

REDEFINING THE BOUNDARY BETWEEN HOSPITAL AND COMMUNITY CARE

POST ACUTE CARE ENABLEMENT TEAM (PACE)

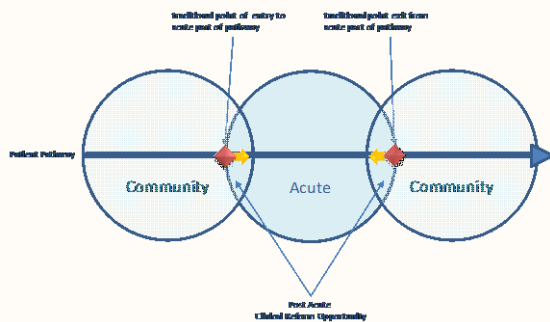
AN OVERVIEW

THE TASK

The acute trust wanted to reduce the bed base and the primary care trust wanted to reduce the cost for non-specialist rehabilitation (treatment code 314).

The acute trust and PCT were determined to work together to design and implement a model to meet the objectives. It took the form of a pilot over a 3 month period.

The work was based on the evidence that there were 3 groups of patients receiving rehabilitation in acute hospital beds. The groups included not only patients in need of specialist rehabilitation but two further classes of patients, most of whom did not require an acute bed.



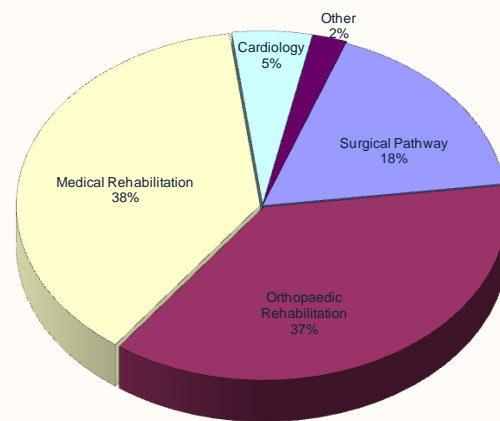
ORGANISING WITH PURPOSE

With support from Saigei two responsible officers began by bringing a team of clinicians representing acute, community and social care together. This clinical team was constituted with two aims

- to prove efficacy and cost-effectiveness of a community based model of post-acute non-specialist rehabilitation (group 1) and to scale the service to manage all demand

- to reduce the instance of acute capacity lost to labile transfers of care (group 1)

A point prevalence study carried out identified groups of patients that could be targeted.



The patient types served included those who:

- no longer required acute care because they were clinically stable
- required short term support to achieve relative independence
- admission to hospital from home
- those identified as having potential to return to independent living

THE CLINICAL MODEL

The overriding aim of the service was to minimise the duration of the patient's convalescence by:

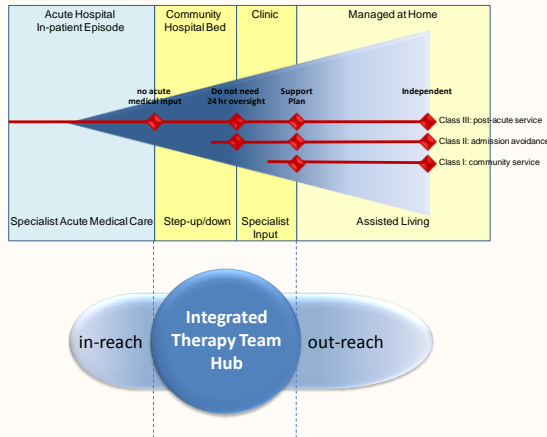
- providing more intensive therapeutic input than is available in hospital and
- delivering the care in the patients home to build confidence and the ability to be more self-sufficient

Led by community clinicians operating a partnership model the service provided short periods of intensive therapy within the patient's

own place of residence supported by care to return then to independence.

In order to realise the full benefit of the care model, some patients needed to pass through a community bed for part of their care.

The service model



A key feature of the service was that it met predictable demand for intensive rehabilitation input following an acute episode. Care was booked in advance ensuring a consistent, equitable response.

THE BENEFITS

Prior to PACE post acute convalescence was delivered in an acute bed resulting in relatively sedentary patients, under the care of a consultant, with low levels of therapy.

In contrast the PACE service is a clinically-led, community based model and has proved that it can deliver value in the following terms:

- A lower cost of care
- Faster outcomes for the target group
- Earlier discharge from acute beds and timely commencement of their convalescence
- A better experience for the patient

Analysis of days coded to treatment code 314 showed a maximum of 54% could be candidates for PACE. The maximum realised opportunity lay between 40-60% of the 54%.

MEASURING OUTCOMES

The impact of this initiative in 3 months has been profound

- 133 patients had their care delivered at home rather than in hospital
- 430 acute bed days saved
- A community service at half the cost of the acute service

GOING FORWARD

The pilot was able to demonstrate a case for the PCT to invest in PACE because it was able to offer a traceable Return on Investment (ROI) of 114% and open the way to better community performance in the future.

The PACE initiative was driven out of the PCT's plan to reduce the cost charged under "treatment function 314-rehabilitation" with the assumption that all patients under this code were candidates for an alternative model: in fact 314 included patients undergoing specialist rehabilitation.

In view of this one of the recommendations to the PCT was to unbundle the rehabilitation element of the tariff, accepting wider application of treatment function 314 (in the absence of a working HRG 4).

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