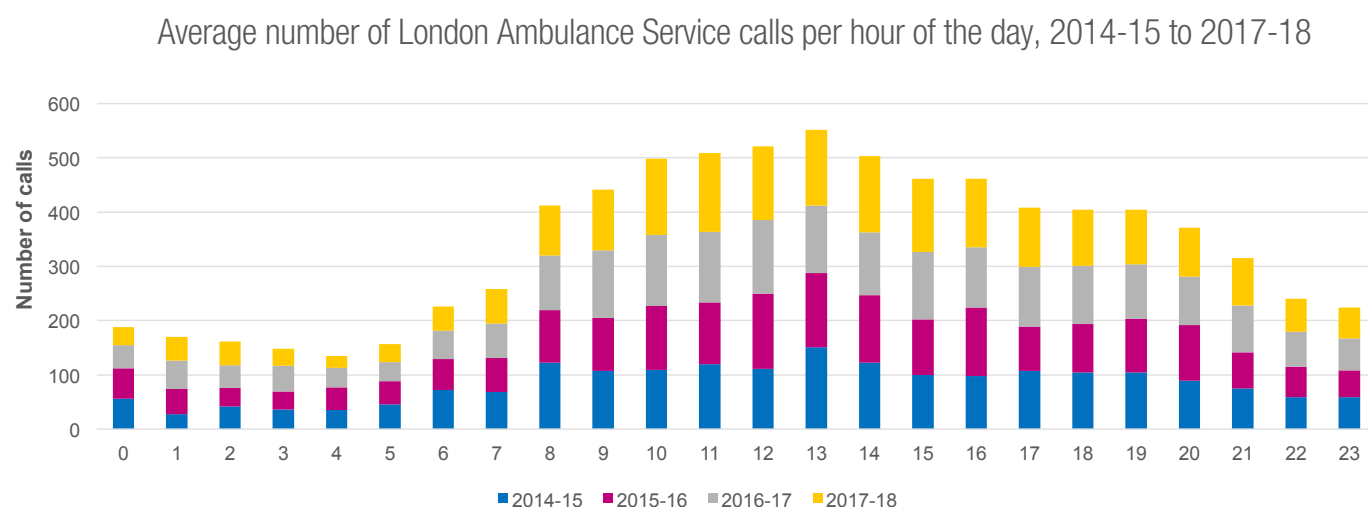
The prevalence of mental health conditions appears to be very low, contributing to only 3% of care home residents attending hospital. However, in Enfield we know that nearly 60% of people admitted to a care home (80% nationally<sup>35</sup>) are diagnosed with dementia and there is an estimated 40% affected by depression in care homes<sup>36</sup>. Mental health episode diagnosis recording in hospitals is unfortunately under reported nationally.

## London Ambulance Service

The London Ambulance Service (LAS) data shows that there were an additional 67 calls to LAS from care homes in Enfield in 2017-18 compared with the number of calls in 2014-15, equating to a 3% increase from 2,020 in 2014-15 to 2,087 in 2017-18, on average 84% of these calls were conveyed to hospital.

There has been a 5% increase in the number of calls to LAS from CHAT managed care homes (from 1,519 in 2014-15 to 1,600 in 2017-18, 81 calls) across a 24 hour period. There has been a 1% increase in the number of calls conveyed (from 85% in 2014-15 to 86% in 2017-18). This data was only available for 31 out of the 39 CHAT care homes. The LAS data provided does not separate calls from individual care homes into hours of the day so we cannot tell if the CHAT supported care homes are calling in CHAT service hours (9-5pm) or out-of-hours (5pm-9am). Given the increased CHAT support in hours and often more availability of other services in hours such as GPs, district nurses, etc one would expect fewer calls in hours. However, we do know that the number of calls to LAS calls in hours (9-5pm) from all care homes in Enfield (96 care homes, not just the 39 CHAT managed care homes) was on average 6% higher in-hours than out-of-hours. This is unexpected given the longer time period classified as the out-of-hours (15 hours compared with 9 in hours). As such, one would expect in-hours to have proportionately fewer calls.

**Graph 10: Average number of London Ambulance Service calls per hour of the day, 2014-15 to 2017-18**



Source: London Ambulance Service, service data 2014 – 2018.

The average number of calls made from all care homes in Enfield to LAS per hour between 9am – 5pm was 121 calls per hour, which is almost double the number of calls made per hour out-of-hours, 64 calls per hour. There was a 15% increase from 1025 calls in 2014-15 to 1182 calls in 2017-18. Compared with 90 fewer calls made out-of-hours, a 9% decrease from 995 calls in 2014-15 to 905 calls in 2017-18. There has not be a substantial change in the number of calls across the years. The number of calls to the 111 \*6 designated care homes helpline was not explored in this study.

Predictably January and December had consistently higher number of calls from care homes to LAS than any other months, 217 and 189 average number calls per month respectively. Followed by March and April with 177 average calls per month, June had the lowest number of calls with 151 average number of calls from 2014 - 2018. Saturday had consistently higher number of calls than any other day of the week, with an average of 321 calls per year, followed by Fridays with an average of 316 calls per year. Tuesday had on average the lowest number of calls, 280 calls per year.

**Table 8: Illness types causing the highest number of London Ambulance Service calls outs**

Year	2014-15		2015-16		2016-17		2017-18	
<b>Illness Type / Number of illness types recorded</b>	<b>Number</b>	<b>%</b>	<b>Number</b>	<b>%</b>	<b>Number</b>	<b>%</b>	<b>Number</b>	<b>%</b>
Dyspnoea (difficulty breathing)	211	8%	179	7%	154	6%		
Generally unwell	263	10%	216	8%	162	6%	139	6%
Head injury (minor)	173	6%	134	5%				
Other medical conditions	328	12%	334	13%	319	12%	322	15%
Pain - Other	149	5%	152	6%	147	5%	133	6%
Sepsis					155	6%	218	10%
Urological							89	4%
<b>Grand Total</b>	<b>2740</b>	<b>41%</b>	<b>2659</b>	<b>38%</b>	<b>2702</b>	<b>35%</b>	<b>2179</b>	<b>41%</b>

Source: London Ambulance Service, service data 2014 – 2018.

Table 8 shows the illness types that are causing the highest number of London Ambulance Service calls outs. Unhelpfully, other medical conditions and generally unwell were the top 2 reasons for call outs.

Current protocol dictates that all head injuries, although recorded as minor, need to be conveyed to hospital, even if a resident will; 1. Not be able to have a CT scan as medically / mentally unable to do so or 2. The outcome of head injury will not change treatment because they are at the end of life and on a palliative care register.

However, GP authorisation is needed to not send a resident to hospital, the majority of GPs are unwilling to authorise this unless they can see all patient care records, which they are unable to currently, therefore, LAS will convey them.

Pain, sepsis and urological are some of the illness types causing the highest number of call outs, however these can arguably be treated in the community by a nurse prescriber, CHAT can prescribe.

## 8 | CHAT SUPPORT TO CARE HOMES

**Table 9:** Type and number of CHAT service visits to care homes.

Year	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19(Qrt 1&2)	Total & (%)
Total no. of residents reviewed (*unplanned / acute, new resident / rolling, post discharge)	3402	2578	4324	4710	4866	2893	22,773
*No. of unplanned & acute reviews with residents	3122	1961	3453	3519	3009	2000	17,064 (75%)
*No. of new resident & planned reviews	280	284	414	774	1446	687	3,885 (17%)
No. of post-hospital discharge reviews	0	333	457	417	411	206	1,824 (8%)
<b>Prevented visits</b>							
Prevented admissions (team view)	1403	960	1840	1679	1792	735	8409
GP callouts avoided (team view)	1438	769	1113	1388	2130	1271	8109

Source: Enfield CHAT team service level data, 2013 – 2018.

CHAT managed 17 care homes with 749 registered beds in 2013-14 increasing to 36 care homes with 1,471 registered beds in 2018-19, with a peak in 2017-18 of 38 care homes with 1,523 registered beds.

The CHAT team have completed a total of 22,773 resident reviews, an average of 3,796 reviews per year. This includes;

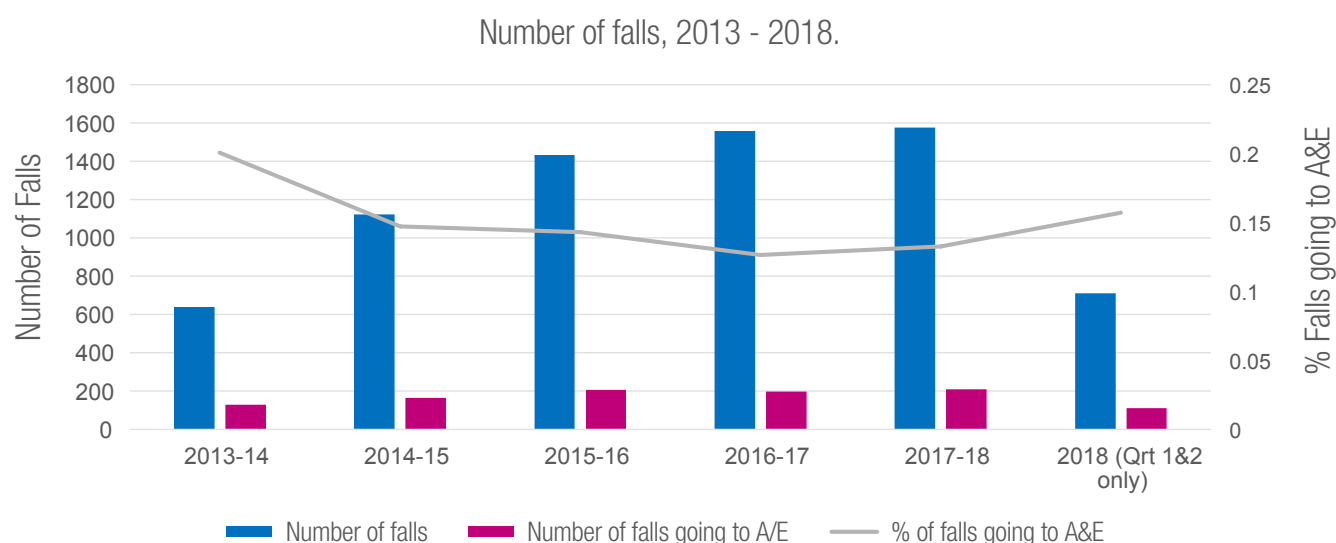
- ▶ Unplanned and acute reviews; 17,064 reviews – 75% of all visits.

Any activity that isn't a post hospital discharge or a holistic geriatric assessment for a new resident is classed as unplanned e.g. family meetings, ACPs/DNAR decisions or reviews, review post fall, suspected infection, pain, bowel care, skin care, palliative care, management or monitoring of long term conditions, mental health crisis, challenging behaviour, placement at risk of breakdown, physical or mental health best interest meetings, same day phlebotomy.

- ▶ New resident holistic geriatric assessments and scheduled rolling reviews; 3,885 reviews - 17% of all visits.
- ▶ Post-hospital discharge reviews; 1,824 reviews - 8% of all visits.

Every time a resident is seen in a care home the CHAT team update their care plan and record the outcomes of the review. In the team's professional clinical opinion they have prevented 8,409 attendances at hospital and avoided 8,109 GP contacts (calls or care home visits).

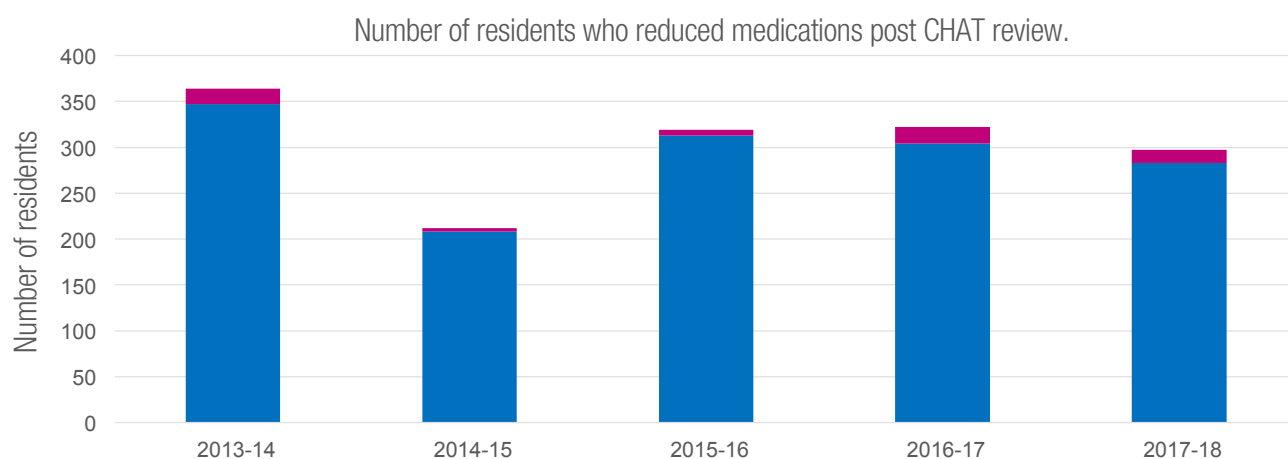
**Graph 11: Number of falls and percentage attending A&E**



Source: Enfield CHAT team service level data, 2013 – 2018.

The number of falls requiring attendance at A&E or non-elective admission decreased from 20% in 2013-14 to 13% in 2017-18, a reduction of 7%. However, the total number of falls has risen from 0.83 falls per registered bed in 2013-14 to 1.04 falls per registered bed in 2017-18.

**Graph 12: Number of residents who reduced medications post CHAT medications review**



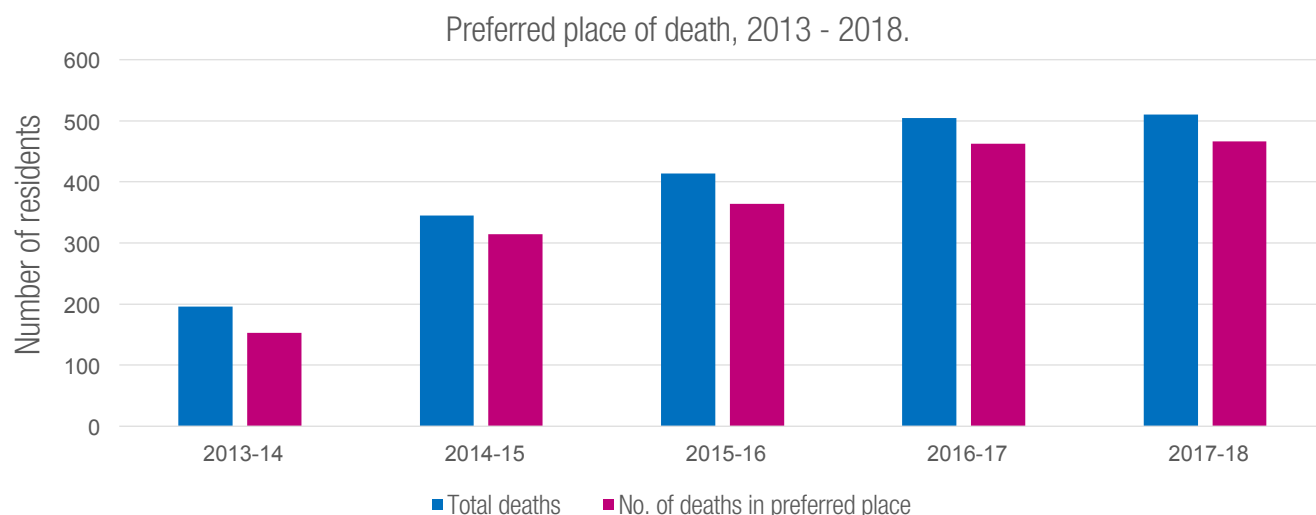
Source: Enfield CHAT team service level data, 2013 – 2018.

Evidence suggests that polypharmacy (using  $\geq 4$  drugs) can lead to 18% higher rate of falls in older adults<sup>37</sup> however reviews increase the likelihood of identifying polypharmacy and potentially reducing falls.

As part of patients rolling reviews (3,885 reviews held in total) the CHAT team review medications, 39% of residents (1,514) have had a reduction or had their medication stopped as part of a review, including; 1455 medications for physical health complaints and an additional 59 residents had an anti-psychotic medication stopped for a mental health complaint. For optimal management of health conditions some residents will have their medications increased.

The cost of the number of stopped medications was calculated for 2018 – 19, one year's reduction in costs of prescribing equated to £7,506 of savings.

**Graph 13: End of life care - preferred place of death**



Source: Enfield CHAT team service level data, 2013 – 2018.

Ensuring dignity in the lives and deaths of residents in care homes at the end of their life is a priority, therefore ensuring a residents wishes for their preferred place of death is followed is fundamental. Ninety nine percent of deaths occurred in the residents preferred place of death, only 1% died not in their preferred place, when that place is known. On average 10% of deaths did not have their preferred place of death recorded.



### **Testimonial** from Sunbridge residential home;

As a new care home manager I am absolutely impressed by the service CHAT offer. I have on two occasions needed urgent support on behalf of a service users health need and have found the service A1. The team go that extra mile on every occasion and follow up cases each day. Nothing appears too much for this team. The team have also been involved in supporting Sunbridge with Relatives Meeting to discuss "end of life care" which has been a very sensitive subject. This is a service to be proud off – supportive, cutting down admission and allowing dignity in care whilst allowing service users to remain in their home.

The average healthcare cost of a nursing home resident in the last six months of life is £3,906. The average cost of care in the last 6 months of life are £8,129 when the location of death is hospital, £4,223 higher<sup>38</sup>.

Training for end of life care planning, understanding of mental capacity in relation to DNARs and managing end of life care and symptom control underpins the resident being able to die in their preferred place of death. When a resident enters the last 12 months of life, CHAT facilitates;

- ▶ Respond within a maximum of 4 working hours to a call for a deteriorating resident.
- ▶ EOL Care Pathway with community palliative nurses
- ▶ Anticipatory prescribing organised
- ▶ DNAR status is completed for residents at this stage, if not already completed
- ▶ Update the palliative care handover form to Palliative Care Centre and OOH services
- ▶ Record the death
- ▶ Bereavement follow up as set out in bereavement policy
- ▶ Reflective discussion on the death at next MDT meeting

CHAT are helping to improve end of life care pathways for residents, supporting sensitive discussions about best interest decisions with families and other health and social care professionals, and ensuring difficult conversations with residents and their families about the resident's wishes for end of life are jointly held where care home staff need support.

### Improved Staff Training

The skill mix and knowledge of care home staff was highly variable across the borough. Despite carrying out demanding roles, the healthcare assistants and nurses working in the borough's care homes had little access to specialist training and support. Residents in care homes can experience limited access to services in the community due to staff having a lack of knowledge of services and the eligibility criteria, how and where to refer.

In an investigation examining 300 CQC inspection reports, training gaps were identified in 71% of care homes who were told to improve by the CQC. Dementia care, safeguarding and the Mental Capacity Act were the topic areas that fared worst. Data from the CQC register of care homes.<sup>39</sup>

The need for training and development was identified locally and a successful Health Education England bid was submitted, £50k was awarded to allow a new Community Matron with teaching experience to be employed.

There have been a total of 7606 care home staff and managers trained, since CHAT started in 2013. CHAT provide mentoring/coaching and clinical supervision, both 1:1 and in small groups. Embedding the skills learnt in training is the unique element of CHAT, rather than an external training provider just delivering a one day course, CHAT leave a lasting legacy by following up with "on-the-job" coaching to staff putting skills into practice in real life situations. The follow up provided after the formal workshops is highly valued and is reported as a key reason why skills and knowledge become embedded on the ground. Feedback on the delivery of training found that training on increasing confidence in a crisis e.g. in death supervision, complex behaviours training, and providing official competency sign off for formal accredited courses such as the care certificate and for new clinical skills such as phlebotomy where the clinical nurses do not have a senior nurse manager were most valued. CHAT undertakes an induction with new care home managers, identifying skills gaps and devising training packages for that home which aids with staff retention.

### Training and workforce development provided by CHAT included;

3. Care planning: Pre admission assessment, Care Planning Reviews, Do Not Attempt Resuscitation (DNAR), Advanced care planning (ACL), End of life care and pain management medications.
4. Mental Health Training: Dementia awareness and challenging behaviour, Delirium signs & symptoms, Mental capacity act/assessment, Deprivation of Liberty (DoLs), best interest assessments, management of stress, anxiety and depression.
5. Physical Health Training: Management of long term conditions, assessment & management of deterioration and unstable patients, falls prevention and bone health training by community physiotherapists and CHAT, medicines management, basic CPR, speech and swallowing difficulties, dietetics and nutrition in the elderly, peg feeding, blood pressure monitoring, signs & symptoms of dehydration, management of oedema, medication/diabetic reviews - managing blood glucose levels, management of constipation/bowel care, assessment and management of a UTI and urinalysis, catheter/haematuria management, mouth care/oral/thrush/eyecare/ear assessment, skin assessments/skin care, pressure area management/wound care, use of inhalers, hand washing & infection control, moving and handling.

**Table 10: Type of training sessions and number of care home staff trained.**

Type of training	2015-16 (Aug-Mar - 8months)	2016-17	2017- 18	2018-19 (Apr-Sept - 6months)	Total all years
<b>All training for care home staff from chat</b>					
Total mental health	58	296	623	407	1384
Total physical health - longer term / conditions	109	407	664	400	1580
Total physical health - acute / shorter term	188	373	942	466	1969
Total end of life	88	269	326	222	905
Total admin/management	53	63	79	41	236
<b>Total informal training</b>	496	1408	2634	1536	6074
<b>Most frequent training sessions (100+ care home staff trained)</b>					
Dementia & Challenging Behaviour	21	227	509	342	1099
Skin/Pressure/Wound Assessments/ Care	46	102	245	130	523
End Of Life Care And Medication	33	157	210	115	515
Assessment & Management of Deterioration	20	112	193	169	494
DNAR & ACP	55	112	116	107	390
Risk/Management of Food/Fluid	21	77	190	64	352
Management of Falls	15	68	108	75	266
Medication/Diabetic Reviews	15	86	96	37	234
Collection of Urine Samples/ Urinalysis	12	26	93	53	184
Mental Capacity Act/Assessment/ DoL	29	44	68	37	178
Phlebotomy	20	36	76	42	174
Management of Constipation/Bowel Care	13	25	88	29	155
Catheter/Heamaturia Management	26	20	60	36	142
Pain Management	9	33	51	41	134
Managing Blood Glucose Levels	18	35	30	25	108
Management And Treatment of a UTI	3	31	35	35	104
"Food First"	9	14	67	13	103
Blood Pressure Monitoring (Inc L&S)	8	25	62	7	102

Source: Enfield CHAT team service level data, 2013 – 2018.

## Trusted Assessors

The CHAT Community Matrons are also used as trusted assessors<sup>40</sup> in Enfield's care homes, the aim for national trusted assessor programme is to reduce the number of patients, and waiting times of patients, awaiting discharge from hospital and help them to move from hospital back home or to another setting speedily, effectively and safely. Trusted assessment is a key element of best practice in reducing delays to transfers of care between hospital and home. CHAT are piloting 7 day working with 16 care homes, to encourage care homes to accept weekend admissions, the CHAT team are on call to support these transfers, the care homes are more likely to accept the

admission, especially if it's a weekend, due to the physical and mental health medical support system CHAT offers and the confidence that has grown over time that care homes have in the CHAT service to support them.

## Developments in data capture

There is always room for improvement; the development of the CHAT service has now led to every hospital attendance being investigated individually. They will start to develop a picture of the number of unwarranted hospital attendances and common reasons why that hospital attendance could have been avoided.

**Table 11: Investigation of hospital attendances and numbers that could have been avoided**

Month in 2018	Number of attendances	Number of attendances that could have been avoided (%)
August	88	8 (10%)
September	114	6 (5%)
October	86	7 (8%)



## Testimonial from June Haydon from Green Trees Care Home;

"Green Trees has benefited from the help and advice from the CHAT team. Everybody connected with the home, myself, staff and of course the residents, they have also helped reduce the workload of our GPs. Their knowledge, experience and willingness to assist has without doubt improved the wellbeing of our residents, and reduced the amount of hospital visits and admissions during the time they've supported us. Their assistance with helping to organise the palliative care team and pre arranging the necessary pain relief for end of life care has been invaluable. In fact I now wonder how we managed before the team became involved in the home"

## 9 | CONCLUSION



### **Testimonial** from a care home;

The improvement in communication and integration between NHS and private sector is a real benefit of CHAT. Previously some staff felt care home nursing had a stigma or there was a perception of low skill levels and NHS nurses/therapists would visit and make unrealistic recommendations and without the transfer of skill or knowledge staff were unable to deliver the recommendations. The additional support has aided the relationship between not only CHAT and the care home staff but other visiting NHS professionals.

The NHSE Long Term Plan<sup>41</sup> published in January 2019, strongly recommends a multi-disciplinary team approach and integrated care networks and services. CHAT is committed to removing the barriers between primary and secondary care, physical and mental health, health and social care and is a best practice example of integrated care. By providing a care co-ordination role and integrated approach there have been significant improvements in quality of life outcomes for residents and enabled more residents to be able to die in their preferred place of death. They reduced the need for acute emergency care and hospital admissions, by increasing nursing support and managing end of life pathways better by ensuring advanced care plans were in place, resulted in substantial

cost savings. They reduced the number of GP visits required, reduced the amount of medications prescribed and the number of falls in care homes leading to hospital admission.

This has been achieved through supporting, training and improving the competence and confidence of Community Matrons and care home staff and integrating specialist Geriatricians and Consultant Psychiatrist input into the community team. Commissioned Geriatricians time was released from secondary care into the community to upskill and train staff as well as provide clinical advice and guidance to support the most complex patient pathologies in care homes.

The Community Matrons have strong and direct links into the Geriatricians and Consultant Psychiatrist and through the training received from them are able to work at the top of their skill set and mix to support care homes, and have subsequently trained the care home staff and managers to proactively manage their resident's conditions and improve quality of life. The qualitative feedback from care homes acknowledge the importance of the support and training they receive, they have easier access to medical help and advice, they have one point of contact to either get direct support via a CHAT team visit, phone call or email or can be signposted to the correct alternative community provision able to help. The training and on the job coaching to care home staff has made the difference in truly embedding knowledge and skills and helped to reduce turnover of staff. The CHAT team also have strong links with primary care and are a single point of access for GPs and / or social care if they need any support or additional information about residents in care homes.

By bringing together commissioners and a range of clinical providers in a co-ordinated way has led to further investments being made which would not have been possible if done in isolation. CHAT successfully attracted additional funding from Health Education England to employ a specific Community Matron with a training qualification and background. NHS England has selected Enfield in which to trial a new pharmacy medications management pilot in care homes. The Community Matrons are now the trusted assessors in Enfield for care homes. They have been able to reduce the number of patients, and the waiting times of patients, awaiting safe and effective

discharge from hospital. Some of the care homes are now accepting weekend admissions, the CHAT team as trusted assessors are on call over extended hours to support these transfers so the care homes are more likely to accept the admission.

Enfield's care home occupancy rate is at 93%<sup>42</sup> ultimately there needs to be a focus on prevention of care home admissions and more support for people to be able to live in their own home for as long as possible. Pro-active identification of older people with key conditions such as frailty and dementia in primary care is needed using standardised risk stratification tools to help those with complex needs (and their carers) in a multi-disciplinary integrated care approach at an early stage.

There are a number of service specific and wider system change recommendations for the future which could further improve care home outcomes, based on the evidence in this report. Health and care partners across NCL have committed to jointly reviewing care homes, recognising there are individual partner and system wide responsibilities to improving support in care homes, therefore we are going to use the learning and recommendations from this report, along with best practice in other boroughs, to collectively inform the care homes review and partnership conversations. Partners across NCL will create a list of recommendations and an action plan in order to improve outcomes across NCL. These recommendations and working action plan will be published alongside this report as the joint care homes review progresses.

### **Testimonial** from The Hollies residential home;

Since having CHAT support it has helped us to access services which we previously could not. Also training for staff is helping us to keep up good practice and prevent admissions to hospital when the care can be delivered in service users own home. For me as a manager and RGN, I no longer feel alone, there is always one of the matrons at the end of the phone line or that I can send an email to get advice and support. Doctors at NMH, care of the elderly who visit the home with CHAT are excellent. Thank you all.



## 10 | RECOMMENDATIONS FOR THE FUTURE

Health and care partners across NCL have committed to jointly reviewing care homes, recognising there are individual partner and system wide responsibilities to improving support in care homes, therefore we are going to use the learning from this report and some of the recommendations made here, along with best practice in other boroughs, to collectively inform the care homes review and partnership conversations.

### Technology - developing technologically-aided solutions

1. A Virtual CHAT: The Airedale and partners Enhanced Health in Care Home vanguards<sup>43</sup> is a best practice example of how to maximise the use of technology. A secure video link is provided to care homes, which connects to a digital care hub. The hub is staffed 24 hours a day, 365 days a year by a MDT of doctors, nurses and therapists. The telemedicine service is particularly useful in residential homes, where a high proportion of the staff are not medically trained, the clinical team are able to assess the resident and are able to advise and suggest treatment for a variety of complex health needs to reduce inappropriate GP call outs, ambulance calls and avoid emergency admissions. CHAT could develop a telemedicine arm of their service particularly as they expand to more care homes in other boroughs. Locally these video links could also maximise links with primary care, facilitate urgent advice and support from Geriatricians and support MDT meetings without the need for the Geriatricians or GPs to travel.
2. Shared records: For joined up care and unnecessary repetition of assessments, especially in out-of-hours care, improvements are required in the access of clinical records. A patient may have an ACP with preferred place of death stated but this cannot be seen by LAS or any other medical professional currently. Nationally and locally within NCL the Health Information Exchange will link health, social care and mental health data providing appropriate access to clinical records, due to commence in 2019/20. An improved interim plan must be in place before then, such as using Co-ordinate My Care (a nationally recognised system for sharing ACPs - [www.coordinatemycare.co.uk/](http://www.coordinatemycare.co.uk/)) and all nursing and residential homes should have a secure NHS.net email address.

### Addressing care home support across the North Central London Geography

3. Share best practice: To improve the quality of care and reduce variation across NCL Barnet should investigate the opportunity of implementing a care home support team / virtual team based on their population demographics. Neighbouring borough Haringey have started to pilot CHAT services. The smaller inner London boroughs of Camden and Islington with significantly less care homes, but place a large number of their residents in the other boroughs, could buy into a proportionate amount of the service or virtual support service only.
4. The medical input into care homes is hugely variable, some care homes purchase additional primary care / pharmacy input to varying degrees. Investigate the possibility of offering care home organisations the opportunity to part fund CHAT to be able to expand the service.
5. CHAT training could be opened up to sheltered accommodation homes due to limited support currently offered to those homes.
6. Nationally there is still a high turnover of staff in care homes. CHAT would like to work with Capital Nursing to increase workforce retention ([www.hee.nhs.uk/our-work/capitalnurse](http://www.hee.nhs.uk/our-work/capitalnurse)) and they should engage in the joint workforce planning and co-ordination workstream across NCL to encourage and retain more people into, and returning to, a career in caring.
7. Commissioners need to review the out-of-hours arrangements for support to care homes, pilot the CHAT service becoming a 7 day extended hour's service (e.g. Monday – Sunday 8am – 8pm) avoiding duplication with other commissioned services. The Enfield Rapid Response OOO service and national 111 \*6 telephone line for access to GP advice have no access to patient records and therefore have a lower threshold than CHAT to convey patients to hospital.
8. Care homes should have a named pharmacist to maximise this underutilised resource<sup>44</sup>, to undertake regular medicine reviews. CHAT are starting to pilot enhanced pharmacy input, which should be evaluated and mainstreamed if successful.

9. More could be done across NCL to share best practice in care homes, through the quality improvement care homes forums.
10. To make sure CHAT continue to support the needs of care homes the key stakeholder's day should be repeated. Sharing their quality dashboard to analyse trends, identify issues and share intelligence and learning.
11. Continue to look for quality improvement opportunities and new ways of working, for example the Enhanced Health in Care Homes workstream recommendations<sup>45</sup> and the new ways of working in adult social care services recommendations<sup>46</sup>
15. Head injuries due to falls: 23% of care home hospital attendances are due to falls, a total of 1139 attendances between 2013-14 and 2017-18, of which 27% resulted in a head injury (303 head injuries due to falls). Any head injury has to go to hospital, even if a resident will; 1. Not be able to have a CT scan as medically / mentally unable to do so or 2. The outcome of head injury will not change treatment because they are at the end of life and on a palliative care register. However, GP authorisation is needed to not send a resident to hospital, the majority of GPs are unwilling to authorise this unless they can see all patient care records, which they are unable to currently. There is the potential to create a care home falls policy.

### **Clinically specific CHAT service recommendations**

In order to reduce hospital attendances the CHAT team can support care homes to;

12. IV antibiotics: Be able to give IV antibiotics in residential homes and potentially other interventions such as outpatient parenteral anti-infective therapy (OPAT) that can be given safely in an outpatient setting.
13. Subcutaneous fluids: Be able to give subcutaneous fluids in nursing homes. Nursing home nurses should be able to initiate subcutaneous fluids, but the majority of nursing homes in Enfield do not, a refresher short course is needed but these are expensive and nurses need time off to attend. District nurses do not go into nursing homes.
14. Deep vein thrombosis (DVT): residents currently have to be sent to A&E for a suspected DVT, bed bound residents can't go to ambulatory clinics. Investigate the opportunity for CHAT to have direct access to doppler ultrasound testing as they already have a TV nurse to undertake training.
16. Register of emergency admissions: The CHAT team have recently started to review every emergency admission to comment whether they believe it was avoidable or not. Highlighting a number of commonalities that could be improved to avoid resident admission, this is very time consuming, but the learning invaluable.

There is a lack of real world evidence base demonstrating integrated mental and physical health support in care homes. CHAT will continue sharing their model of best practice and enter their evidence base into an academic journal to help advocate for the needs of older people in care homes.

**Caveats of the data**

- ▶ Hospital data only includes those aged 65+ because of original commissioned age, but CHAT see all patients under 65 as well who are often more complex and take more time.
- ▶ The 65+ year old general population includes data from Barnet and Chase Farm Hospital (subsequently managed by and the Royal Free) and North Middlesex University Hospital.
- ▶ The 65+ year old general population health needs are not the same as the health needs of 65+ year olds in care homes.
- ▶ The CHAT service level data only includes data from North Middlesex University Hospital and Barnet and Chase Farm Hospital, data is not collected from other hospitals across North Centre London where residents could possibly attend.
- ▶ The capacity of care homes continually change, care homes close, new ones open and the number of beds within homes change. The data reflects the most up to date information of care home capacity at the time from the CHAT team, not the CQC website.
- ▶ Not all care home beds are full at any one time.
- ▶ Woodlands residential care home is located in Enfield however their hospital attendance records are not accessible due to an error in hospital data capture, therefore have been excluded from the data.
- ▶ Where CHAT managed care homes within a financial year hospital attendances are recorded to the nearest quarter.
- ▶ Patients who died on route were counted as an A&E attendance.
- ▶ Unfortunately SUS data was only accessible from 2013-2014 onwards, a comparison of outcomes before and after CHAT implementation was unavailable.
- ▶ This evaluation does not have matched comparators so it is not possible to attribute all changes to the CHAT intervention, other factors might also have been changed at the time and impacted these outcomes, e.g. national emphasis on prevention of falls, pressure sores, significant 7 training, etc. Furthermore, it might not be the CHAT per se that has made the difference but one or two elements of the CHAT provision or the way they provided it.

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