

## CONFERENCE ABSTRACT

### Home ward: our partnership journey towards integrated care

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Home ward Ealing is an integrated intermediate care service, which was launched on 01 October 2015. NHS Ealing CCG commissioned the new service, working in partnership with Ealing Council.

West London Mental Health NHS Trust is the Lead Provider for the service, and delivers the service with Ealing Council, Central and North West London NHS FT, Chelsea and Westminster NHS FT and London Central and West Unscheduled Care Collaborative.

Home ward is commissioned to maximise opportunities to avoid general hospital admissions (hospital at home), support early discharge from hospital, and promote recovery through managing a wide range of patients during and following a sub-acute phase of illness. The service operates as a consultant-led multidisciplinary service delivering alternative to acute hospitalisation and rehabilitation in patients' homes and an intermediate care facility (20 beds). The service delivers integrated physical, mental health and social care.

After a full year of operation, we now present a comprehensive review of the service against commissioners' aspirations.

Activity and outcomes data is presented by the service provider: an analysis of the 5000 patients referred to the service, 3000 'claimed' admissions avoided, tracking through sharing of pseudonymised data indicating a 30-day readmission rate of ~16%, which compares favourably to acute hospital readmission rates for similar cohorts. The cost per case is compared to UK benchmarks.

We describe challenges and successes of integrated working, from the perspective of providers, commissioners, referrers and patients including consideration of:

- improving health and wellbeing
- improving care and quality
- improving productivity and efficiency,

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and the impact of such initiatives upon our local health economy, which includes London's smallest district general hospital, and a rapidly aging population, and increasing levels of comorbidity.

We also describe our contribution to North West London's plan to develop a standardised model for intermediate care across eight boroughs, and our recent expansion to provide the service with partners in three additional boroughs, now covering a population of 1,000,000 residents.

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**Keywords:** intermediate care; london; hospital at home; admission avoidance; frailty

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