



# **Better Care, Closer to Home**

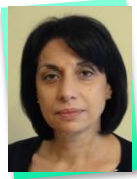
*Our three-year strategy for coordinated, high  
quality care out of hospital*

2012 – 2015

V0.3 – 17.05.2012

**Ealing Clinical  
Commissioning Group**

## Foreword



Ealing Clinical Commissioning Group (ECCG) came into existence in April 2011.

Our objective is to provide the right care at the right time and at the right place for the residents of Ealing.

Our vision is to ensure that our health care system keeps patients well and at home and, when patients do become unwell, provides cost-effective, evidence based and timely care at the right place appropriate to their needs.

As demand rises with increasing health needs and the development of new treatments, we need to respond to the challenges while delivering the highest quality of care. We need to build and preserve what we do well and continue to look for new developments to deliver the best standards of care.

There are times when we use hospitals to provide care for patients when that care could be provided closer to their home and in the community. Developing the right care outside hospital is a key part of how we will continue to maintain the provision of quality and cost effective care for the residents of Ealing.

This is our three-year strategy to design and deliver out of hospital care.

To achieve this, our out-of-hospital initiatives will be:

- **Inclusive:** We want our services to be inclusive and for this to happen we will involve patient and public groups in our proposals. As we develop our initiatives it should be clear to all users how we are developing our plans.
- **Integrated:** We will work with all our stakeholders who provide out of hospital care e.g. primary care, community services, social care, nursing homes, voluntary groups to provide joined up care.
- **Sustainable:** Our approach will be sustainable and we will invest when we need to deliver the care.

Our strategy aims to improve quality and efficiency across the system, the experience of all patients, and make the best use of our resources.

We recognise this is a different and substantial shift from how we deliver health today. In the coming months we will be meeting with patient and public groups to explain our plans and to fully involve you as we develop our initiatives.

We need to continue to respond to the challenges we face and to evolve to deliver the best sustainable health care for the residents of Ealing.

**Dr. Mohini Parmar, CCG Chair, Ealing**

# Executive Summary

This strategy sets out how Ealing CCG will deliver better care for people, closer to home. It focuses on care provided out of hospital and follows the launch earlier this year by NHS North West London on Shaping a Healthier Future.

## 1. The case for improving out of hospital services

- Demand for care is growing as people live longer, chronic and lifestyle diseases become more common and new developments in treatments become available
- In order to meet this demand within the resources available, we need to improve prevention, early intervention and care at home and reduce demand on hospitals
- To make these improvements we need to change and work in partnership with primary, community and social care to improve access, quality and capacity

## 2. Our vision of how care will be different

Our vision is that patients will feel confident and secure in the care they receive out of Hospital.

- This will mean joint working between GPs, community and social care, hospital and consultants, with early intervention and care in the right place and at right time
- Patients will have easier access to consistently high quality primary care
- More consultant led planned care will take place closer to home
- Patients with long term conditions who need care from different services will receive better coordinated care with one package of care
- Patients will be supported when they are discharged from hospital
- We are developing standards to hold ourselves and other providers to account for delivering high quality care out of hospital

## 3. How we will deliver better care, closer to home

The examples of the initiatives we have and we are developing are:

- **Urgent Care Centre:** this is already providing 24 hour urgent care to patients at Ealing hospital
- **111 and single point of access:** this will be piloted in Ealing from April 2013
- **Improving access to GPs:** we will work with our GPs to improve access to GPs

- **Integrated Rapid Response Service:** this will start in July 2012 to provide a response to patients to provide care in their home and to support them on discharge from hospital.
- **Children's nursing service:** we have developed a children's nursing service to provide care for children closer to and in a more convenient location for them and their families.
- **Palliative care service:** we are working with the Marie Curie service to provide a rapid response team to assist and support those people who wish to die at home.
- **Psychiatric liaison:** we are piloting a psychiatric liaison service at Ealing hospital to provide a rapid response to patients who need this care.

#### 4. How we will work together

We have identified better coordination of services as a priority in order to improve care. For example:

- Ealing GPs will work in six Health Networks ensuring care is clinically led and consistent across GP practices
- Within our six geographical multi-disciplinary groups, we will roll out the Integrated Care pilot to provide integrated care across health and social care
- We will work closely with partners in community and social services to support patients to use health and social care services effectively
- We are developing a service to provide coordinated and joined up care to Ealing residents who are in nursing homes

#### 5. Supporting the change

In order to make these changes we have identified some key things we need to do:

- We will step up patient, user and carer engagement and improve our patient education and information
- We will ensure that we have the right contracts and incentives to improve care, to underpin the new ways of working
- We will put in place network governance and define the standards to which care will be delivered
- We will put in place the right information systems and tools to support networks.
- We will provide training to networks to support professional and organisational development in leadership, governance, teamwork, IT skills and patient engagement

## **6. Investing for the future**

To deliver this vision of out of hospital care we will invest in our staff, estates and IT.

- We will need more clinical staff and we will invest in our workforce to deliver the changes we need.
- We will invest in better IT systems, to allow us to share clinical information (with the patient's consent) to provide seamless care
- We will invest in our estates to allow us to deliver more care closer to home

## **7. Next steps**

We recognise this is a different and substantial shift from how we deliver health care today. This will require commitment from all service providers - secondary care, mental health, community services and social care - to work together to ensure its success.

We need to continue to respond to the challenge we face and to evolve to deliver the best sustainable health care for the residents of Ealing.

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# 1. The case for improving out of hospital services

In this three-year strategy we set out our plans to transform out of hospital care in Ealing. We need to do this because population changes are increasing the demand on healthcare services and the resources available are not increasing at the same rate. As the population ages and the number of people with a long term conditions (LTCs) increases; the way we currently use hospital is becoming unsustainable.


Improving our out of hospital services will make care better and will cost less. By intervening earlier, joining up care better and supporting patients at home who are currently being admitted to hospital, we will be able to improve outcomes, and patient satisfaction while spending less. Better care, closer to home is our way to maintain the quality of care in the face of increasing demand and limited resources.

We need to change the way we deliver care. At present access to care and the quality of care are variable across the borough. Improving the access, quality and scope of out of hospital services will require new ways of coordinating services, investment and greater accountability. Exhibit 1 sets out reasons for transforming out of hospital care. Further details are found in NHS North West London’s *Shaping a Healthier Future* programme and in the appendix to this document.

## EXHIBIT 1

### There is a strong case for improving out of hospital services

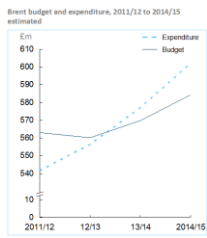
**1**



The residents of North West London have **changing health needs**, as people live longer and with more chronic and lifestyle diseases - putting pressure on social and community care.

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**2**



Under our current model of care, **we can't afford** to meet future demand. Hospital is too often seen as the answer and we need to have **more planned care, earlier**, outside of hospital.

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**3**



However, this needs a **transformation of primary, community and social care**. Currently there is variation in both **quality and access** and standards must improve.

## 2. Our vision of how care will be different

This section sets out our vision for how care will be different for patients in the future.

Our vision for out of hospital care is to work in partnership with patients, public, community and hospital clinicians and managers, out-of-hours services, social care and the voluntary sector to provide integrated care pathways for people with a LTC. This will include changing the way we fund healthcare services to ensure different providers work together better.

We have broken this vision down into five themes to describe how care will be different as shown in exhibit 2:

### EXHIBIT 2

#### We will achieve our vision through five strategic goals

	Ealing's five strategic goals	Specifically, this means
1	 <ul style="list-style-type: none"> <li>▪ <b>Easy access</b> to <b>high quality, responsive primary care</b> to make out of hospital care first point of call</li> </ul>	<ul style="list-style-type: none"> <li>▪ GPs and primary care teams will be at the heart of ensuring everyone who provides care does so to consistently high standards of care</li> </ul>
2	 <ul style="list-style-type: none"> <li>▪ <b>Clearly understood planned care pathways</b> that ensure out of hospital care is not delivered in a hospital setting</li> </ul>	<ul style="list-style-type: none"> <li>▪ Whenever possible, patients will have access to services closer to home</li> </ul>
3	 <ul style="list-style-type: none"> <li>▪ <b>Rapid response to urgent needs</b> so that fewer patients need to access hospital emergency care</li> </ul>	<ul style="list-style-type: none"> <li>▪ If a patient has an urgent need, a clinical response will be provided within 2 hours</li> </ul>
4	 <ul style="list-style-type: none"> <li>▪ <b>Providers (social and health) working together</b>, with the patient at the centre to proactively manage <b>long term conditions</b>, the <b>elderly and end of life care</b> out-of hospital</li> </ul>	<ul style="list-style-type: none"> <li>▪ Patients will have a named coordinator who will make sure they have all the services they need. If a patient's condition becomes more complex, GPs will be able to direct to a clinician with specialist skills close to home</li> </ul>
5	 <ul style="list-style-type: none"> <li>▪ <b>Appropriate time in hospital</b> when admitted, with <b>early supported discharge</b> into well organised community care</li> </ul>	<ul style="list-style-type: none"> <li>▪ Care providers will know when an individual patient is in hospital and will manage discharge into planned, supportive out of hospital care</li> </ul>



This vision builds on our aims set out in our commissioning intentions, as shown in Exhibit 3:

**EXHIBIT 3 – COMMISSIONING INTENTIONS AIMS**

**“Our vision is to commission and deliver the best healthcare in London”**

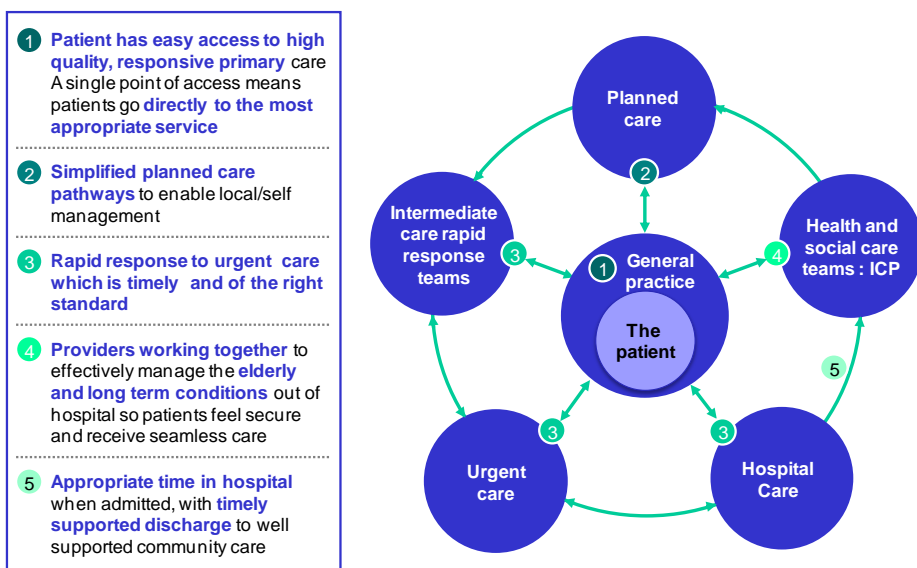
- Patients feel that they are at the heart of the system, and are confident that they're getting the best quality care.
- We enable all health professionals to do the best for their patients, thereby reducing health inequalities and improving health for all.

- We provide joined-up care for everyone who needs it – working together effectively with our patients and across different healthcare providers.
- We practise smart spending, with sound financial management that enables us to control our own destiny and ensure that the Ealing NHS survives and thrives.

We are seeking to deliver joined up care across health and social care in Ealing, with all services working together to provide the best possible care for patients as represented in Exhibit 4:

**EXHIBIT 4 – JOINED UP HEALTH AND SOCIAL CARE FOR EALING**

**Objective: Joined up care across health and social care in Ealing**



This section describes our vision for how care will be different for patients in the future in each of these five areas. In addition, section 2.1 sets out the out of hospital standards which apply to all out of hospital care and which will help us measure if the new approach is working. In section three we describe our initiatives to make these goals a reality, across the same five themes.

## **2.1. EASY ACCESS TO HIGH QUALITY RESPONSIVE PRIMARY CARE**

There is variation in the quality and access to primary care within Ealing and improving this is a local priority.

### **A. Access**

We are committed to improving access to primary care so it meets patients' expectations. Improving access will mean opening at convenient times, offering a wider-range of services and being located in the right places.

To provide access at convenient times means being open when people want to use services and managing demand at peak times. Out of hospital care will operate as a seven day a week service, with telephone advice and triage, like the Urgent Care Centre, available 24 hours a day, seven days a week. To improve access at peak times, we will work to develop a range of access routes into services as appropriate (for example, face-to-face, by telephone, by email, by SMS texting and by video consultation). Some of our practices already offer email consultations, or contact people by text and we will expand this for those patients who want this rather than more traditional consultations.

We will also improve access by offering a wider range of services out of hospital. For example, GPs, working with the Ealing Improving Access to Psychology Therapies (IAPT) service and working in the Integrated Care Pilot will be able to support more people with common mental illnesses such as depression and anxiety, as well as people with stable enduring mental illnesses, providing better access to care.

Access will also improve by locating care in the right place. More services, such as anticoagulation and spirometry will be delivered in practice networks meaning the service will be available to every patient locally.

### **B. Quality: Our out of hospital standards**

Improving quality will mean ensuring that care is being delivered to the right clinical standards, in good facilities. Improvements in facilities are described in section 5.1d: our standards to drive improved quality are set out below. Patients and the public need to be confident in the quality of care as we change where and how patients are cared for, so we have agreed to implement clinical standards for out of hospital care, which are set out in exhibit 5. Our intention is to deliver these over the next three years.

These standards emphasise that GPs will have a central role in the coordination and delivery of out of hospital care. The standards apply to both core primary care delivered by GP practices and more broadly to care delivered outside of hospital. They aim to shift care delivery from more reactive unplanned care to proactive planned care. Ealing Clinical Commissioning Group will ensure transparency of information in order to help raise standards of care: we will publish our progress on a regular basis so our patients can see how we are doing in achieving these standards.

The standards in Exhibit 5 below have been agreed across North West London and we will be seeking to implement them locally:

**EXHIBIT 5 – OUT OF HOSPITAL STANDARDS**

Domains	The standards are covered in four key domains
Individual Empowerment & Self Care	<ul style="list-style-type: none"> <li>▪ Individuals will be provided with up-to-date, evidence-based and accessible information to support them in taking personal responsibility when making decisions about their own health, care and wellbeing</li> </ul>
Access convenience and responsiveness	<ul style="list-style-type: none"> <li>▪ Individuals will have access to telephone advice and triage provided 24 hours a day, seven days a week. As a result of this triage:                             <ul style="list-style-type: none"> <li>▪ Cases assessed as urgent will be given a timed appointment or visit within 4 hours of the time of calling</li> <li>▪ For cases assessed as not urgent and that cannot be resolved by phone, individuals will be offered the choice of an appointment within 24 hours or an appointment to see a GP in their own practice within 48 hours</li> </ul> </li> </ul>
Care planning and multi-disciplinary care delivery	<ul style="list-style-type: none"> <li>▪ All individuals who would benefit from a care plan will have one</li> <li>▪ Everyone who has a care plan will have a named 'care coordinator' who will work with them to coordinate care across health and social care</li> <li>▪ GPs will work within multi-disciplinary groups to manage care delivery, incorporating input from primary, community, social care, mental health and specialists</li> </ul>
Information and communications	<ul style="list-style-type: none"> <li>▪ With the individual's consent, relevant information will be visible to health and care professionals involved in providing care</li> <li>▪ Any previous or planned contact with a healthcare professional should be visible to all relevant community health and care providers,</li> <li>▪ Following admission to hospital, the patient's GP and relevant providers will be actively involved in coordinating an individual's discharge plan</li> </ul>

**2.2. HIGH QUALITY PLANNED CARE**

An increasing number of patients will be seen in community facilities so they do not have to travel to hospital for outpatients, underpinned by robust and clear care pathways. For example, ophthalmology (eye) patients can now use a consultant led service at Grand Union Village Health Centre and Hanwell Health Centre. In addition, we are currently discussing with local GPs how the increasing number of patients who need warfarin can be seen in local practices. Our survey of patients told us that patients needing this service preferred going to local services, rather than having to go to hospital. New care pathways offering an increasing range of outpatient provision in the community will include ECG (heart tests), blood tests and spirometry (lung function test) services.

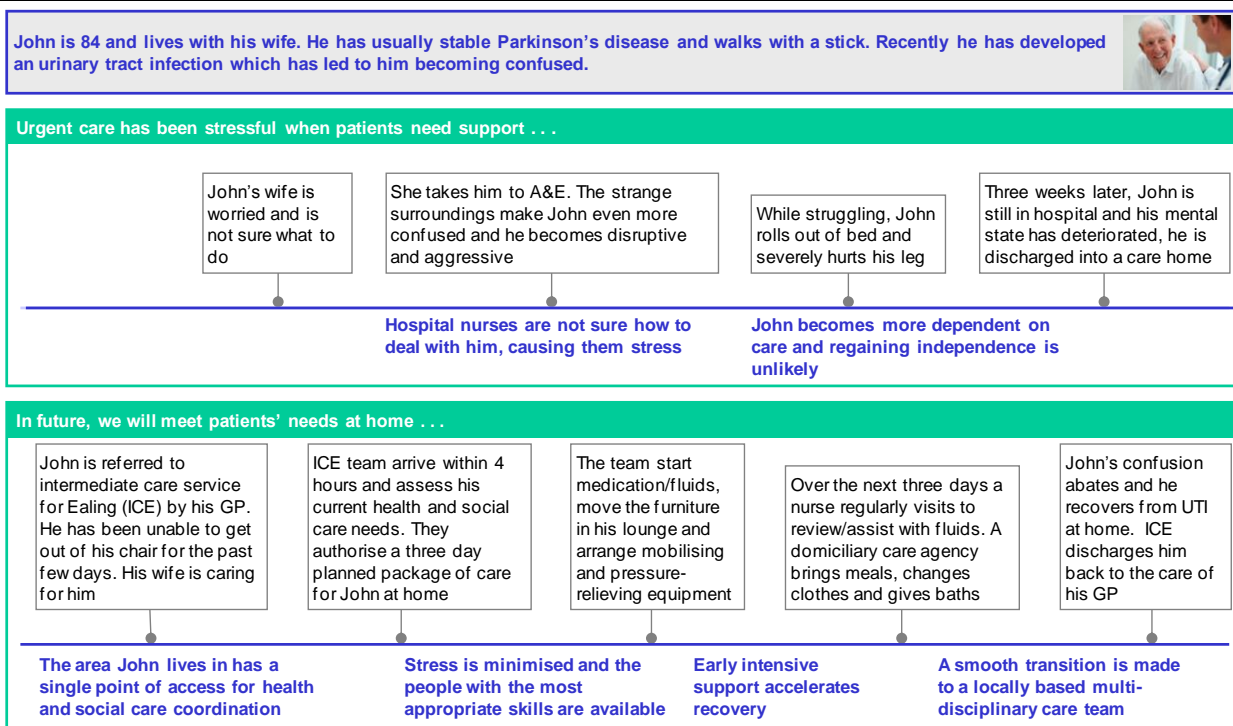
Care pathways are becoming more consistent and efficient as a result of our Referral Facilitation Service (RFS). Through this service significantly more patients are referred directly to the most appropriate clinician first time. We expect this to improve further over time. With the new technology we are rolling out patients can expect that clinicians, with the patient's consent will be able to share and access patient information with other health care professionals who are involved in providing care to the patient. This will mean that previous or planned contact with a healthcare professional should be visible to all relevant community health care providers, resulting in better informed care, reduced duplication and improved patient satisfaction with the care offered.

### 2.3. RESPONSIVE URGENT CARE

In future, more patients will be supported at home by our rapid community response service (intermediate care) which most patients prefer instead of having to go to hospital. Any individual who is clinically assessed to be at risk of an emergency admission to hospital, which could be prevented, will be visited by the rapid response team, within four hours, depending on their clinical urgency. Packages of care to support people in their own home will typically be delivered by experienced community nurses, therapy staff and supported by Ealing’s Reablement Team. If necessary, patients will be able to access an inpatient rapid response facility, such as Magnolia ward. Some patients will also be supported to return home from A&E by our rapid response service as an alternative to being admitted to hospital. Mental health patients will be provided with additional support by our Mental Health Crisis Resolution Team, which aims to support people with severe and enduring mental health problems to stay out of hospital.

Exhibit 6 sets out an example of how improved rapid response will change patients’ experiences:

#### EXHIBIT 6



### 2.4. HEALTH AND SOCIAL CARE PROVIDERS WORKING TOGETHER TO DELIVER THE BEST CARE FOR PATIENTS

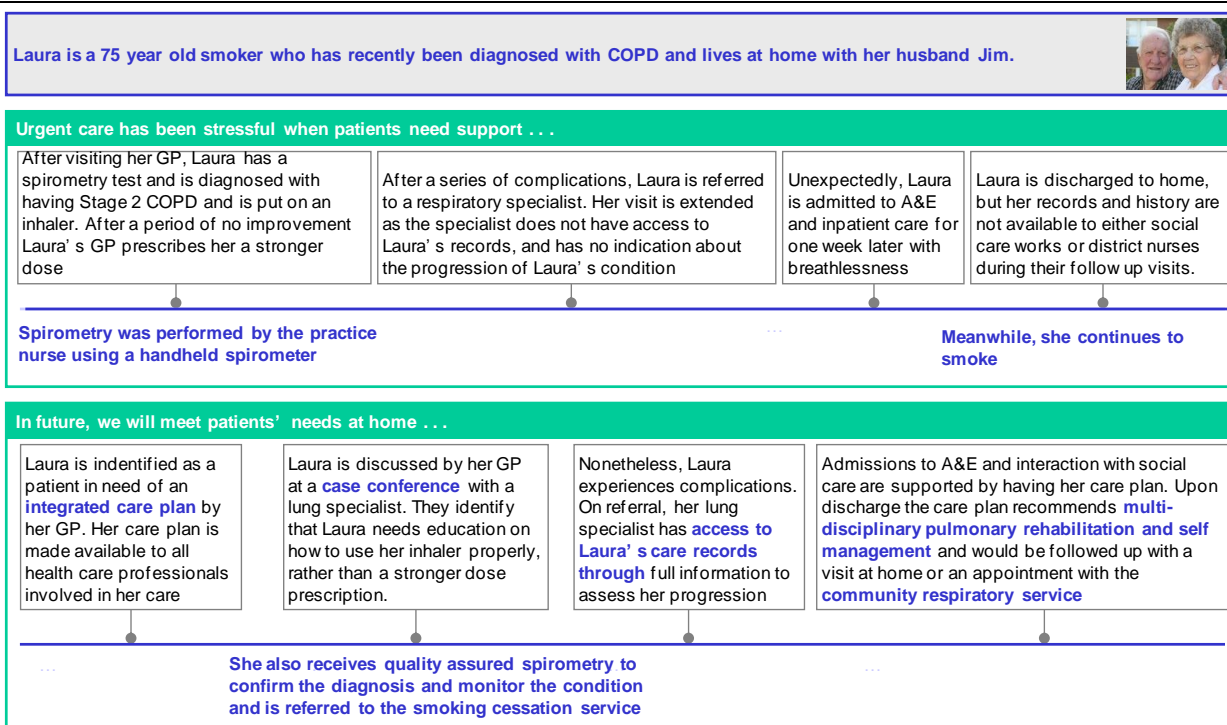
We want Ealing residents using community health and care to experience coordinated, seamless and integrated services using evidence-based care pathways, case management and personalised care planning. All patients will benefit from the greater coordination between services we are developing in local healthcare networks. Some examples of more joined up care patients will receive in future are set out below:

Patients with diabetes and older people will have a care plan, which will be developed jointly with a clinician and their carer to ensure that all parts of their care, including social care are coordinated. Care plans will help people stay well, avoiding a worsening of their condition and in knowing what to do if they see existing problems re-starting it. Additional information on this can be found in Section 3.

The most vulnerable sick children and elderly patients in nursing homes will also benefit from our two new specialist teams. For children there will be a community nursing service with close links Social Services and schools. This will seek to provide proactive care helping children with illnesses such as cancer stay at home and children with long term conditions, such as diabetes, to stay well. Nursing home residents in all of the borough's 22 nursing homes will benefit from a new service involving GPs, pharmacists and nurses that will support them and work with nursing home staff to deliver the best care. Additional information on both these schemes can be found in Section 3.

Exhibit 7 sets out an example of how improved working together will change patients' experiences:

EXHIBIT 7



**2.5 SUPPORTED DISCHARGE**

In future, following admission to hospital the patient's GP and relevant providers will be actively involved in coordinating an individual's discharge plan to meet on-going or continuing care needs. As a result we expect there will be fewer people staying in hospital longer than they need or wish to, due to lack of adequate support for discharge.

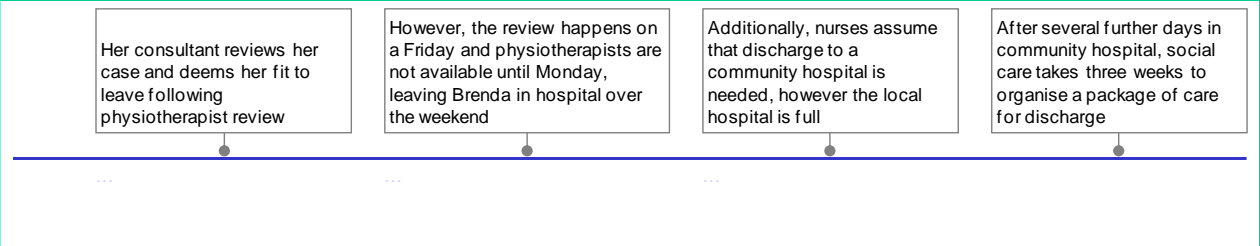
Exhibit 8 sets out an example of how better supported discharge will change patients' experiences:

EXHIBIT 8

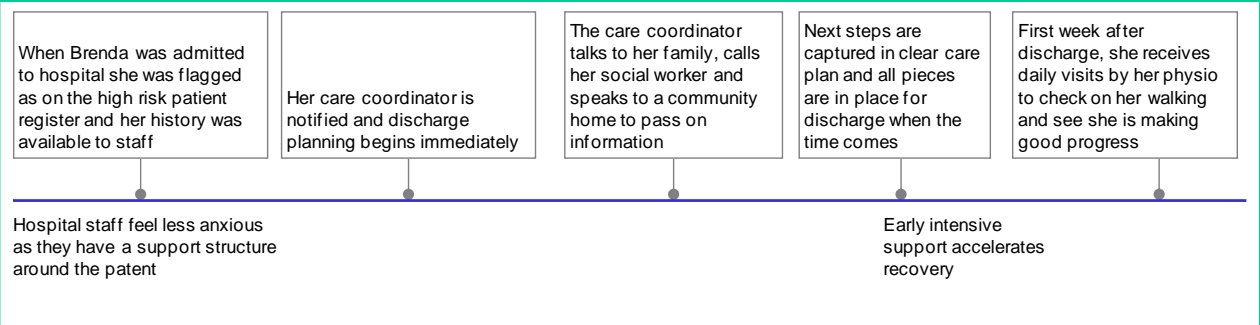
Brenda is 79. She is a complex elderly patient with both diabetes and COPD. She has recently fallen, fractured her hip and been admitted to hospital, where she has had an operation and is soon ready to go home.



Urgent care has been stressful when patients need support . . .



In future, we will meet patients' needs at home . . .



### 3. How we will deliver better care, closer to home

This section describes what we are doing to make our vision a reality in each of the five areas described in section 2.


Some of these initiatives are already successfully in place in Ealing, and others are new for our borough, including several organised at a wider level, for example, NHS 111 and the North West London Integrated Care Pilot. Our initiatives for improving out of hospital care are set out in exhibit 9:

EXHIBIT 9

Ealing's population will have:
1A Initiative described in this section

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1




**Easy access to high quality, responsive primary care to make out of hospital care first point of call for people with urgent, but not life threatening, needs**

- 1A We are working with primary care to form into health networks to improve access and quality and deliver care closer to home
- 1B The 111 pilot in Ealing will provide a single point of access for patients, carers and clinicians to access the appropriate level of care
- 1C The existing urgent care centre at Ealing Hospital will provide a primary care alternative to A&E for observation, diagnostics and treatment.
- 1D Developing practice based mental health teams will improve access to primary care for mental health patients

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2




**Clearly understood planned care pathways that ensure out of hospital care is not delivered in a hospital setting**

- 2A The referral facilitation service will ensure all patient referrals are directed to the most appropriate clinician and everyone has the same access to the care available
- 2B Some outpatient and elective procedures will be moved out of hospital into a community setting

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3




**Rapid response to urgent needs so that fewer patients need to access hospital emergency care**

- 3A The rapid response team is available with a broader scope and skillset, for example, in reach into hospitals to prevent avoidable admissions and keep people at home where possible or to provide emergency respite care where necessary
  - Everyone – patients, carers and clinicians – knows about the alternatives to hospital or know to contact 111 for advice. This is particularly important for some groups of patients including nursing home residents, dementia patients, people recently discharged from hospital and those at the end of their lives

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4




**Integrated care with providers (social and health) working together – with the patient at the centre – to proactively manage long term conditions and other at risk groups:**

- 4A There will be six multidisciplinary groups across Ealing who will work together to identify and review patients at risk of becoming ill. Initially this will focus on diabetic patients and the over 75s.
- 4B Active case management for high-risk children and in nursing home
  - Specialised care management plan for end of life patients, coordinated by the district nurses with specialist training.

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5



**Appropriate time in hospital when admitted, with early supported discharge into well organised community care:**

- 5A Establishing a psychiatric liaison service at Ealing Hospital will facilitate smooth discharge out of hospital care for mental health patients

### **3.1. EASY ACCESS TO HIGH QUALITY RESPONSIVE PRIMARY CARE**

#### **3.1A: Developing Primary Care**

- We will work with primary care to organise into health networks of 50,000 - 70,000 patients to improve access and quality and deliver care closer to home.
- We will work with practices to embed a system of peer review built around strengthening joint working and sharing of data on prescribing and activity, in order to reduce variance and to share skills and resources.
- We will review the appropriateness of practice opening times, the quality of our facilities and explore new ways of triage and communicating by making better use of the latest technology, for example, Tele-health.
- We will support collaboration to increase the capacity and quality in primary care and will build the right incentives to ensure general practice is actively involved and is driving forward service improvement and development.

#### **3.1B: 111 Pilot**

- The 111 pilot in Ealing will provide a single point of access for patients, clinicians and the wider public to access the appropriate level of care.
- By January 2013 the CCG working closely with colleagues in Harrow, Brent and Hounslow will establish a Borough-wide 111 service with 1 provider across all 4 boroughs.
- The service will use a local directory of services, which we are currently developing, to direct people to a range of clinically appropriate services
- Call handlers will be able to book appointments at the Urgent Care Centre and at your GP practice

#### **3.1C: Ealing Urgent Care Centre**

- The existing urgent care centre at Ealing Hospital provides a 24 hour primary care alternative to A&E for observation, diagnostics and treatment of minor illness and minor injuries.
- £3 million is being invested in the Urgent Care Centre. It provides an alternative to A&E for those people with more minor illness or injury.
- The centre is also aiming to reduce total urgent attendances by 5% a year through better access to primary care and patient education.
- Since it opened in July 2011 the service has already seen over 42,000 people and in its first year we estimate it will see up to 50,000 people. We have plans to expand this to see up to about 70,000 people a year.



## **3.2. HIGH QUALITY PLANNED CARE**

### **3.2A: Referral Facilitation Service (RFS)**

- Our redesigned Referral Facilitation Service will ensure all outpatient referrals are directed to the most appropriate clinician first time thereby reducing duplication and unnecessary costly appointments.

### **3.2B: Outpatients appointments in the community**

- New treatment pathways will increase the number of outpatient appointments that take place outside a hospital setting. Care will be delivered by consultants or, in the case of certain musculoskeletal services, physiotherapists. The services we will focus on initially will include an anticoagulation service, a pulmonary rehabilitation service for patients with chronic obstructive pulmonary disease and community diabetes, musculoskeletal and ophthalmology services. These will be delivered in community facilities.
- We are currently advertising for organisations to express an interest in providing a pulmonary rehabilitation service. We expect the new service to be in place from November 2012.
- We are working with practices to agree how they will provide anti-coagulation services in each network. The new capacity should be in place by July 2012 and will be for those on warfarin and for those needing to start it
- In conjunction with Macmillan Cancer Relief and Ealing Integrated Care Organisation (ICO) we are launching a pilot scheme which will better coordinate and manage the care of patients who have had cancer. More people are now surviving cancer and we need to provide more help and support outside of hospital to make sure they keep well and that we spot any reoccurrences early.
- As part of our planning for 2013/14 we are developing plans to increase the number of services available in the community so we will see more patients with heart and lung diseases seen in the community. We are starting to plan in our initiatives for the next two years and we will be able to share more details by the end of July 2012.

## **3.3. RESPONSIVE URGENT CARE**

### **3.3A: Rapid response admission avoidance (to be known as ICE – Integrated Care Ealing)**

- We are developing a rapid response team with a broader scope and skill set, including in reach into A&E departments to prevent avoidable admissions and keep people at home where possible and clinically safe. ICE will start to operate in the new model from June 2012 and will be fully operational by November 2012.
- Our rapid response team will be multi-disciplinary, including hospital consultants, GPs, social care, occupational therapists, physiotherapists, nurses and mental health professionals.

- They will provide timely assessments and will be able to organise care packages to keep people out of hospital. Assessment will occur within 4 hours and where necessary will be followed by intensive intervention for up to 72 hours and/or on-going rehabilitation and reablement for up to 6 weeks.
- Care packages will include nurses and therapy staff visiting people in their own homes, or community beds (Magnolia ward) with 24/7 nursing care. The rapid response team should prevent around 4,000 emergency hospital admissions each year.
- A similar but smaller service focusing on providing rapid support for patients at the end of their life has recently been set up. This service is accessible to patients who have a palliative or end of life care plan and is designed to help patients and their families or carers to avoid an unnecessary hospital admission, wherever patients choose to end their life in their own home or usual place of residence.

### **3.4. HEALTH AND SOCIAL CARE PROVIDERS WORKING TOGETHER TO DELIVER THE BEST CARE FOR PATIENTS**

#### **3.4A: Roll out the Integrated Care Pilot across Ealing**

- We are establishing six healthcare networks across Ealing, including one which has already started to function in Acton. Clinicians in each network will work together to identify and review patients at risk of becoming ill. Initially their focus will be on diabetic patients, patients with chronic obstructive airways disease and older people. This is a roll out of the pilot already taking place in Acton and develops the model used successfully in Inner North West London.
- GPs will use specialist I.T tools to identify the patients who are at highest risk of unplanned admission to hospital and who could benefit from more proactive care.
- Care plans will be developed with the patient and carer (where appropriate), ensuring all the services that the patient is assessed as needing are working together.
- Case conferences will bring together hospital specialists, GPs, community health providers, social workers, mental health specialists and others to discuss how best to manage the care of complex patients. Case conferences will also further develop clinicians' knowledge of conditions and the roles other services can play.
- Since many people with long term conditions also have mental health problems such as depression, mental health specialists will play a central role in the programme so that patients receive better coordinated care.

#### **3.4B: Active case management for sick children and elderly patients in nursing homes**

- In addition, two multi-disciplinary teams are being established to provide case management for these two vulnerable groups. The children's nursing team will support children at home as described in section two and will work closely with schools, social care and acute hospitals to ensure all aspects of their care is well coordinated.

- Secondly, the nursing home team will comprise GPs, pharmacists and nurses and will provide specialist medical services for patients living in any of the 23 nursing homes within the borough of Ealing. This service will be tailored to meet particular needs of elderly patients who live in nursing homes through good care coordination, including good end-of-life- care planning. This service will be in place by the end of 2012.

## **3.5. SUPPORTED DISCHARGE**

### **3.5A Supported discharge**

- We will ensure that the work of the community services which we commission and the efforts of Ealing Social Services and of voluntary sector organisations are aligned to the efforts of acute hospitals to reduce un-necessary delays in hospital discharge once patients are ready to return home. We will achieve this by requiring our community services to develop integrated teams and joint working protocols with the main acute hospitals and with Ealing Social Services.

### **3.5B Establish a psychiatric liaison service at Ealing Hospital**

- The psychiatric liaison service was set up in March 2012 to provide care for patients with significant mental health needs in acute settings (outside specialist mental health units), train other hospital staff to enable them to support patients' mental health needs and provide integration with other parts of the health system including GPs
- The service will improve coordination with out of hospital care providers and housing services, meaning a higher proportion of patients can be discharged directly to their own homes
- The service is being piloted for three months but we anticipate that funding will continue for this service which is provided by West London Mental Health Trust (WLMHT) at Ealing Hospital.

## 4. How we will work together

To achieve our vision will require new ways of working in Ealing. There are a number of aspects to consider as set out in Exhibit 10.

A further key part of how we work together will be empowering patients and carers as described in section 5.1.

### EXHIBIT 10

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#### How we will work together

- 1 We will work in new **local healthcare networks** based on patient populations in order to:
  - a Better co-ordinate the provision of care
  - b Deliver services
  - c Develop our workforce
  - d Develop our estates

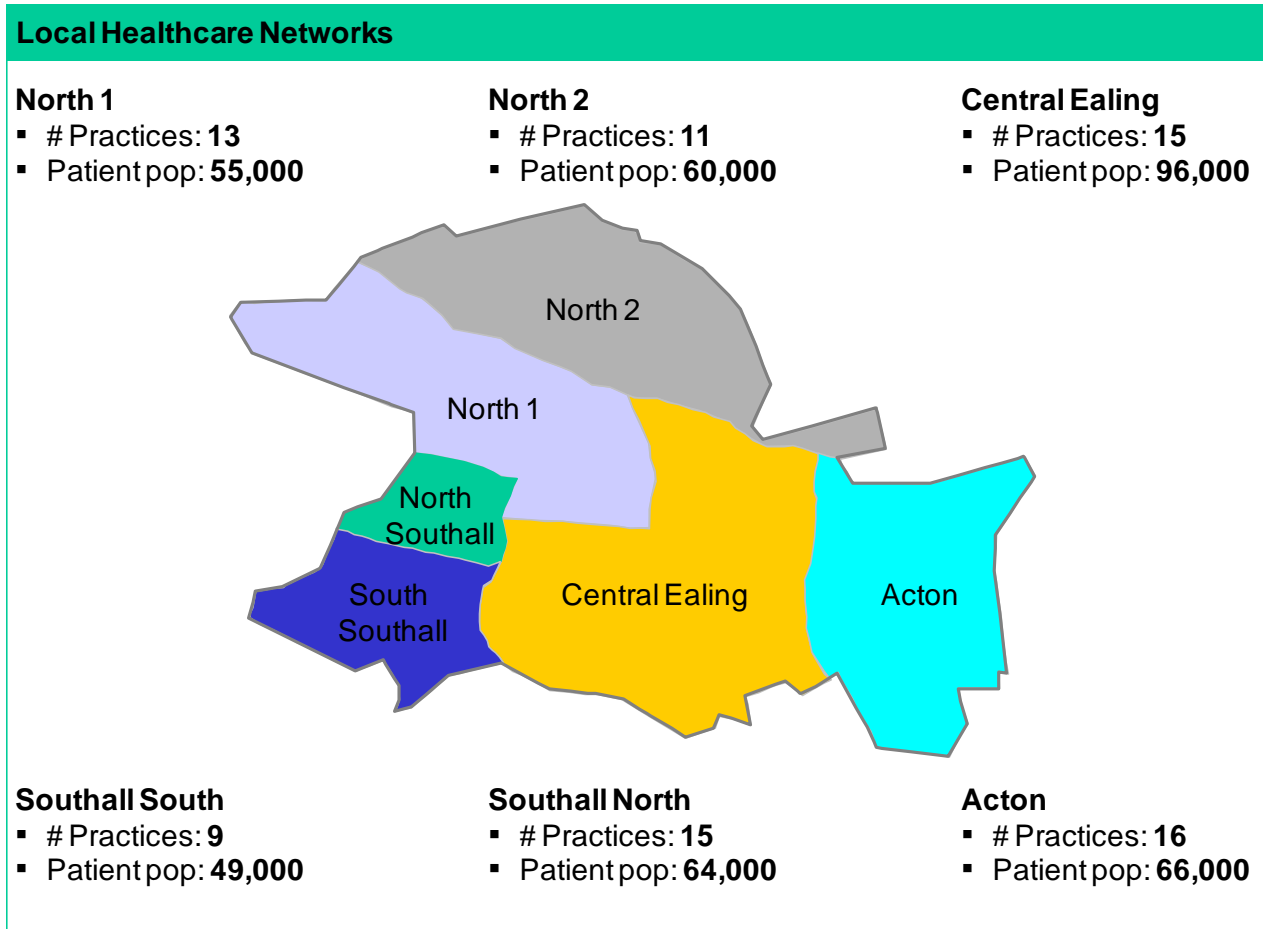
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- 2 To support this collaborative working, the CCG is setting out how it will **cooperate with its partners** in social care and the voluntary sector to deliver care to the people of Ealing

#### 4.1. WORKING IN NEW HEALTHCARE NETWORKS

In order to deliver our out of hospital strategy we are forming healthcare networks, which are based on patient populations of 50,000 – 70,000. These will involve GPs in a geographical area working together to coordinate care, deliver services and develop our workforce. Our proposed local healthcare networks are set out in exhibit 11:

EXHIBIT 11



**A. Coordinating care**

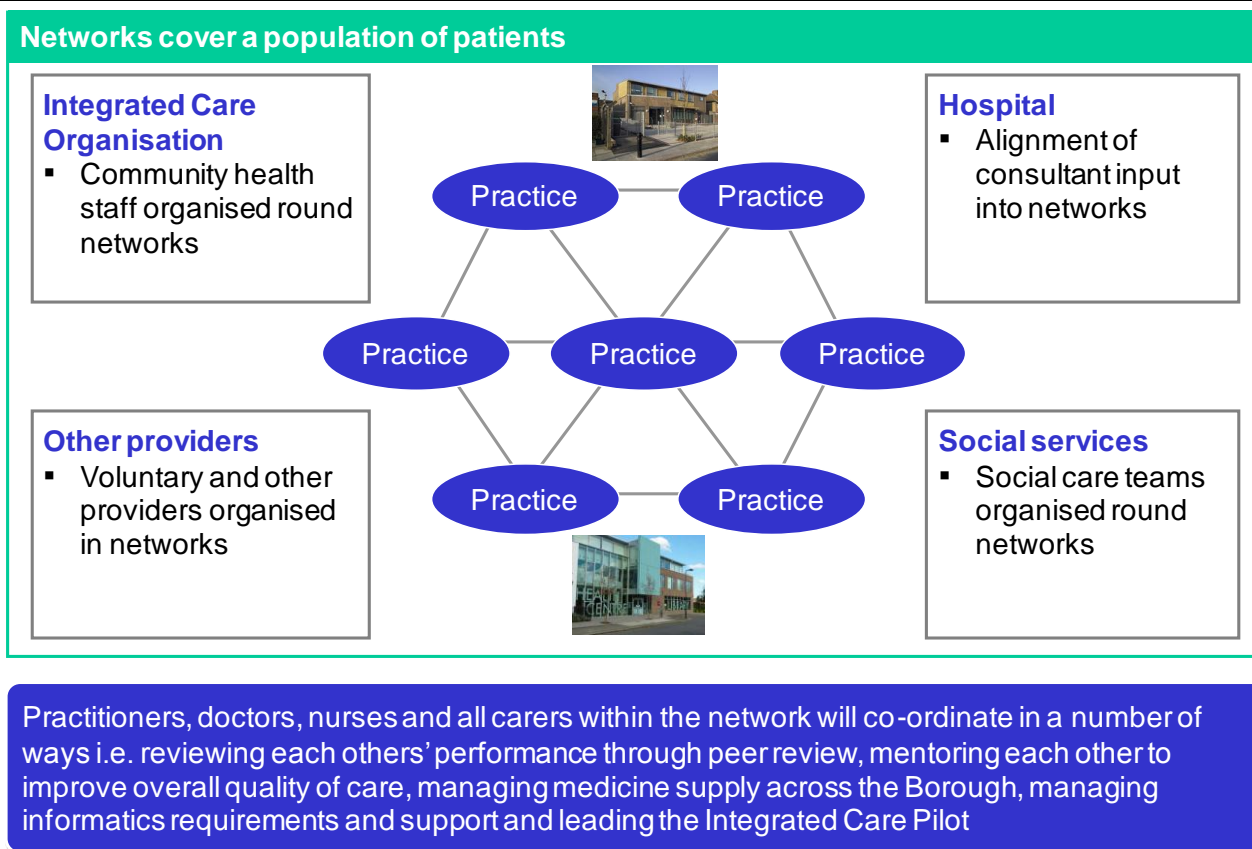
Patients receive better care when the different clinicians providing care are working closely together. However, we cannot afford to have specialist nurses, community matrons and other healthcare professionals working in every practice. By forming healthcare networks we can enable clinicians to work together more closely. In order to do this, we are geographically aligning health and social care services round patient populations of 50,000 – 70,000.

As part of the Integrated Care Pilot, GPs from every participating practice, acute consultants, social workers and district nurses, practice nurse and mental health nurse representatives will discuss agreed patient case management in multi-disciplinary case conferences. Initially, these will focus on patients with diabetes, mental health and care for the elderly, to be extended to COPD (chronic obstructive pulmonary disease) and CHD (coronary heart disease) and other long term conditions, as described in section three.

Health networks will also improve the coordination of care through the alignment of services. Community and social services will align their services to work within health networks as set out in exhibit 12. For example, in each health network, there will be a member of the district nursing team leading community nurses within the health network, who will work with the GP

chair of the multi-disciplinary group to ensure effective working between district nursing and general practice within the network.

EXHIBIT 12



As well as developing the way we coordinate services locally, we are improving the ways we share learning between different areas, so that each healthcare network can benefit from best practice elsewhere. The integrated care pilot puts in place a structure which sets out how each multi-disciplinary group interacts with the supporting teams at a borough and North West London wide level. This means that clinicians have local organisational support allowing them to focus on patient care. In addition, GP leaders of local groups will share what is working well in their healthcare network so the most effective local innovations spread.

**B Delivering Services**

Healthcare networks will offer services that can be delivered in GP surgeries or network hubs, but which are not necessarily provided by all GP surgeries. Examples of services offered within the networks will be anticoagulation, heart tests such as ECGs, ambulatory blood pressure monitoring and spirometry.

Working as healthcare networks will increase the capacity of clinicians to invest and innovate to meet local health needs. As part of the integrated care pilot, an innovation fund is available, which healthcare networks will be able to use to meet local health needs. For example, in the Acton area the healthcare network has employed a specialist diabetic nurse

to meet a need identified through multi-disciplinary group discussions. Practices could also work together to improve access, for example, by coordinating extended opening hours or emergency appointment availability across the network.

### **C Developing our workforce**

Healthcare networks provide an opportunity for our workforce to develop, through participating in multi-disciplinary groups, through peer review and through localised support. Offering the opportunity to discuss the care of a patient with a consultant psychiatrist and diabetic specialist consultant gives clinicians the opportunity to develop their own knowledge and their ability to treat conditions.

Peer reviews within practices in healthcare networks will review information such as attendances of their patients in A&E, inpatient admissions, referrals for different conditions and mental health activity, providing clinicians with opportunities to learn from each other and develop plans to improve quality.

Healthcare networks will be supported by the CCG through access to financial planning, analysis of activity data, informatics, data management and medicine management and the support of a network manager.

### **D Developing our estates**

Our plans to move care out of hospital and into community settings will mean continual improvement and development of our facilities. We will make the best use of existing infrastructure including the use of Ealing Hospital, which will continue to provide an essential element of our out of hospital strategy given its central location and excellent transport links. This will take the strategic use of capital. As we develop local infrastructure of clinical expertise, different healthcare networks will choose to deliver services in different ways. For example, in some networks every practice may deliver anticoagulation, while in another this may be concentrated in a few hubs.

Our initial strategy is to ensure there is a hub offering extended opening hours and a range of services within each local healthcare network. Exhibit 13 provides extended services that will be delivered in each of these hubs, examples of further services that will be located in some hubs but not others and the criteria we will use to decide where different services will be located.



EXHIBIT 13

**We will use a range of criteria to decide which services to locate at hubs within local healthcare networks**

Each of our hubs will deliver extended services

Services at all local network hubs
<ul style="list-style-type: none"> <li>▪ GP practice</li> <li>▪ Extended hours</li> <li>▪ Diagnostics</li> <li>▪ Base for local healthcare network</li> </ul>

Examples of services that could be located in hubs

Further services that could potentially be delivered at hubs
<ul style="list-style-type: none"> <li>▪ Community outpatients – cardiology, respiratory, MSK, dermatology, diabetes, paediatrics</li> <li>▪ Community health services: district nursing, community matrons</li> <li>▪ Additional capacity for care planning</li> <li>▪ Staff coordinating health and social care (not a current Ealing initiative but an option for future)</li> <li>▪ Non-clinical space and meeting rooms</li> </ul>

The services offered will be based on a range of criteria

<p><b>Scale of activities</b> How many hubs can be supported economically?</p> <p><b>Clinical effectiveness</b> What number of hubs make sense for the number of clinical specialty appointments?</p> <p><b>Patient convenience</b> Which configuration of hubs covers an area in walking distance?</p> <p><b>Estates availability</b> Which locations can we use (pragmatically)?</p>
--

Hubs already exist at Grand Union, Jubilee Gardens, Featherstone Road Clinics and Hillview Surgery. We are planning to invest in enhancing services at Acton Health Centre, Mattock Lane Health Centre and Featherstone Road, as well as linking with Harrow CCG for the joint use of Alexandra Avenue Clinic which is very accessible for residents of North Northolt.

By August 2012 we aim to have confirmed the location of a hub within each local healthcare network and detailed the services to be located (locations and service offerings at different locations are still under discussion). Exhibit 14 outlines potential hubs in each network and summaries the services offered at that location at present.

EXHIBIT 14

**Each network will have a hub that will offer additional services**

**Location of hubs and current services offered at these locations**

**1 North 1: Grand Union Village<sup>1</sup>**

- ✓ 1,500m<sup>2</sup>
- Open 12 hours / day, 7 day/week
- Simple diagnostics
- Advanced community health services with a focus on children's and sexual health services
- 3 GP practices (list size 8,900)

**2 North 2: Hillview Surgery<sup>2</sup>**

- ✓ GP practice (list size 9,400)

**3 Central Ealing: Mattock Lane Health Centre**

- 👷 850 m<sup>2</sup>
- 2 GP practices (list size 14,200)

**4 Southall 1: Jubilee Gardens**

- ✓ 1,250 m<sup>2</sup>
- 2 GP practices (list size 10,700)
- Community health services

**5 Southall 2: Featherstone Road**

- ✓ 600 m<sup>2</sup>
- GP practice
- Open 12 hours / day, 7 day/week

**6 Acton: Acton Health Centre**

- 👷 1,000 m<sup>2</sup>
- Community health services

**Ealing Hospital and Urgent Care Centre**

✓ Already operating as local hub  
👷 Planned further investment

1 Areas given are net internal area  
2 Alexandra Avenue in Harrow is also a possible site for a hub for North 2

**4.2. WORKING WITH OUR PARTNERS TO DELIVER BETTER CARE**

To meet our goal of coordinated care for the residents of Ealing, the Ealing Clinical Commissioning Group commits to working closely with our partners. For example:

**A. Hospital Providers**

- We are working with several acute providers and our neighbouring Commissioning Groups to ensure the needs of Ealing residents are a core component of local hospital provision and continue to be so, whatever the outcome of the potential merger of Ealing & North West London Hospitals NHS Trusts and the reconfiguration programme currently being developed.
- We are working with all Commissioning Groups in Northwest London, to commission specialist services from our acute hospitals (e.g. specialist cancer care and renal services).
- We also work with acute hospitals to manage a shift in service provision from acute setting into the community, which allow hospital consultants to run clinics in community

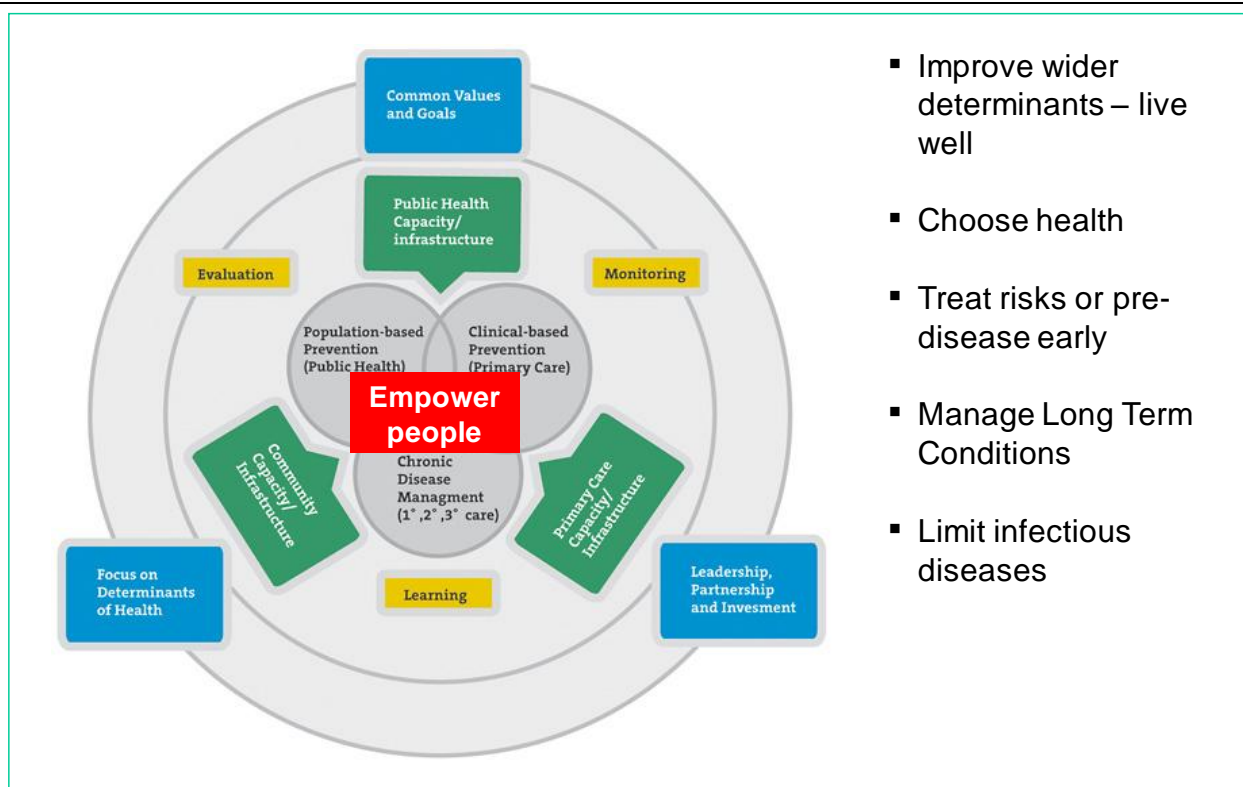
facilities (for example the provision of consultant-led diabetic outpatient appointments in the community).

## B. Ealing Health and Wellbeing Board (HWBB)

Under the leadership of the HWBB a joint prevention strategy is being developed and will be ready by August 2012.

- The HWBB will provide guidance for our commissioning by describing how we will be more pro-active in preventing illness and reducing the impact and burden of diseases. For example it will describe plans to increase the number of people helped to stop smoking, increase the number of NHS health checks, tackle obesity locally and increase the uptake of screening e.g. to identify bowel, breast and cervical cancers early so treatment can be provided.
- The HWBB will also give strategic direction to how the CCG and Ealing Council work together to prevent ill health. They will build on our Public Health Strategy, which is set out in Exhibit 15:

### EXHIBIT 15



SOURCE: LB Ealing Public Health, adapted from Canadian Public Health Association

At the heart of this strategy is the coordinated multi-agency support for local residents to understand the factors that impact on their health and to help them to take actions that help them stay healthy or manage their condition with confidence in a way that allows them to live independent and fulfilling lives.

## **C London Borough of Ealing**

- NHS Ealing and Ealing Social Services have a well-established joint commissioning function. This covers the commissioning of services where a common strategy and approach is required across a range of local services (e.g. young people, mental health, care of the elderly, physical disabilities and learning disabilities). The work of each of these areas is overseen and coordinated by specialist boards which in turn feeds into and supports the overall strategy of the Health and Wellbeing Board.
- A key area of joint work with Ealing Social Services is the development of common response to technology enabled care (Tele-care and Tele-health). This relates to technology that supports the delivery of health and social care and promotes independence. Following a successful evaluation of the impact of Tele-health technology for patients with COPD and heart failure in 2011, we will develop a strategy for Tele-health and Tele-care, which will set out our aspirations and approach to rolling out technology as a means of supporting better health and social care in 2012. Our strategy will build on the work the Council are already doing, e.g. in supporting people with dementia to live at home.
- Another important area of collaboration is our Falls Strategy, which we are currently updating to have a specific focus on helping those at risk of falls and fragility fractures. Our strategy will support those at risk of falls to improve their physical health, prevent or minimise the harm suffered if they fall and help them to continue to live independently.
- We are increasing the amount of money we spend on equipment to use at home, for example for specialist beds and hoists. We are doing this both through specific schemes such as ICE and through the general equipment service, which is largely managed by social care and community nurses and therapists.
- We are currently developing a joint strategy on dementia services involving London Borough of Ealing as well as partners in the voluntary sector, carers etc. This will be ready by June 2012 and will support the out of hospital care strategy by enhancing services provided in the community such as memory clinics as well as support for people with dementia to stay in their own homes. A major focus of the work is on better supporting carers as we recognise this is currently a gap.

## **D Ealing's Voluntary Sector**

- In 2012/13, jointly with Ealing Social Service, we spent nearly £3 million on funding voluntary sector organizations to support over 60 projects covering advice, information and advocacy services, respite, day opportunities, counselling and health promotion services.
- Funding priorities are informed by the Joint Strategic Needs Assessment and Ealing's shared commissioning outline for Independent Health and Well Being.
- Provision is designed to complement statutory services in particular focussing on prevention, early intervention, re-ablement, access to services and building connections in the community that help vulnerable people stay well. The voluntary sector has an important role in supporting community based provision and therefore is key to the Out of Hospital Strategy.

## 5. Supporting the change

We have identified five key enablers for better care, closer to home as set out in Exhibit 16:

EXHIBIT 16

To be successful we need to...	Requirements
<p>1 Engage patients and carers </p>	<ul style="list-style-type: none"> <li>Inform patients, listen to them and act on their input</li> <li>Engage GPs, community and hospital providers and other stakeholders to ensure buy-in and commitment to shared solutions</li> </ul>
<p>2 Develop our people and our organisation </p>	<ul style="list-style-type: none"> <li>Develop behaviours to work effectively together</li> <li>Communicate using face to face, email, SMS and other methods</li> </ul>
<p>3 Agree on how we will be governed </p>	<ul style="list-style-type: none"> <li>Commit to common set of clinical standards and process of monitoring and variance management</li> <li>Assign roles and responsibilities</li> <li>Create development plan to ensure consistency and clarity on our accountabilities</li> </ul>
<p>4 Put in place the right information tools </p>	<ul style="list-style-type: none"> <li>Unified IT systems providing shared records, leading to better patient care and transparency on performance</li> </ul>
<p>5 Develop the right contracts and incentives </p>	<ul style="list-style-type: none"> <li>Align contracts and incentives for all providers, to ensure delivery of care to appropriate clinical standards</li> </ul>

### 5.1. ENGAGEMENT WITH PATIENTS AND CARERS

Engagement with patients and carers is essential to deliver improvements to services. In our Engagement Strategy we set out in more detail how we will improve in this area.

Exhibit 17 shows our new commitments to patients on how their views will inform decision-making and how they will be kept informed about changes we are making:

EXHIBIT 17

Our commitment	How we'll deliver
<p><b>You'll be involved</b></p>	<ul style="list-style-type: none"> <li>▪ Patients will be represented on key committees and project teams involved with service redesign</li> <li>▪ Every network will have a patient group supported by LINK / Health Watch and other partners</li> <li>▪ Care plans will be co-developed with you</li> </ul>
<p><b>You'll be informed</b></p>	<ul style="list-style-type: none"> <li>▪ We'll set out the standards we are aiming for and report to you how the CCG, localities and individual practices / care providers are performing against them</li> <li>▪ We'll explain what is changing, why it is changing, and how your input shaped decisions using clear concise language</li> <li>▪ We will make sure that communication across health and social care are clearly understood by you and your carers</li> </ul>
<p><b>Your input will shape services</b></p>	<ul style="list-style-type: none"> <li>▪ We will hold events to consult on key issues, such as commissioning intentions and our Out of Hospital strategy</li> <li>▪ We will work with the widest possible range of health service users, by working with LINK, Health Watch and the voluntary sector to get input from difficult to reach groups</li> <li>▪ We will use nationally and locally collected patient experience data to inform decision making</li> <li>▪ We will commission services which provide evidence of listening to service users' views</li> </ul>

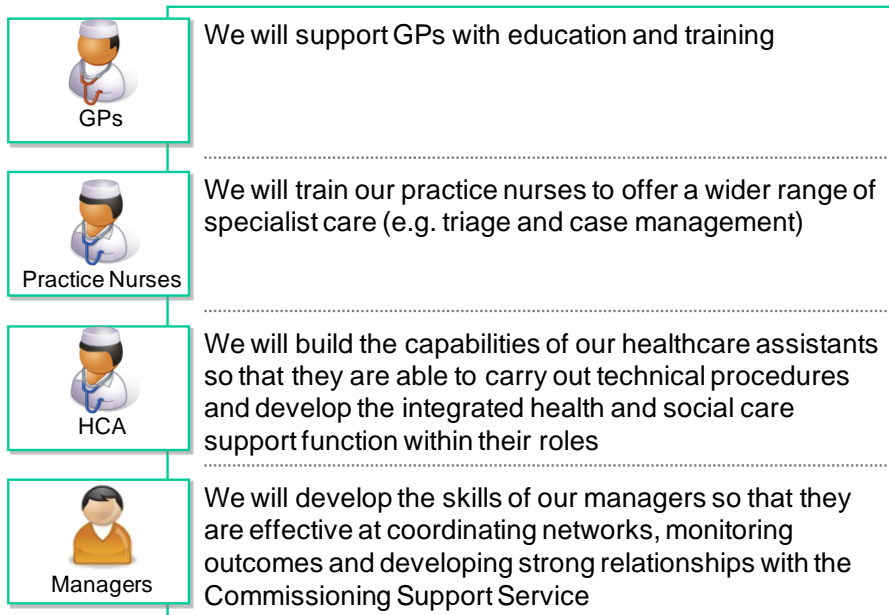


**5.2. DEVELOPING OUR PEOPLE AND ORGANISATION**

This strategy requires primary care teams to take on new and exciting roles. To allow this happen, we need to develop our member practices through closer team-working within networks and sessions focussed on learning, development, team working etc. within the new networks. Leadership and management training will be provided to facilitate the development of a range of formal and informal leaders within networks. Support with information technology skills will also be made available.

Development will also be tailored to professionals' needs; some examples are set out in exhibit 18:

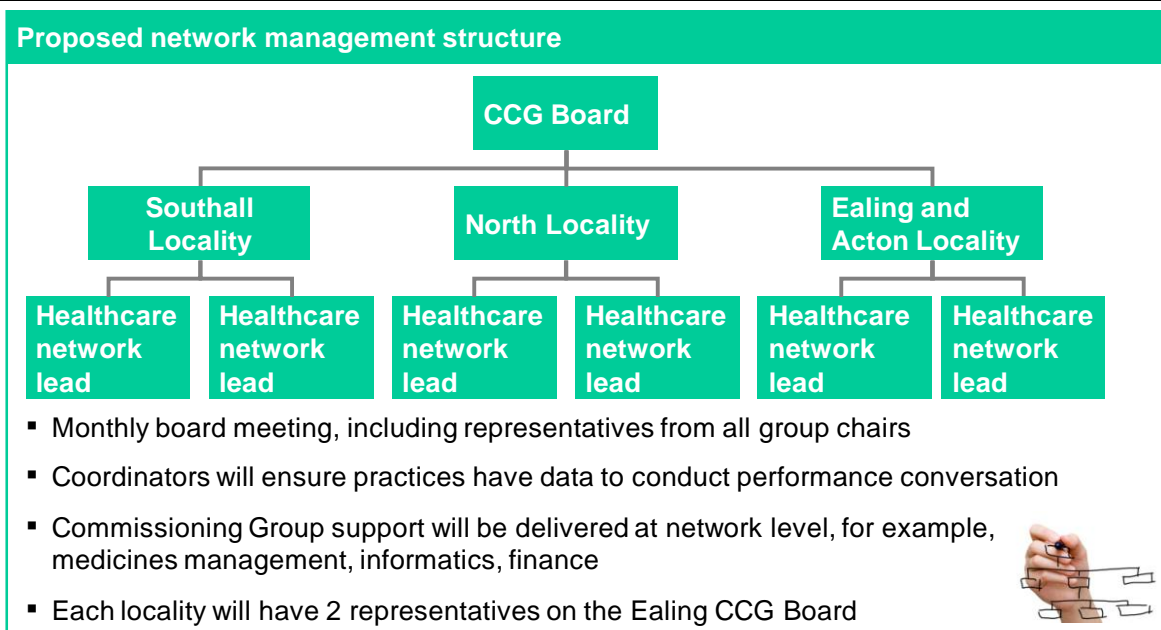
EXHIBIT 18



**5.3. GOVERNANCE AND VARIANCE MANAGEMENT**

There will be a clear governance structure which will have the CCG board underpinned by the six networks (see Exhibit 19):

EXHIBIT 19



Ealing CCG will also put in place ways of working together to ensure patients see the benefits of changes in how care is delivered. To achieve this, we will develop a performance framework based on the steps set out in exhibit 20:

**EXHIBIT 20 – OUR ASPIRATIONAL PERFORMANCE FRAMEWORK FOR ALL SERVICE PROVIDERS**



This will build on current work practices are doing to work together to peer review against benchmarked information e.g. prescribing and emergency admissions. We will define the process, but typically it could be on a monthly basis for key metrics such as data on prescribing. Indicators will look both at a practice’s performance on its key primary care activity, but also how it is doing in reducing emergency admissions, outpatient referrals and A&E attendances.

**5.4. INFORMATION TOOLS**

We aspire to have real-time shared records across GPs, community, acute and mental health teams. We have already started to develop an information management strategy to support and enable the delivery of more care out of hospital. We expect to have this completed by summer 2012.

The benefits we hope to realise by more effective information sharing are set out in Exhibit 21 below:



EXHIBIT 21

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**What better information sharing will achieve**






1. Better clinical decisions can be made with the better information a real-time electronic record can provide shared between GPs/Community and Secondary care clinicians.
2. Transparency of information gathered will help us drive up standards across Ealing
3. Planned care becomes more consistent as
  - Sharing of data allows better evaluation of GPs use of planned care, supporting a better referral facilitation service
  - GPs have access to granular reporting on referrals
4. Urgent care becomes better informed as
  - Relevant information input by GP is visible to staff at UCC
  - Care is visible to GP and prompts are given for follow-up actions
5. Long term care becomes more pro-active through
  - Risk stratification of patients by GPs
  - Care plans being put in place
  - Enabling regular check ups and early intervention
  - Decrease repetitive investigation and prescribing

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**5.5. CONTRACTS, INCENTIVES AND PAYMENTS**

As we introduce new services and new ways of working, we need to ensure that the contracts and incentives that we have in place will support this and reinforce the behaviours we want to see. Exhibit 22 shows our five key goals the targets that we will set for each and the new types of contracts, incentives and behaviours that will align with these.

EXHIBIT 22

	<u>Target</u>	<u>Behaviors this will require</u>	<u>Re-imbursement to support this</u>
 <p><b>Easy access to high quality, responsive care</b></p>	<ul style="list-style-type: none"> <li>Improve access</li> <li>Improve satisfaction</li> </ul>	<ul style="list-style-type: none"> <li>Meeting minimum primary care requirements</li> </ul>	<ul style="list-style-type: none"> <li>Incentives for delivery</li> </ul>
 <p><b>Simplified planned care pathways</b></p>	<ul style="list-style-type: none"> <li>Reduce Outpatient attendances</li> <li>Elective admissions</li> </ul>	<ul style="list-style-type: none"> <li>Peer review/referral management system</li> <li>Inter-practice referrals</li> </ul>	<ul style="list-style-type: none"> <li>Referral management scheme</li> <li>Shared incentives across network to reach targets</li> </ul>
 <p><b>Rapid response to urgent needs</b></p>	<ul style="list-style-type: none"> <li>Reduce A&amp;E attendances</li> <li>Improve reliability</li> </ul>	<ul style="list-style-type: none"> <li>111, UCC, extended hours</li> <li>Walk-in centres</li> </ul>	<ul style="list-style-type: none"> <li>Robust contracts with UCC, rapid response and extended hours</li> </ul>
 <p><b>Integrated care for LTC and elderly</b></p>	<ul style="list-style-type: none"> <li>Reduce NEL admissions</li> <li>Increase integration</li> <li>Increase proactive care</li> </ul>	<ul style="list-style-type: none"> <li>Coordination ratings</li> <li>Care plans</li> </ul>	<ul style="list-style-type: none"> <li>Payments for care plans</li> <li>Payments for clinicians to attend case conference</li> <li>Shared incentives across providers to reach targets</li> </ul>
 <p><b>Appropriate time in hospital</b></p>	<ul style="list-style-type: none"> <li>Reduce length of stay</li> </ul>	<ul style="list-style-type: none"> <li>Discharge coordinator</li> <li>Co-ordination with social care</li> <li>Rapid response</li> </ul>	<ul style="list-style-type: none"> <li>Contracting with social care, discharge coordinator and rapid response teams</li> </ul>

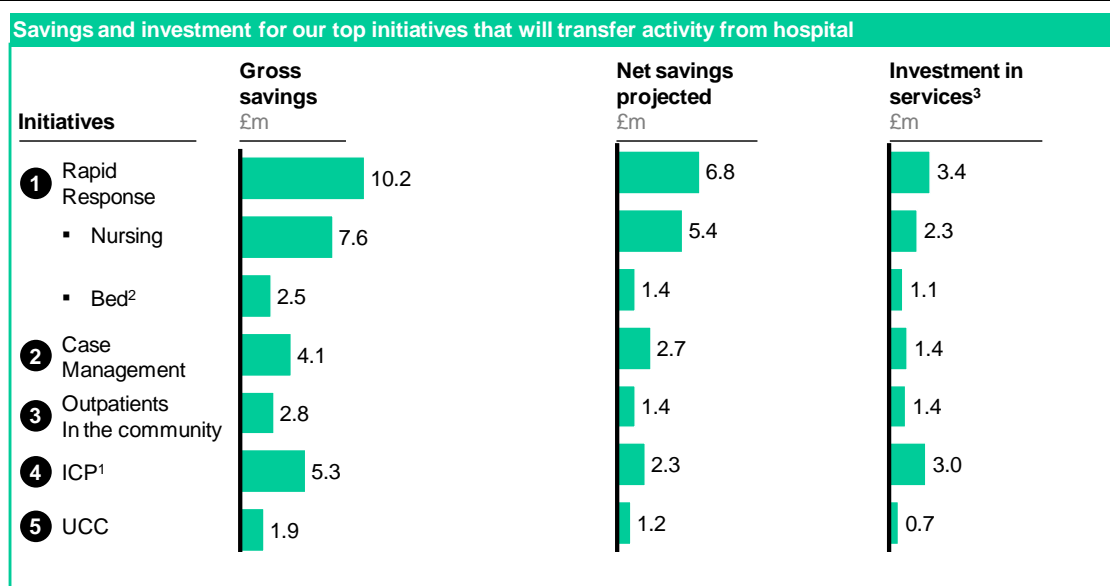
## 6. Investing for the future

This section summarises investment we anticipate making to achieve realise our strategy. We break this down by investment needed to reduce activity in hospital, investment in different settings of care and the workforce implications of our strategy.

### 6.1. INVESTING IN OUT OF HOSPITAL CARE

This strategy has started to set out our vision for a fundamentally different model of care. As we reconfigure the hospital landscape we will invest in out of hospital care. Exhibit 23 outlines our projected savings and investment for our main initiatives. These investments are recurrent costs of running the services. In addition to this, we will have to develop separate plans for capital expenditure where development of our estates is required and for funding the transition to out of hospital care, including development of our IT and organisational development. We also know that we will have to fund the additional costs of more people in the community e.g. needing equipment, drugs etc.

EXHIBIT 23



1 Based on Outer NWL ICP strategy drafted March 2012. Includes investment spend on initiatives with no out-of-hospital activity implication

2 Could be virtual beds

3 In addition to this, there is additional investment of ~£0.7m which do not expand resources (e.g. referral standardisation)

The major investment that will be made is in employing additional clinicians out of hospital to deliver these initiatives. These may come from the existing out of hospital workforce, if efficiency savings are made elsewhere, from the acute sector or may be additional roles. The types of staff delivering each initiative are set out below:

EXHIBIT 24

Initiative	Who'll do it	What they'll do	
<b>1</b> Rapid Response			
▪ Nursing	▪ Nurses, healthcare assistants and allied healthcare professionals under consultant leadership	▪ Support patients stay at home instead of needing to be admitted to hospital	▪ None (delivered at patients' homes)
▪ Bed	▪ A nursing team	▪ Provide step-up care in a community facility such as Clayponds	▪ 890
<b>2</b> Case Management	▪ Nurses and allied health professionals	▪ Support patients who frequently need hospital to manage their health	▪ None (delivered at patients' homes)
<b>3</b> Outpatients In the community	▪ GPs and consultants	▪ Provide outpatient appointments in community facilities	▪ 180
<b>4</b> ICP <sup>1</sup>	▪ GPs, consultants, nurses and allied health professionals	▪ Care planning, case conferences and performance reviews	▪ 300
<b>5</b> UCC	▪ Consultants, GPs and nurses	▪ Provide urgent care for minor illnesses and injuries	▪ No additional space

<sup>1</sup> Investment in estates is not included in calculation of investment above



SOURCE: Ealing – DSU Team

These initiatives will take place at peoples home and in primary care facilities. Some initiatives, such as the ICP will take across GP practices. Others, such as outpatients at in the community are will be concentrated in to a smaller number of community facilities. The numbers on the additional workforce are current estimates based will be refined and may change significantly as we produce detailed business plans.

EXHIBIT 25:

**We have made an initial forecast of the staff it would require to deliver this**

**Investment by 2015<sup>1,2</sup>**

Where you will receive care <sup>3</sup>	Services offered	Additional Investment	Additional space	Additional workforce
<b>At Home<sup>2</sup></b> 	<ul style="list-style-type: none"> <li>▪ Community care</li> <li>▪ Elderly care</li> <li>▪ Admission Avoidance</li> </ul>	<ul style="list-style-type: none"> <li>▪ £4.5-5.0m</li> </ul>	<ul style="list-style-type: none"> <li>▪ Access to consulting rooms/team room</li> </ul>	<ul style="list-style-type: none"> <li>▪ 75 – 80 WTE</li> </ul>
<b>In primary care</b> 	<ul style="list-style-type: none"> <li>▪ nGMS plus extended hours</li> <li>▪ Core primary care services</li> <li>▪ ECG, possibly ultrasound</li> <li>▪ Rapid access to various diagnostic tests</li> <li>▪ Rapid access referral to hub/hospital</li> </ul>	<ul style="list-style-type: none"> <li>▪ £4.5-5.5m</li> </ul>	<ul style="list-style-type: none"> <li>▪ 1,350-1.450m<sup>2</sup></li> <li>▪ &lt;10 consulting rooms</li> <li>▪ Team rooms</li> <li>▪ &lt;20 beds</li> </ul>	<ul style="list-style-type: none"> <li>▪ 50 – 55 WTE</li> </ul>
<b>TOTAL</b>		<b>£9-11m</b>		

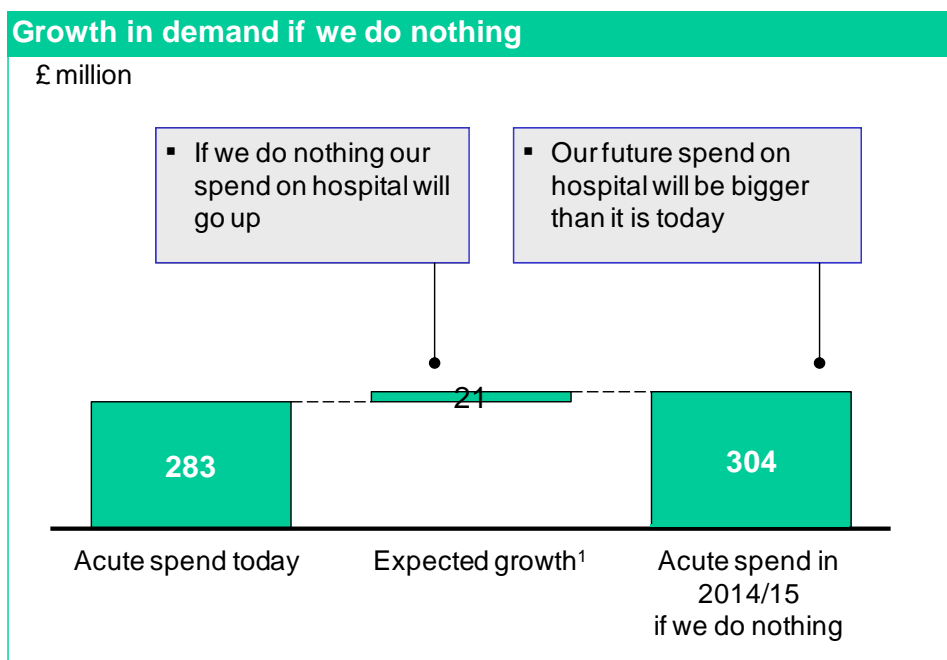
1 Based on bottom up calculation of saving initiatives. Each initiative build on granular assumptions: e.g. "Outpatient at lower cost" initiative assumes re-provision cost of 0.8 GP appointment of 12 minutes & 0.2 Consultant appointment of 30 minutes per patient per year for 5% of total outpatient cohort  
 2 Assumptions based on pilots outcome of Brent Intermediate Care 2009 and Harrow Unplanned Care Initiatives 2011, QIPP 11/12 business cases, Healthcare for London, CCG input and expert interviews  
 3 Initiatives includes: "At Home" - e.g. Rapid Response (Nursing), Case Management, ICP; "AT a GP Practice" - e.g. Outpatient at lower cost, ICP; "In a community health centre" - e.g. Rapid Response (Bed), Outpatient at lower cost, Outpatient at lower cost (telephone advice), ICP  
 SOURCE: NHS NWL Team; Commissioning Service Plan, 1st December 2011, QIPP plans 15th December 2011, QIPP revision, Healthcare for London; HES; CCG input and expert interviews

The staffing and investment identified in the figure above is indicative based on CCG strategic plans and is dependent on the release of funding from acute providers as activity transfers from acute settings to community settings. Specific investments will be agreed through the normal planning and governance processes of the CCG and as such the production and agreement of robust business cases demonstrating both value for money and affordability to the CCG.

The reductions in acute activity planned by the CCG are consistent with and reflected in the acute PCBC base case modelling.

These initiatives will deliver the acute savings we need to make to meet rising demand with limited resources. As shown by exhibit 26, if we do nothing, our spending on acute services will go up.

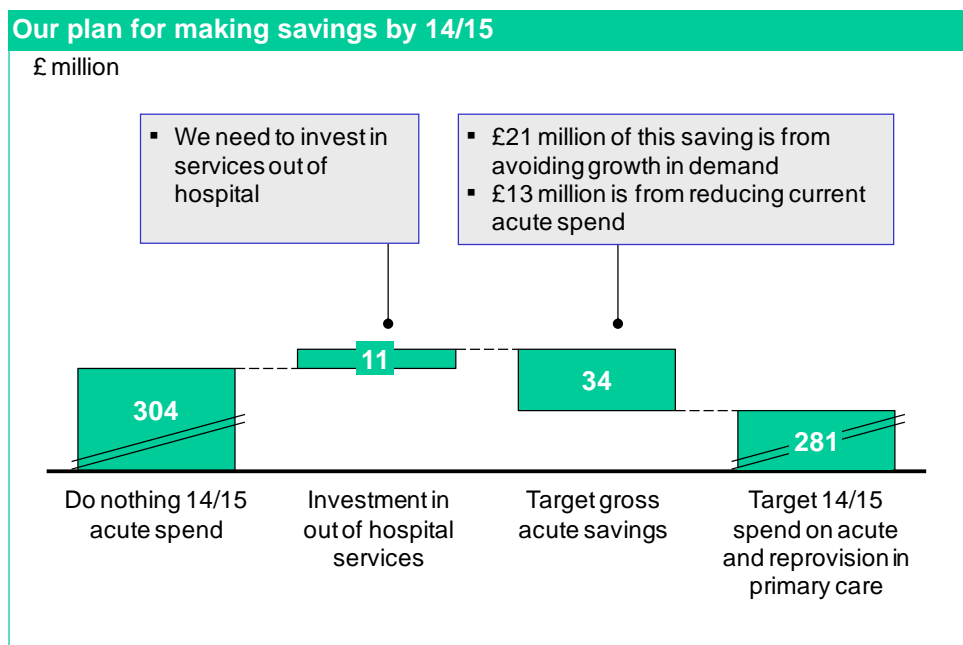
EXHIBIT 26:



<sup>1</sup> From 2011/12 – 2014/15  
SOURCE: Ealing CSP

The savings identified in exhibit 23 will come from both preventing demand on hospital going up and reducing the current level of spending, as shown by exhibit 27.

EXHIBIT 27:



SOURCE: Ealing CSP

## 7. Next steps

In this strategy we have set out an ambitious vision for transforming out of hospital care in Ealing. We need to move quickly to implementation in order to make early improvements for patients and to make the scale of the savings that are needed by 2014/15. In this section we outline timelines for delivering elements of the strategy.

### 7.1. IMMEDIATE STEPS

Our immediate steps focus on sharing the strategy with our partners and getting their endorsement, then developing our internal structures to deliver the strategy. Exhibit 28 summarises the immediate next steps we will take:

#### EXHIBIT 28

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Crucial step
1 <b>12/13 budget is set</b> in line with strategy
2 <b>Strategy is endorsed</b> by: <ul style="list-style-type: none"><li>Health and Wellbeing board</li><li>CCG board</li><li>All practices</li></ul>
3 <b>Performance framework is agreed</b> by CCG (including metrics, targets, thresholds and escalation process)
4 Appropriate <b>governance structures</b> in place for <b>managing performance</b>
5 <b>Capabilities are in place</b> to deliver strategy including <ul style="list-style-type: none"><li>Management support in CCG</li><li>CSS support</li><li>New workforce required to deliver service</li></ul>

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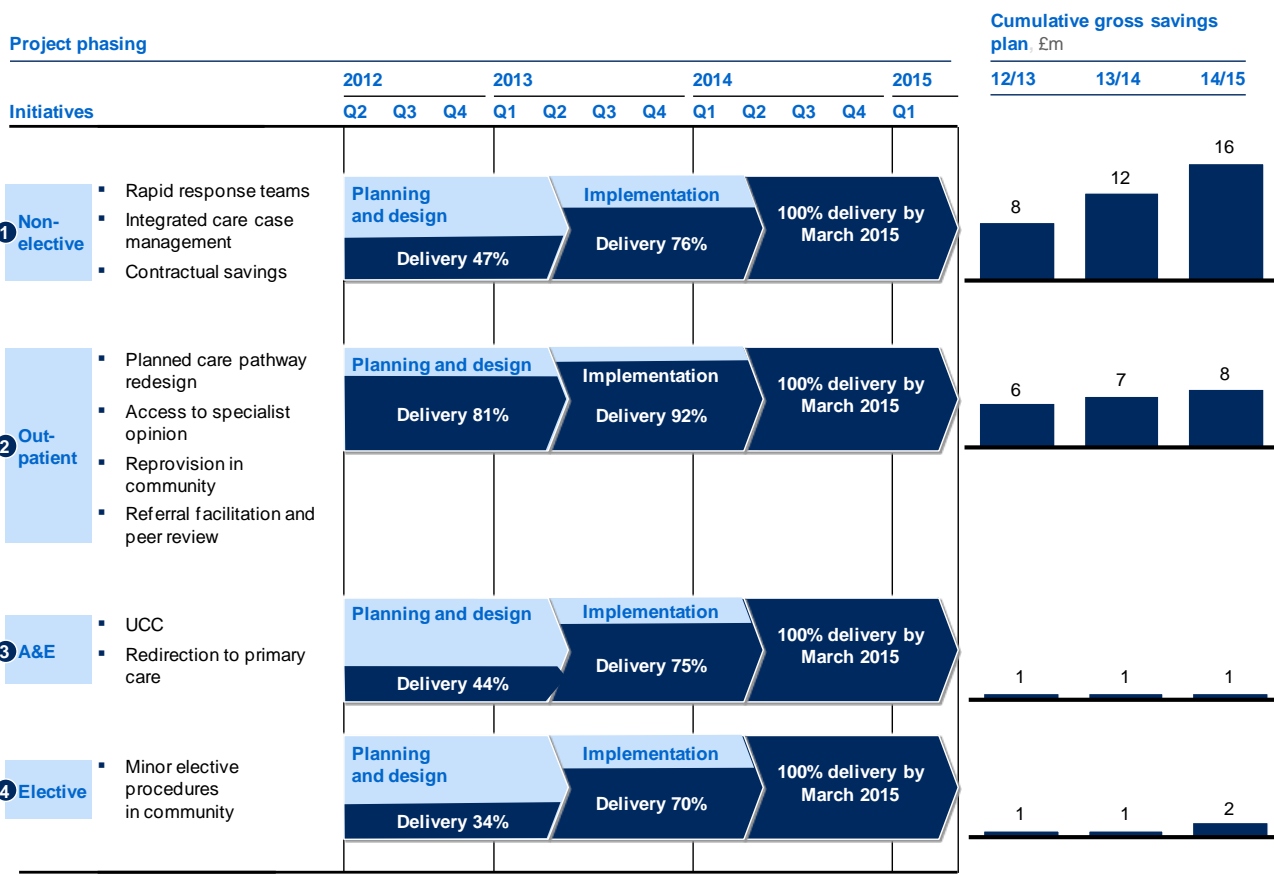
### 7.2. IMPLEMENTING OUR KEY INITIATIVES

As we have described work has already started on developing business cases for some the initiatives in this strategy. These will include detailing the investment required, how costs will be covered, the impact that will be achieved - qualitative and quantitative - and will include mapping other activities that may overlap.

Each scheme is at a different stage, for example, the extended Intermediate Care Service will be in place from July, community ophthalmology service is already in place and seeing people.

Exhibit 29 sets out the timelines for the schemes we have agreed so far that will be in place during this year. Services start operating during the implementation stage and during the ramp-up stage are having an increasing impact on reducing demand on hospital services. During the steady state stage they will continue to have an impact on demands placed on hospital but this impact is no longer increasing.

EXHIBIT 29



SOURCE: Commissioning Service Plan, 1st December 2011, QIPP plans 15th December 2011, QIPP revision; NHS DSU; CCG finance teams



### 7.3. IMPLEMENTING OUR SUPPORT FOR CHANGE

Work on the those things that will enable us to make our strategy happen - patient involvement and communication, governance, contracts and incentives, information technology and professional development - will also take place in parallel with the creation of business cases for the new initiatives. Exhibit 28 outlines our timeline for implementing key changes to support our strategy.

EXHIBIT 30

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Revised picture under  
construction by the DSU

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