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CONFERENCE ABSTRACT

# Home ward Ealing: commissioners and providers working together to deliver a new integrated model of intermediate care

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The London Borough of Ealing is in the centre of eight boroughs which make up North West London, and has been part of a pioneering programme of whole systems approaches to integrated care since 2011.

**Ealing**: The borough is one of the largest, most diverse and densely populated in London, with the largest Somali population in the UK and Sikh, Hindu and Muslim populations are significantly higher than the London average. The borough has areas of affluence and deprivation and large number of patients in hard to reach groups including those who are homeless or with problematic use of alcohol or drugs. Ealing's population is above the national upper quartile for diabetes, and with an aging population across North West London, there is a growing number of patients suffering from other long term conditions including asthma, coronary heart disease, COPD and heart failure.

Due to the geography of Ealing, a high proportion of patients from the borough are admitted to acute hospitals in neighbouring areas.

**Integrated Intermediate Care Service**: In 2015, Ealing Clinical Commissioning Group in conjunction with the Local Authority, reprocured a newly specified integrated intermediate community care service for Ealing patients, which was designed with clinicians to provide a rapid, more responsive service that maximises admission avoidance and supports early discharge through managing a wide range of patients in a sub-acute phase in which they may need more than GPs and other community services can offer, but do not need an acute hospital bed.

West London Mental Health NHS Trust led a group of other local providers from primary care, community care and secondary care, and worked with social services to develop an innovative

delivery partnership which was designed to offer triple integration (vertically, with social care and mental health care), to maximise relationships with services in neighbouring boroughs, and to be delivered through accessing a single electronic patient record, shared with primary care.

Together, the providers launched *Home ward Ealing* on 01 October 2015, and are collaboratively working in an open-book manner with commissioners to evolve the service to meet the needs of Ealing residents.

**Outcomes and obstacles overcome**: We present outcomes and activity data from the predecessor service and the first six months of Home ward Ealing and outline the approaches taken to working across organisational boundaries, including the sharing of information, financial and clinical risk in an innovative integrated approach. We also outline links with other Ealing integrated care initatives, including Care Coordination and Navigation, Primary Care Mental Health and Dementia Link Workers and public health (Smoke Free Ealing) as part of a population health approach.

**Keywords:** nhs; integrated care; intermediate care; better care fund