Adult Social Care and Health Overview and Scrutiny Committee

October 31st 2012

Review of South Warwickshire Community Emergency Response Team (CERT) and other developments in community services

1. Introduction

This is a review of developments that have taken place in Community Services in the last 12 months.

12 months ago concerns were raised about the ability of services in the South of the County to be able to deal with demand over the winter. The number of emergency admissions was rising, there were breaches of the 4 hour A&E target, and patients were waiting weeks for a bed in a community hospital. Modelling identified that an additional 9-26 beds would be required over the previous year to cope with the predicted demand.

It was proposed that Arden Ward, a community hospital ward at RLSRH should reduce in beds from 28 to 18 and should move onto the acute site, into the space vacated by Dugdale Ward. The resources from the closure of the 18 Acute and 10 community beds would be invested into enhanced community services, particularly a Community Emergency Response Team (CERT). SWFT agreed to pump prime the new service, with double running of the CERT team and community hospital for a period.

The proposal paper also noted that changes were happening at the Nicol Unit and in the development of Community Services in the Stratford area.

2. Report on Developments

CERT

A Community Emergency Response Team was developed in the Warwick District. This team consists of nurses, physiotherapists, Occupational Therapists and assistants. Recruitment took longer than was initially estimated, but the team was in place and fully operational from April 2012. The team is attached to the Intermediate Care Service. They accept referrals both for facilitated discharge from hospitals and admission prevention, from GPs, to enable patients to be cared for in their own homes. The team has a 2 hour emergency response time. Patients are fully assessed and provided with nursing care or rehabilitation as necessary in their own homes.

Initially it was hoped that patients would be transferred on to other services in 72 hours but this has not but this has not been achievable. Following their initial urgent care response, patients are either: discharged as independent; transferred to Intermediate Care routine flow for ongoing therapy; referred to Reablement; or to Adult Social Care for a package of care.

Additional resources were also put into the Stratford ACT team that had previously been developed under the Cutting the Cost of Frailty project. This team was then also able to develop and urgent response service and was renamed the Stratford CERT team to avoid confusion from referrers.

The CERT teams, Reablement and the hospital discharge coordinators worked closely together to develop patient pathways. Reablement has also expanded during this time frame and now accept referrals directly from CERT using trusted assessments, avoiding duplication and improving patient flow.

Arden Ward

It was proposed that Arden ward should move to Warwick Hospital, following the closure of Dugdale ward in April 2012. Winter pressures and the demand on emergency beds (Year to date adult emergency admission are 10% above plan) meant that it was not possible to close Dugdale Ward. The number of beds on Arden ward did reduce initially to 24 beds in April.

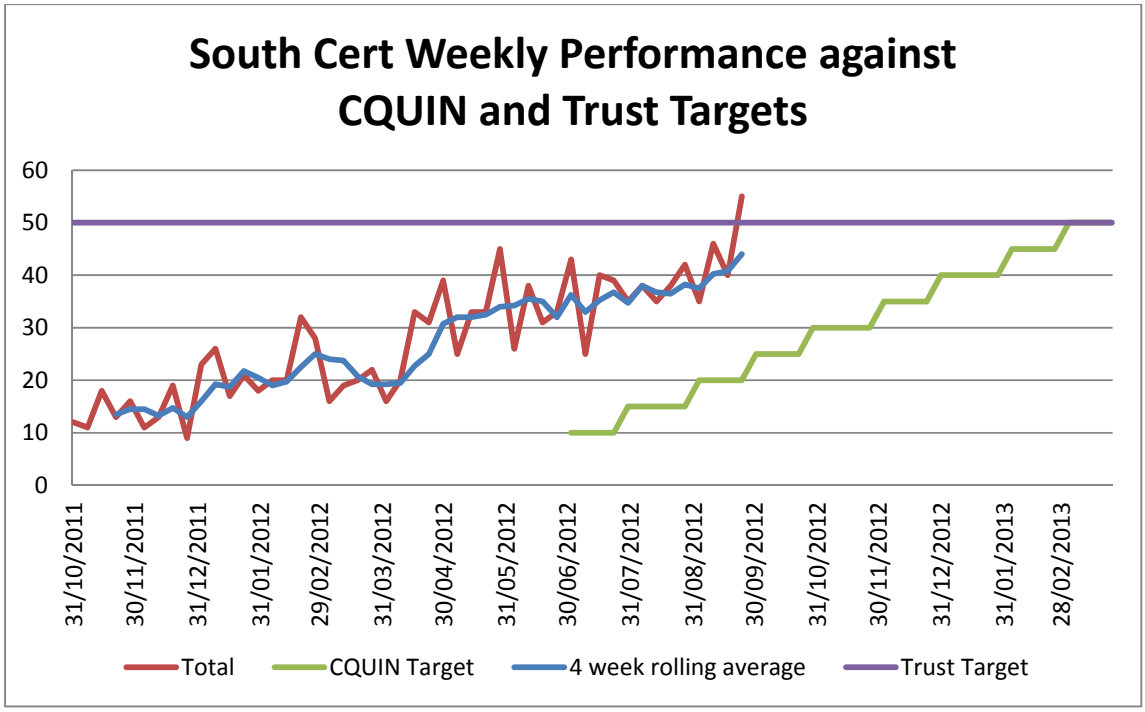
With funding available for rebuilding on the Royal Leamington Spa Hospital site for the expansion of the Acquired Brain Injury Unit, it became necessary for Arden to vacate the site in September 2012. An alternative site for Arden ward was found on the Helen Ley site in North Leamington, 4 miles away from RLSRH. Following refurbishment of the site Arden ward moved into the Helen Ley Centre on 27th September. This site will provide 18 community hospital beds. It remains under the full management of SWFT, the nursing, medical, therapy and support services have all moved with the patients and continue to provide all care. The ward had an inspection from CQC on 3rd October which was completely satisfactory and the ward has been fully registered with the CQC.

3. Outcomes and benefits

The project has been extremely successful. More patients are now cared for in their own homes and the pressure has been reduced on Warwick Hospital. The A&E target (95% of patients discharged or admitted with 4 hours) which was missed in 3 of the 4 quarters in 2011/12 – has been met every month since the new services started, aligned with additional changes to emergency medical processes at Warwick Hospital..

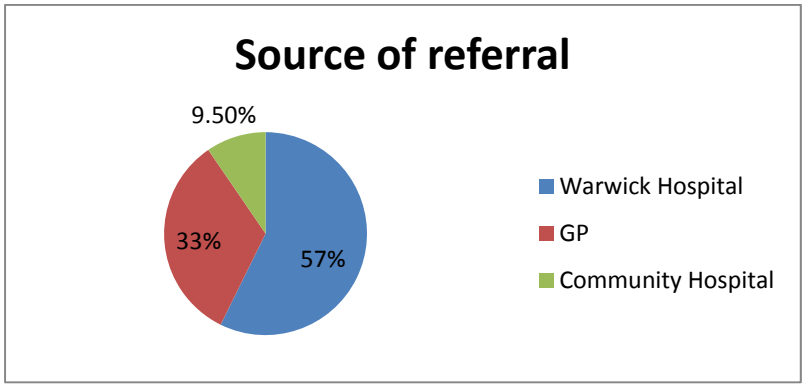
3.1

CERT has been given a Care Quality Indicator (CQUIN) target by the CCG of achieving 50 referrals a week to the service by April 2013. It is on track to meet this target. The graph below shows the number of referrals accepted against the target. Between April 2012 and October 2012, Warwick CERT received 521 referrals and Stratford CERT, 393, a total of 914 in six months compared to a baseline figure of 250 prior to the changes.

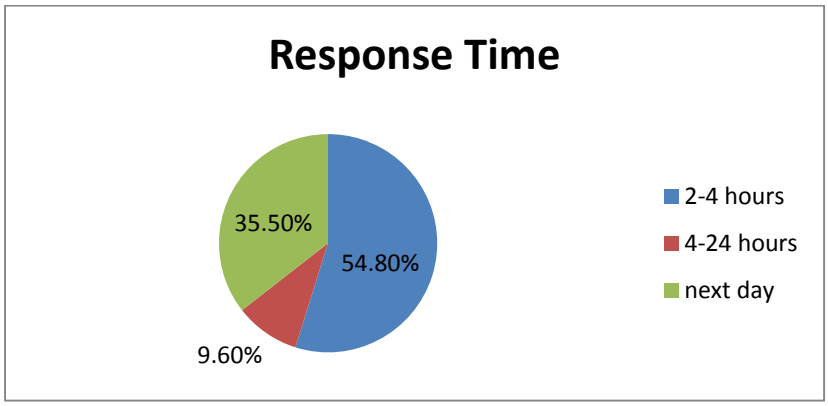


3.2 An audit of a sample of referrals received between April and October shows:

Source of referral:

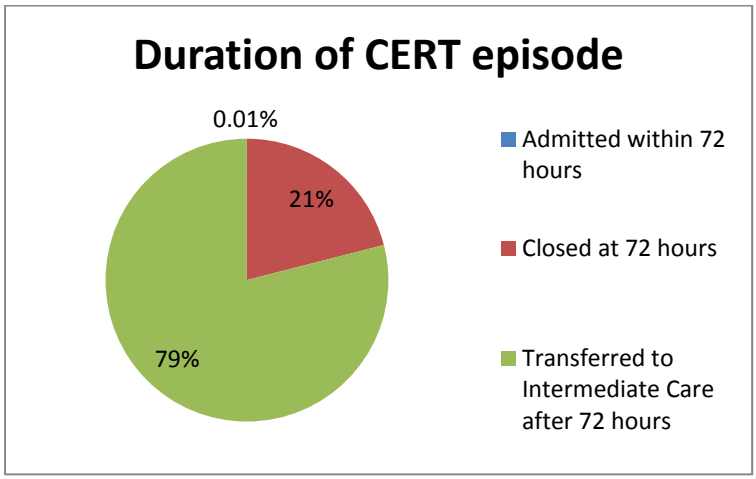


Response times for admission prevention cases:

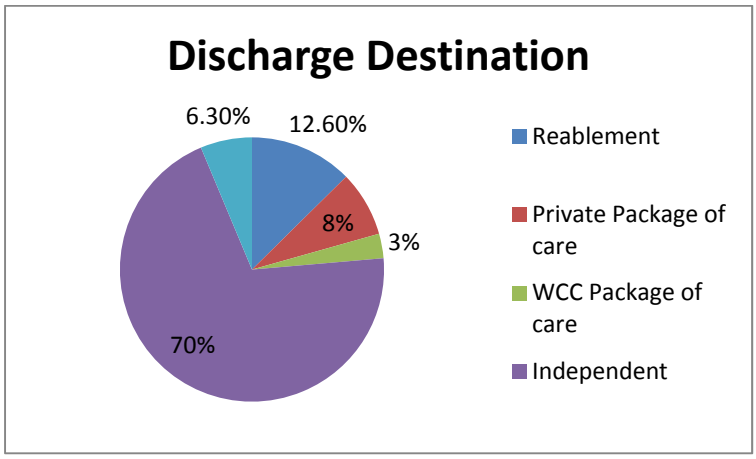


55% of patients were seen within 2 hours. Where patients had to wait until next day, this was often at the request of the family when making arrangements.

Duration of CERT episode:



Services patients referred to on discharge from CERT:



The patients identified as Independent were able to manage in their own homes with no further support.

System Outcomes.

As part of the wider transformation programme we are measuring a number of indicators across the system. The first 5 months data in comparison with the same 5 months in 2011/12 are encouraging.

- 7% increase in elderly discharges from EAU (short stay admissions)
- 15% reduction in deaths (in elderly and frail elderly)
- 3% reduction in frail elderly readmissions
- 15% reduction in % of Frail elderly discharged to NH who were previously living at home.

Next Steps

1. An action plan is in place to help us reach and sustain our CQUIN target of 50 referrals per week which identifies case finding, skill mix, changes to shift patterns and communication as factors to be considered.
2. We are currently reviewing our community services in the Shipston and Alcester areas. We are working with the Shipston GPs to review the level of community services required in the area to meet demand. We are reviewing the utilisation of the inpatient beds at Ellen Badger Hospitals looking at developing the model of care as at the Nicol unit and developing a more responsive admission prevention option. As part of this review we are modelling to determine the most suitable number of inpatient beds at the facility.
3. We are working with the Alexandra Hospital in Redditch to further develop discharge pathways for Warwickshire patients.

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15.10.12