Appendix 1

Bromley CCG Winter Resilience Scheme Review 2018/19

1. BACKGROUND:

For Winter 2018/19, Bromley CCG commissioned several Resilience Schemes aiming to provide additional capacity across a range of community services. This included increased primary care capacity through additional GP appointments, an advanced nurse practitioner home visiting service and a multidisciplinary Bromley @Home Team was piloted to prevent avoidable admissions from the community and facilitate earlier discharges from the hospital. An additional nurse post was implemented for Extra Care Housing units to support proactive and clinical management of patients to reduce LAS call outs. There was also increased capacity commissioned across urgent care centres and a performance matron post within the hospital to support patient flow.

2. OUTLINE OF BROMLEY CCG WINTER PRESSURE SCHEMES AND SPEND

Bromley CCG Winter Schemes (Total Budget £646k)			
Lead Organisation	**Scheme Title**	**Scheme Description**	**Cost**
Bromley Healthcare	Bromley @Home Service	Integration of existing health and social care admission avoidance provision with enhances primary care, end of life and mental health cover to provide a hospital @ home model of care to prevent escalation of need and avoid admission/attendance	£205,788
Bromley Healthcare	Nursing Support for ECH	Providing proactive support and clinical management to providers with the highest LAS call out rate	£46,969
Greenbrooks	Additional HCAs	Additional HCA cover in both UTC sites to improve productivity and increase capacity	£32,928
Greenbrooks	Christmas / New Year GP Rota Fill	Provide enhanced rates for hard to fill and last minute sessions to match other local sessional work available.	£16,000
Greenbrooks	Patient Champion extended to 7 days per week	Extend existing 5 day per week patient champion roll to 7 day service	£18,702
CCG CHC	Enhanced community support for temporary health conditions	Providing additional resource to support more people to be discharged with temporary health conditions that do not meet the threshold for CHC funding	£100,000
BGPA	Additional hub appointments	Providing additional hub appointments during key pressure times	£51,243

Total Spend			£638,666
BGPA	GPOOH over Christmas and New Year GPOOH resilience	Additional capacity for GPOOH over Christmas and and New Year period where previous years' there had been an surge in demand.	£13,838
BHC	Home visiting service	Provide healthcare professional support (including ANPs) to undertake GP home visits, reducing demand on GP call out	£128,411
KCH	Performance Matron	Responsible for the management of the patient pathways, supporting the clinical site manager and clinical staff to optimise patient flow.	£23,776
CCG	Winter Communications	Flu Advertising Campaign - Digital and Leaflets	£1,012

3. REVIEW OF SCHEMES - Highlights

Bromley @Home Service

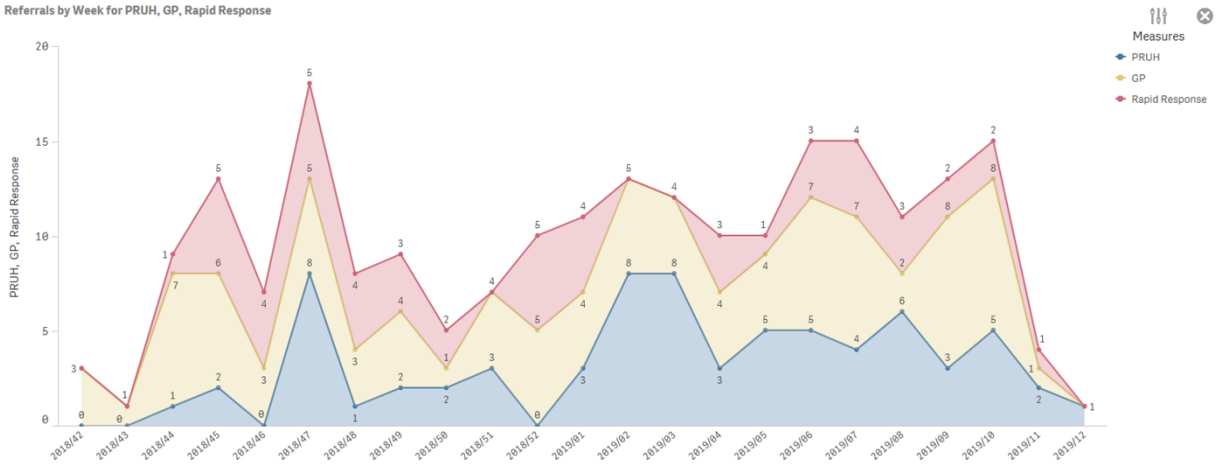
The @home service is now coming close to the end of the pilot phase. The service has been in operation since 16/10/18 and is comprised of ANP and HCA support 7 days a week, with input from therapists Monday to Friday. In addition the service utilises the D2A GPs to assist in identifying patients in the hospital. The development of the role of the GP has not been as successful as anticipated as the current scope is limited and various contractual and indemnity issues need resolving. This will be reviewed in future development of this service.

The service has the dual aims of admission avoidance and supported discharge for patients who no longer need the level of care offered in hospital.

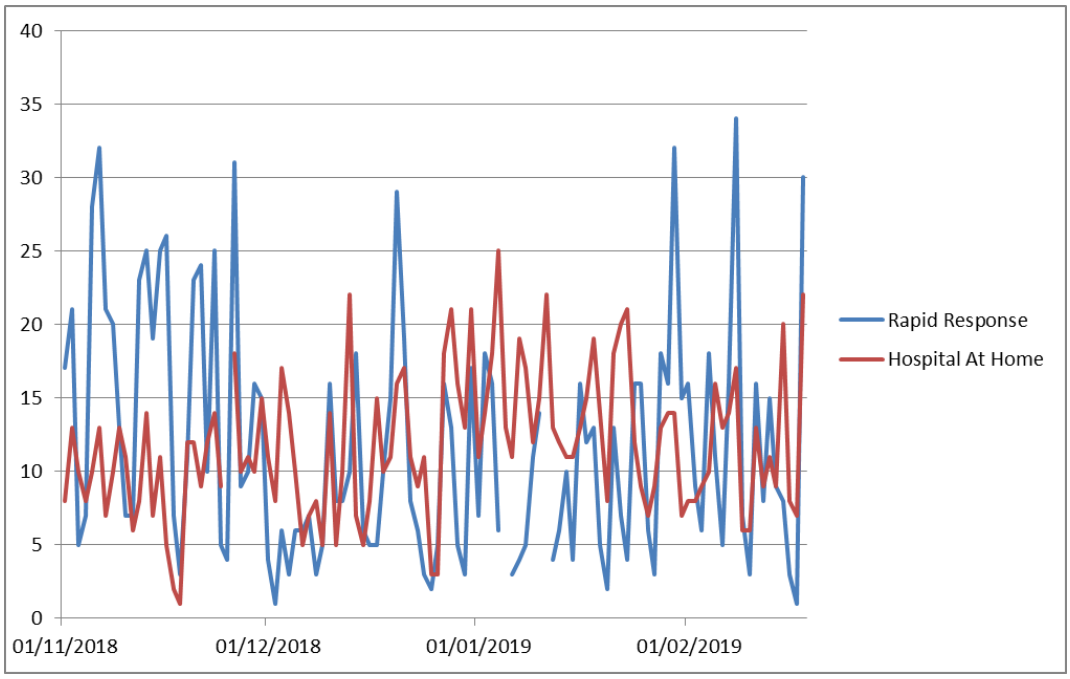
Up to the 18/3/19 the @home service had taken a total of 256 patients.
Consisting of:

- 62.2% female and 37.8% male
- 18 patients were under the age of 65 years
- A large number of patients were 75+ (182 patients in total)

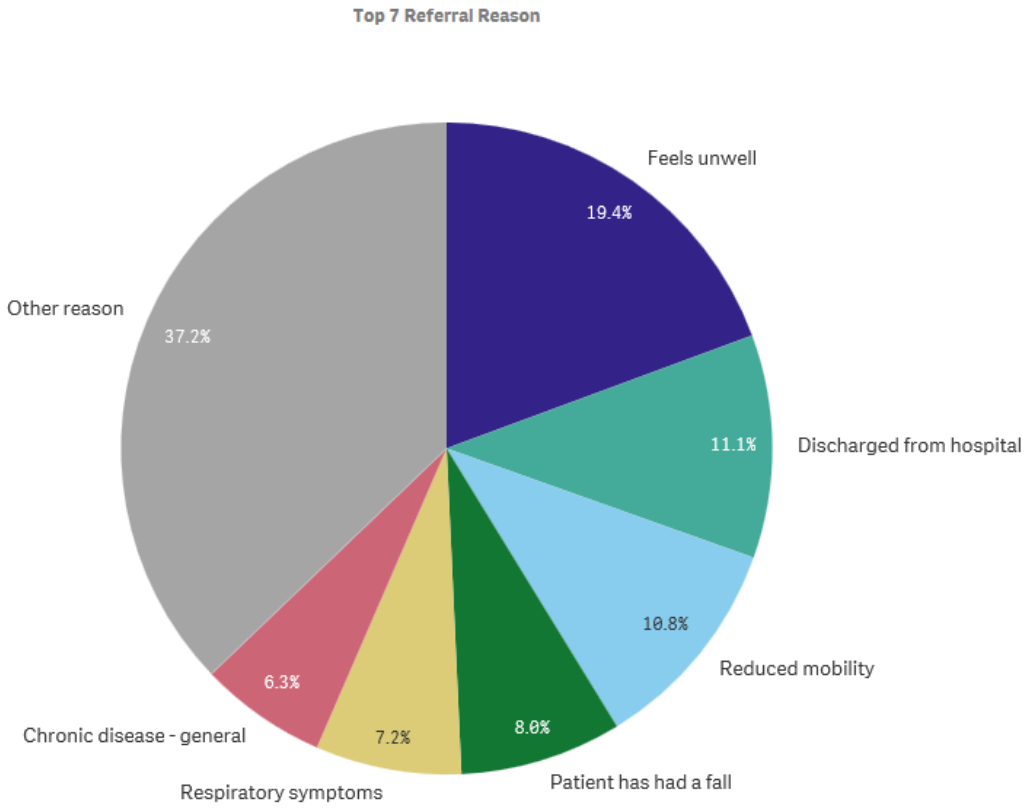
Initially referrals were predominantly from GP practices or were patients taken by rapid response who were then identified as being appropriate for @home following the initial assessment. Although referrals from the hospital have grown following a concerted effort to inform the wards of the new pathway, total referral volumes are still low and below the capacity available.



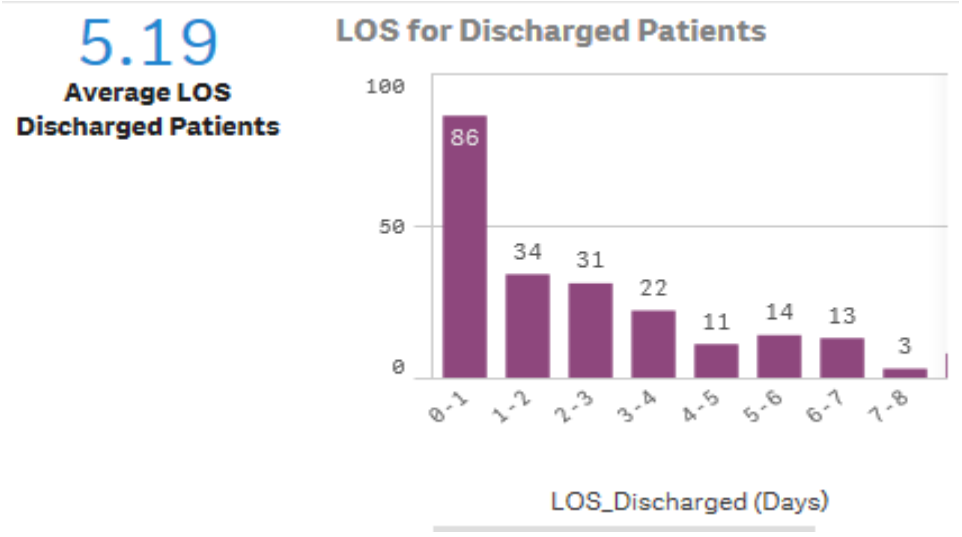
Although a number of the GP referrals were originally made with the intention of rapid response and then diverted into @home following discussion with the GP, it should be noted that this has not been a direct substitution effect and that the volume of activity for rapid response, as illustrated in the graph below. As both rapid response and @home are delivered by the same staff group it has allowed us to utilise the unused resource within @home to increase capacity within rapid response. Increased numbers of referrals from LAS have been seen but again more liaison needs to be completed, particularly with their Vulnerable Patient Team.



The reason for referral captured at the point of clinical triage is illustrated in the chart below. The 'other reason' category is made up Chronic disease general, problems with activities of daily living, wound care, generalised pain, confusion, and dizziness/balance problems in relatively equal measure. The box graph on the next page shows a collection of all referral reasons, including secondary reasons which show a slightly different picture to the primary reasons.

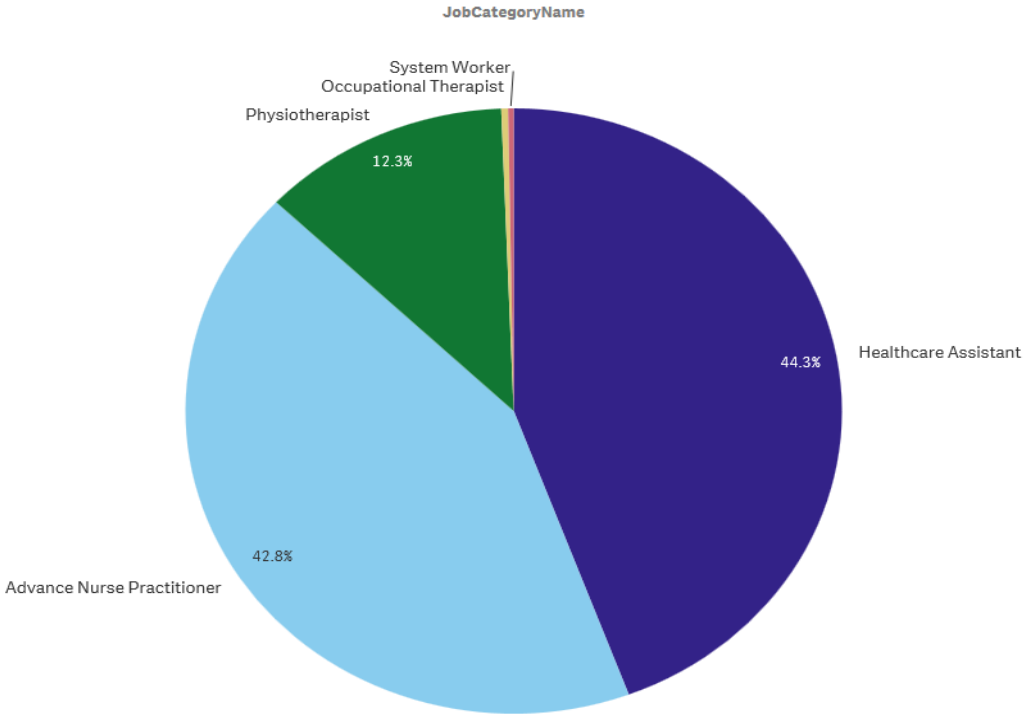


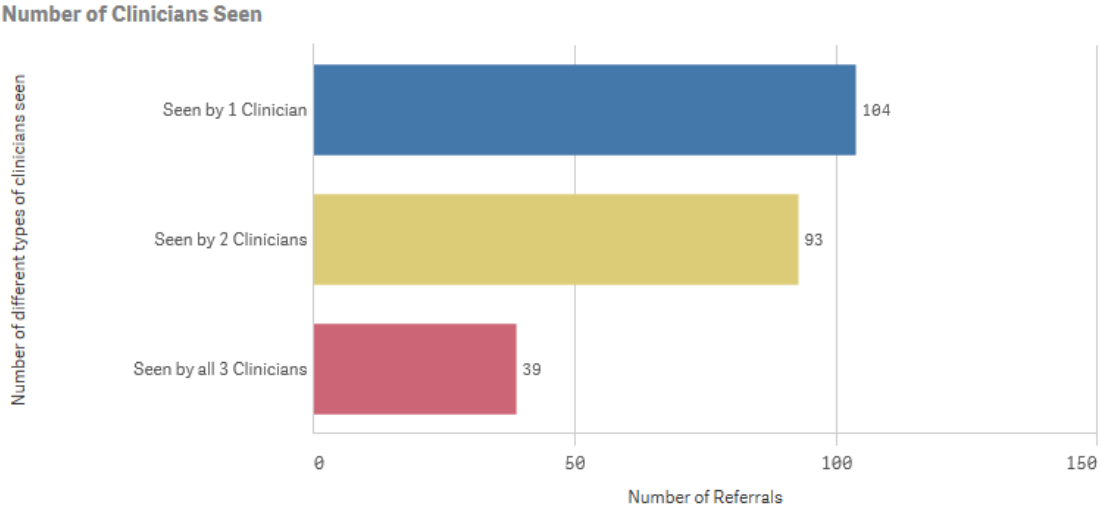
The following chart shows data relating to total visits for patients discharged from @home. The overall average number of visits was 5.19 which is increasing. We need to consider social care package of care provision for long stay patients.



The mix of visit type (by healthcare professional) is illustrated in the following pie chart. Although HCA visits are shorter in duration than ANP and Physio visits the data suggests we may need to increase the proportion of HCA time within the staffing model. 55% of patients saw at least 2 or more types of health professional, as illustrated in the bar chart. This shows the multidisciplinary value of the @home service. It should also be noted that the ANP input is

understated for those patients that were referred from rapid response, as the ANPs initial assessment will be recorded within rapid response activity.





Graph above summarises number of patients seen by either all the three group of clinician ,two or just one clinician.

The chart below provides information as to what onward referrals have been made from the @home service. A significant portion (43%) are also being referred back to their GP. Alternative models of care with GPs in the service might potentially be able to manage some or all of these patients.

System saving generated to date

Based on the premise that 256 seen within the @home service might have led to a hospital admission (or prolonged hospital stay) if the service had not been in place, a potential estimate can be made of the system wide saving delivered by the @home service. However, these figures should be treated with considerable caution as it is not clear if some of these patients form 'unmet need' and because the assessment of admission avoidance has been subjective, and made against criteria that have not been agreed or clarified.
Bearing these issues in mind, based on an average length of stay in the PRUH of 5 days and the hospital bed cost of £400 per day the total saving equals:

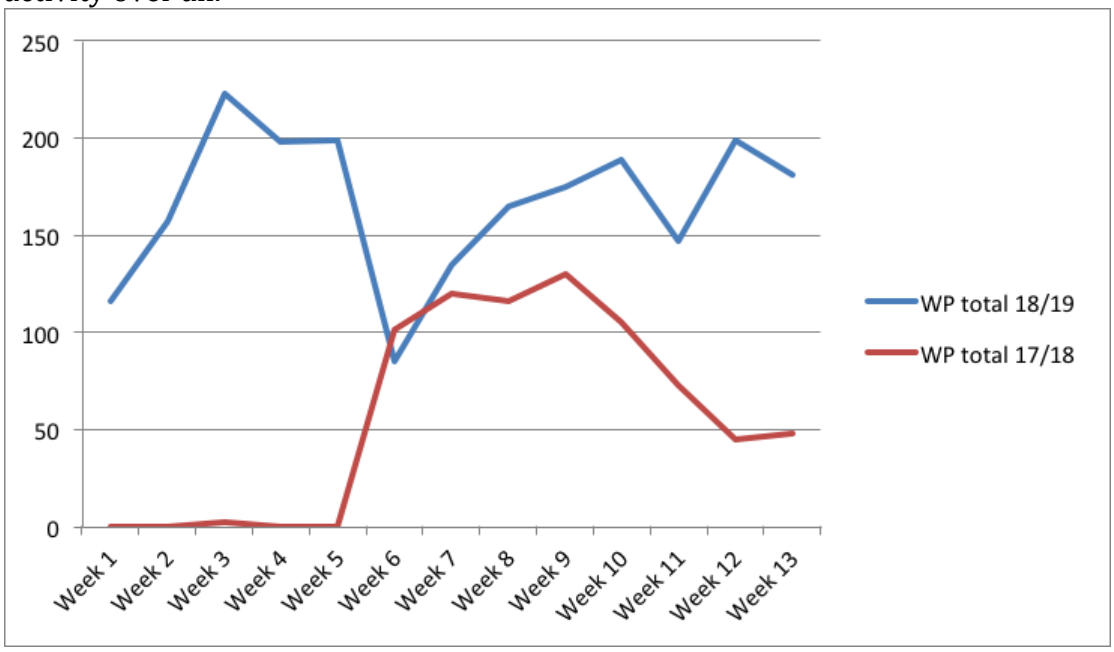
@home patients (253) X Ave PRUH bed days (5) X Daily bed cost (£400) = £506,000

The current cost for delivering the service to date is £190k, potentially generating a system return on investment of £ 316,000 or £2.66 for every £1 invested.

ANP Home Visiting Service (see Appendix A for full summary)

- Bromley Healthcare provided additional ANP (Advanced Nurse Practitioner) home visiting capacity within the Rapid Response Team from Monday 19th November 2018 to 15th February 2019 to support practices in managing increased demand for home visits over winter.
- All practices made at least one referral to the service. However, 62% of practices (28/45) used less than half of their weekly allocation, and 24% of practices (11/45) used less than a quarter. Only two practices exceeded their weekly allocation. See Appendix A for breakdown of referrals by practice.
- Breakdown of the total referrals by practice into all rapid response services over the winter period (including RRT, @Home and the same day service) shows that there is a similar overall referral pattern to that for the same day service alone.
- This may suggest that there are a number of practices who are not engaged in the use of these services and further communication is required, or it may indicate that some practices are able to manage home visit demand in house and therefore do not benefit from additional BHC service capacity.

- Overall activity - Activity remained higher throughout the duration of the service compared to the previous year, when it tailed off considerably. To note, there was more capacity this year, which helps account for higher activity over all.



- The number of 'first visits' undertaken each day following a referral was much lower than planned. The expected number of visits each week was 135, whereas the actual average number of visits (over Week 3 – Week 13) was 87. However, many follow-up visits and actions were generated following the initial visit, and when these are taken into account, the average count of activity each week increases to 169.
- Administrative time taken to set up the service i.e. recruitment and training of additional ANPs is high. Productivity of recruited agency staff is lower than substantive staff would be.
- In some ways, it has been helpful to have a single point of access to all three services via the Rapid Response call centre, but there has been some confusion about which service to refer patients to with consequent data coding errors, and GPs referring to the service of 'least resistance'.
- It may therefore be helpful to remove the '2 hour' criteria for the Rapid Response service (it is not seen as helpful by GPs and is often gamed), and, instead, a discussion with the Rapid Response team would be held to determine the level of need of the patient (and therefore whether the @Home team needs to be deployed) and the urgency of the situation (whether a visit is needed within a few hours / same day / next day).

Extra Care Housing Support Service

The service has been commissioned to provide support for the ECH sites by seeing patients discharged from hospital to ensure they are less likely to be readmitted via means of a holistic assessment of their needs and safety. The service consists of one advanced nurse practitioner (with support from the wider Rapid Response team if required) and also carries out training and advice

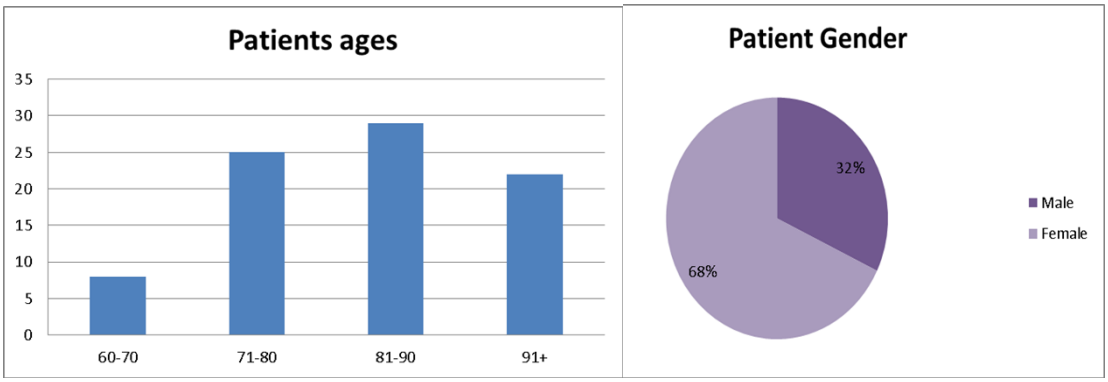
to the ECH site staff as well as advising on best practice and acting as a navigator for health services if required.

- Take up from the homes has been varied and to date the following number of visits have been carried out:

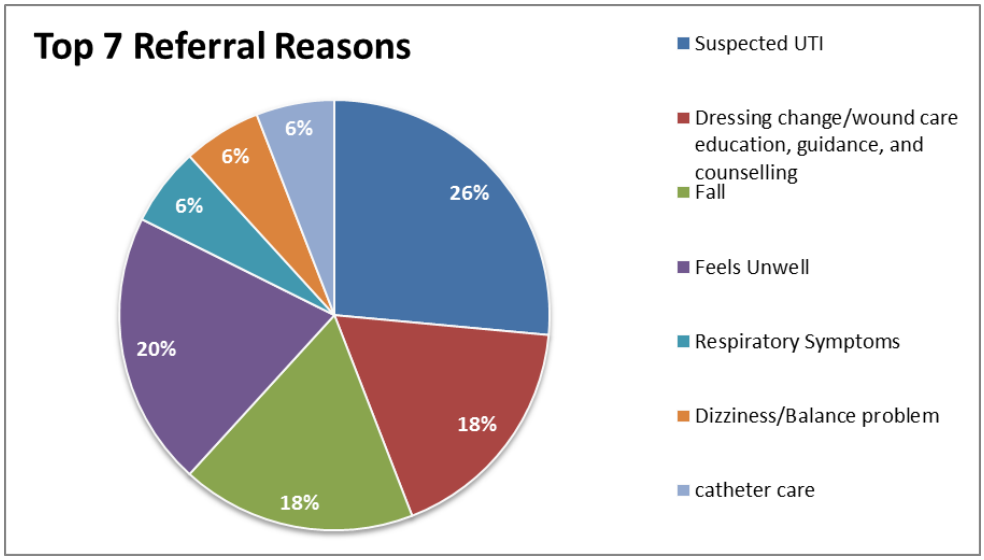
Location	No. of visits
Sutherland	21
Crown Meadow	87
Durham House	5
Norton Court	4
Regency Court	2
Apsley Court	4

  - These visits provided the opportunity to share and support care staff with talks on:
    - Sepsis
    - Falls
    - Pressure area care
    - The unsafe use of Emollients creams can result in serious or fatal injuries from fire

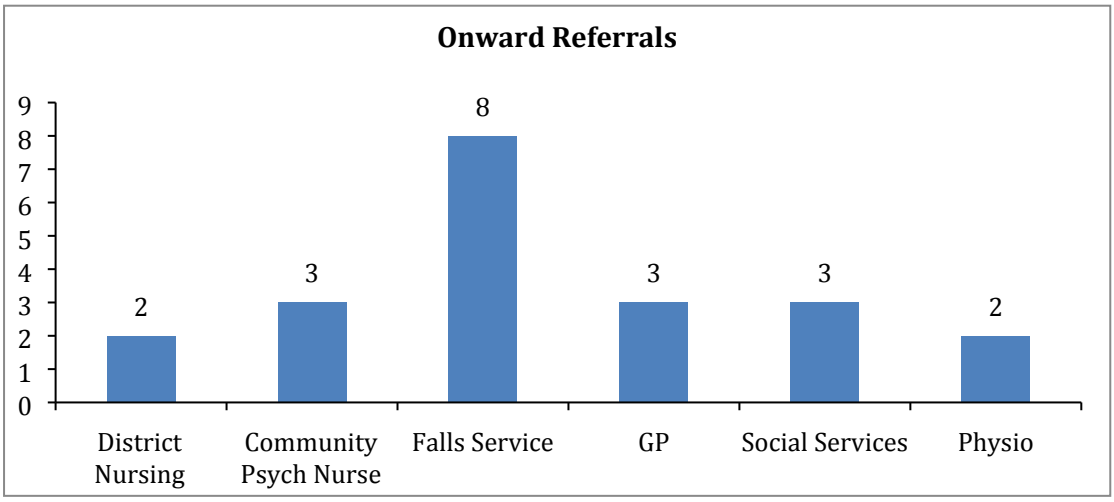
  - Up to the 26/03/2019 the service had taken a total of 84 patients. As illustrated in the charts below the patient group is largely female and made up of aged groups 70+.



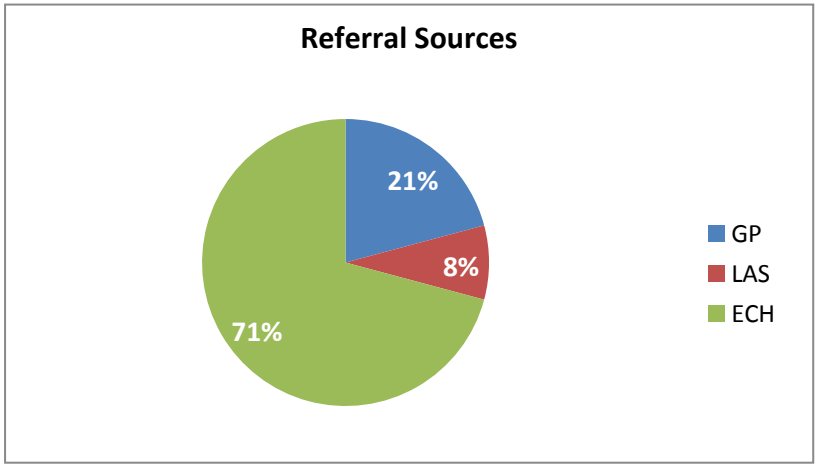
- 84% of patients have been seen for a first appointment with a small percentage (16%) requiring a follow up
- Referral reasons are in line with what was expected with 'suspected UTI' and 'Falls' being main reasons. There are a number of dressing change and wound care/education which was not expected and a significant number of the patients where the initial reason for referral states 'feels unwell'. The Feels Unwell patients excerpt is shown below, two of the patients have more in depth referral reasons and the others have a clear diagnosis following visit.



- The service has made a number of onward referrals, as you can see from the graph below the Falls Service has been the service most required for this cohort. As a result the ECH ANP worked closely with the specialist falls lead to develop specific training material for the ECHs.



- As you would expect the majority of referrals have come from the ECHs, however we have had a small number from LAS and GPs.



Increased GP Access Hub Appointments:

- 2260 additional appointment slots for GP practices. This represents a 10% increase in total hub appointments and equates to an increase in weekly practice allocation of 0.6 to 4.2 depending on list size.
- Utilisation of all Access Hubs appointments remained high over the six month period at an average of 96% with an 8% DNA rate. This is in keeping with performance during the non-winter period.
- To note, 300 of the additional 2260 winter resilience appointments were not offered to patients due to difficulty finding GPs to provide the sessions, therefore these appointments are being offered as additional appointments over the Easter period.

Did it achieve its aims?

- As in previous years, the assumption is that additional Access Hub appointments inherently help support primary care to manage additional demand by providing additional capacity, which therefore also helps prevent avoidable emergency admissions and attendances.
- Without an analysis of appointments available in general practice we cannot confirm that overall the availability of GP appointments increased over the winter period. However, even if the number of overall appointments did not increase, there is still benefit to practices and patients in that GP time is freed up to manage the care of other patients, thereby supporting practice resilience.
- It is important to bear in mind the relatively high cost of this provision. Bromley hub appointments cost the CCG £36.42 each (the average cost across SEL is £40.85 (range £69.44 to £25.80)). To compare to the cost of commissioning general practice appointments, for the 2014-15 winter resilience programme the CCG reimbursed practices at a rate of £20/appointment.

Increased Capacity for GP Out of Hours and Urgent Care Centres

As commissioned last year, the three elements were:

- Extended patient champion hours which supports redirection and increases use of hub appointments including advice and sign-posting to reduce avoidance attendances. The majority of redirections were to the GP Hub, own GP, Pharmacy, Sexual Health Clinic or other specialty.
- Enhanced GP rates ensuring rota fill across both sites including bank holidays and weekends enabling the UCCs to support ED and see as many patients as possible.
- Increased Health Care Assistants, which allowed clinical staff to focus on treating and discharges more patients with HCAs completing ECGs, observations, plastering and some dressings.
- Additionally this year the CCG commissioned GPOOH to provide additional capacity over the Christmas and New Year period to alleviate

Enhanced community support for temporary health conditions

- Provided additional resource to support more people to be discharged with temporary health conditions that do not meet the threshold for CHC funding.
- Where there wasn't clarity around funding of a patients care, temporary packages of care were put in place to allow for the funding discussion to occur outside the hospital, reducing bed days.

Performance Matron

The CCG have funded a performance matron for post acute medicine to be responsible for the management of the patient pathways, supporting the clinical site manager and clinical staff to optimise patient flow. The main key performance indicators measured are:

- Increasing number of early discharges
- Identification of reasons for delayed discharge.
- Quality improvement of community healthcare discharges (specifically Bed Based / Home Based Rehab).
- Reduction of 'medical outlier' patients.

The post started on January 7th and will run until May 7th. The CCG and PRUH Head of Post Acute Nursing and General Manager for Post Acute are currently assessing the post for a more detailed evaluation.

Winter Communications:

- The CCG funded a flu advertising campaign both in print and digitally to encourage take up of the flu vaccinations specifically in over 65s.
- The CCG also designed an information poster for Care Homes called 'Are you concerned about a resident?' to support care homes to contact alternative care pathways instead of ringing 999 where appropriate. The poster included different avenues of support to care homes such as NHS 111*6, Rapid Response, Pharmacists, Mental Health and Palliative Care support. The poster was sent out to all residential, nursing and extra care housing units in Bromley.

4. LEARNING AND RECOMMENDATIONS FOR NEXT WINTER

- Where funding commitments and strategic priorities permit, it is preferable to plan for winter resilience additionally sufficiently in advance (by August latest) so that additional staff known to the organisation can be recruited via the bank. In addition, a more realistic approach needs to be taken by commissioner and provider with regard to staff recruitment requirements.
- The principle of increasing capacity within existing services to support smooth implementation and higher 'uptake' has been shown to be sensible

Community:

- **Pathway clarity and links to other Bromley Healthcare home visit services** – As well as the existing Rapid Response Service (urgent home visits within two hours), the Hospital@Home service also started in autumn 2018. Therefore there were three home visit services operating over winter. In some ways, it has been helpful to have a single point of access to all three services via the Rapid Response call centre, but there has been some confusion about which service to refer patients to with consequent data coding errors, and GPs referring to the service of 'least resistance'.
- Mobilisation and monitoring of GP Hubs service is relatively quick and easy, which is somewhat balanced against the relatively high cost of appointments. However, a long lead-in time is required to fill GP rotas –ideally two months.

Acute:

- Despite PRUH A&E performance worsening this winter, all Type A&E attendances have decreased slightly when compared to the previous year. This could be a combination of the mild weather for the most of the winter period and a consequence of the various community admission avoidance pathways such as the integrated care networks proactive care pathway and additional capacity in the community.

- DTOCs continue to decrease compared to previous years and remain below the target plans for both NHS attributable and Social Care Attributable delays. The decrease in DTOCs has led to a reduction of 416 (75%) lost hospital bed days compared to the previous year. Bromley is now ranked 7th best performing Borough in London out of 32.

- This in part can be attributed to the expansion of the Discharge to Assess Pathway Pilot which has increased the number of patients leaving the hospital earlier with temporary packages of care whilst the full assessment is done in the community.

- Although all services offered were utilised and showed positive impact, significant numbers of people still required hospital based care, especially those with complex health and social care situations. Due to the complexity and demographic of patients further work is required to provide a more integrated community response to admission and attendance avoidance that is able to be accessed by a range of community providers including domiciliary care services and placements as well as the Emergency Department.

Recommendations:

1. Planning and mobilisation as early as possible of schemes to allow for staff recruitment, preferably during late summer and early autumn.
2. Further develop an integrated urgent and emergency care system in the community providing a single point of access to a range of community services able to provide brief acute level interventions to support more people at home, preventing the need for hospital based care and support. A

multiagency workshop has been planned for 30th April to consider these issues and agree next steps

3. The new Primary Care Networks will offer an opportunity to commission winter resilience schemes differently and in a way that is more focused on the needs of different practices. However, given the need for long lead in times, the 2019/20 may be too soon for this.

Appendix A: 2018/19 ANP Home Visiting Winter Resilience Scheme Evaluation

The Service

The demand for home visits has increased by over 50% in the past two years, and feedback from the vast majority of practices shows that practices are finding it more and more difficult to meet this demand without there being an adverse impact on delivery of other primary care services. The timely provision of home visits intended to relieve the pressure on general practice and help prevent patients falling into crisis and therefore avert potential far costlier A&E attendances/admissions.

Bromley Healthcare provided additional ANP (Advanced Nurse Practitioner) home visiting capacity within the Rapid Response Team from Monday 19th November 2018 to 15th February 2019 to support practices in managing increased demand for home visits over winter.

The additional ANPs provided same day visits to patients who requested a home visit and were deemed by the GP as suitable to be seen by an ANP.

Practices could refer in via the usual route of phoning the BHC Care Coordination Centre to speak to an ANP in the Rapid Response Team and asking for a same day visit. This call could be made by a non-clinician who had the relevant clinical information regarding the reason for the visit. Alternatively, the BHC SPE (Single Point of Entry) referral form could be used to send the referral.

Practices were given a nominal allocation of visit requests they could make each week based on the weighted list size. Practices were requested to refer in line with their weekly allocation to maintain parity of access.

Evaluation

Demand for the service

All practices made at least one referral to the service. However, 62% of practices (28/45) used less than half of their weekly allocation, and 24% of practices (11/45) used less than a quarter. Only two practices exceeded their weekly allocation. See Table 1 for breakdown of referrals by practice.

Table 1

	Total	allocation	usage %
Station Road	65	52	125.00%
Gillmans Road	14	13	107.69%
London Lane	72	78	92.31%
Pickhurst	33	39	84.62%
Norheads	10	13	76.92%
Bromley Common	36	52	69.23%
Forge Close	18	26	69.23%
Addington Road	33	52	63.46%
Chislehurst Medical	49	78	62.82%
Crescent	8	13	61.54%
Stock Hill	30	52	57.69%
Chelsfield	22	39	56.41%
Knoll	29	52	55.77%
Link Medical	29	52	55.77%
Derry Downs	14	26	53.85%
Whitehouse	7	13	53.85%
Elm House	47	91	51.65%
Green Street Green	19	39	48.72%
Robin Hood Surgery	12	26	46.15%
Oakfield	11	26	42.31%
Poverest	22	52	42.31%
Summercroft	22	52	42.31%
Ballater	20	52	38.46%
South View	22	65	33.85%
St James	13	39	33.33%
Bank House	8	26	30.77%
Dysart	16	52	30.77%
Park Group	12	39	30.77%
Broomwood Road	15	52	28.85%
Southborough Lane	15	52	28.85%
Woodland Practice	15	52	28.85%
Wickham Park	7	26	26.92%
Cornerways	10	39	25.64%
Tudor Way	10	39	25.64%
Charterhouse	6	26	23.08%
Manor Road	6	26	23.08%
Sundridge	5	26	19.23%
Eden Park	6	39	15.38%
St Mary Cray	2	13	15.38%
Cator	5	52	9.62%
Anerley	1	13	7.69%
Cross Hall	1	13	7.69%
Family Surgery	2	26	7.69%
Highland Road	1	26	3.85%
Trinity Medical	1	26	3.85%

Actual demand for this service is therefore significantly lower and patchier than expected, particularly as a 'deep dive' into home visit provision in practices in summer 2018 confirmed that the demand for visits puts significant pressure on practices.
There is not an obvious reason for the lower than expected usage; the service was well advertised in advance of go live via the practice bulletin and cluster meetings, and the referral route was made as easy possible by making it the same as the usual RRT route and further more non-clinicians were able to send the referral.
Each month, there were 3-4 days when the service reached capacity, but only 1-2 referrals had to be rejected.

Table 2 below shows total referrals by practice into all rapid response services over the winter period. This includes RRT, @Home and the same day service. This shows that there is a similar overall referral pattern to that for the same day service alone. This may suggest that there are a number of practices who are not engaged in the use of these services and further communication is required, or it may indicate that some practices are able to manage home visit demand in house and therefore do not benefit from additional BHC service capacity.

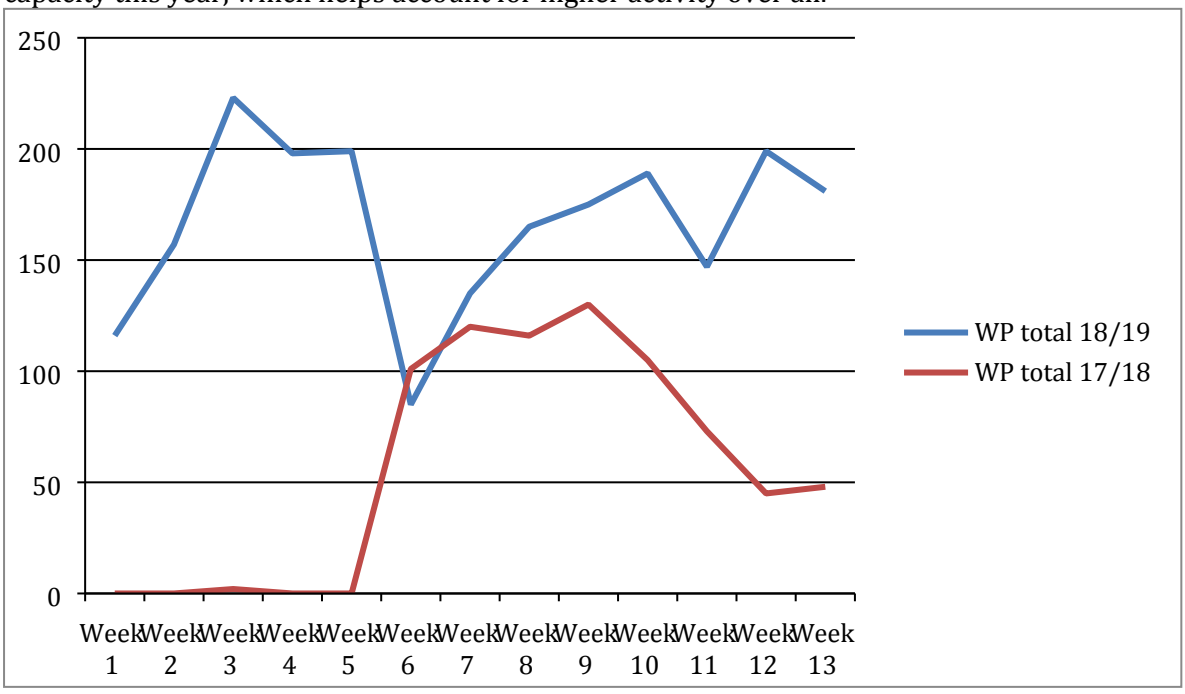
Table 2

Referral Sources	Nov-18	Dec-18	Jan-19	Feb-19	Grand Total	Rate/1000
STATION ROAD SURGERY	17	42	35	22	116	**10.7**
PICKHURST SURGERY	9	16	21	12	58	**8.3**
LONDON LANE CLINIC	16	30	31	24	101	**7.1**
Robin Hood Surgery	4	6	8	5	23	**5.2**
ADDINGTON ROAD SURGERY	8	17	13	8	46	**5.2**
GILLMANS ROAD SURGERY	3	2	5	5	15	**5.1**
Bromley Common Practice	5	19	9	10	43	**4.9**
Norheads Lane Surgery	1	3	6	3	13	**4.8**
STOCK HILL MEDICAL CENTRE	11	14	17	7	49	**4.8**
Green Street Green	3	9	11	9	32	**4.6**
Elm House Surgery	7	29	30	6	72	**4.4**
BANK HOUSE SURGERY	3	4	7		14	**4.4**
Forge Close Surgery	2	5	14	4	25	**4.2**
Knoll Medical Practice	6	10	16	7	39	**4.0**
Chislehurst Medical Practice	6	17	22	12	57	**4.0**
CRESCENT SURGERY	3	3	3	1	10	**3.9**
BALLATER SURGERY	6	7	14	8	35	**3.8**
LINKS MEDICAL PRACTICE	5	19	9	7	40	**3.7**
ST JAMES' PRACTICE	2	12	7	2	23	**3.6**
CHELSFIELD SURGERY	2	12	7	6	27	**3.4**
POVEREST MEDICAL CENTRE	3	11	10	5	29	**3.3**
Summercroft Surgery	2	10	9	10	31	**3.0**
DERRY DOWNS SURGERY	2	7	7		16	**2.9**
Dysart Surgery	10	9	9	1	29	**2.9**
CHARTERHOUSE SURGERY	3	6	6	1	16	**2.8**
OAKFIELD SURGERY	2	1	5	3	11	**2.7**
WOODLANDS PRACTICE	4	2	10	5	21	**2.3**
CORNERWAYS SURGERY	1	6	8	3	18	**2.2**
SOUTHBOROUGH LANE SURGERY	4	7	10	2	23	**2.2**
Park Group Practice	5	5	2	3	15	**2.1**

Tudor Way Surgery	1	3	7	3	14	**2.1**
SOUTH VIEW PARTNERSHIP	3	9	6	6	24	**2.0**
WHITEHOUSE SURGERY	1	2	1	2	6	**1.9**
BROOMWOOD ROAD SURGERY		5	8	6	19	**1.8**
Wickham Park Surgery	1	5	1	1	8	**1.7**
Manor Road Surgery	1	2	2	3	8	**1.5**
EDEN PARK SURGERY	1	4	4	2	11	**1.4**
Family Surgery		2		2	4	**1.0**
SUNDRIDGE MEDICAL PRACTICE	2	3			5	**1.0**
Anerley Surgery			1	1	2	**0.8**
Cator Medical Centre	2	1	1	3	7	**0.8**
Highland Road Surgery	1	1	1		3	**0.7**
ST MARY CRAY PRACTICE			1	1	2	**0.7**
CROSS HALL SURGERY	2				2	**0.7**
Trinity Medical Centre	1			1	2	**0.4**

Operational management and delivery

Overall activity - Activity remained higher throughout the duration of the service compared to the previous year, when it tailed off considerably. To note, there was more capacity this year, which helps account for higher activity over all.



The number of 'first visits' undertaken each day following a referral was much lower than planned. The expected number of visits each week was 135, whereas the actual average number of visits (over Week 3 – Week 13) was 87. However, many follow-up visits and actions were generated following the initial visit, and when these are taken into account, the average count of activity each week increases to 169.

Productivity – Bromley Healthcare spent a significant amount of administrative time setting up the service, especially recruiting the additional ANPs. The productivity of the newly recruited agency staff was then lower than it would have been for substantive staff due to time spent training, more time spent on undertaking the visits and there was also less consistency in delivery of care.
It would be more practical for patients referred in the afternoon to be seen the next morning rather than same day. This is because most referrals come in late morning, so the bulk of activity is after 11am, but it is not easy to recruit staff to only cover an afternoon shift.
Pathway clarity and links to other Bromley Healthcare home visit services – As well as the existing Rapid Response Service (urgent home visits within two hours), the Hospital@Home service also started in autumn 2018. Therefore there were three home visit services operating over winter. In some ways, it has been helpful to have a single point of access to all three services via the Rapid Response call centre, but there has been some confusion about which service to refer patients to with consequent data coding errors, and GPs referring to the service of 'least resistance'.
It may therefore be helpful to remove the '2 hour' criteria for the Rapid Response service (it is not seen as helpful by GPs and is often gamed), and, instead, a discussion with the Rapid Response team would be held to determine the level of need of the patient (and therefore whether the @Home team needs to be deployed) and the urgency of the situation (whether a visit is needed within a few hours / same day / next day).
Bromley Healthcare struggled to recruit sufficient agency staff to meet the requirements of the ANP home visit service, @Home and the ANP for Extra Care Housing.

Feedback on the service
There were no Quality Alerts received regarding the service, and the primary care team did not receive any feedback from practices following a request for comments in a practice bulletin. Bromley Healthcare did not receive any patient concerns or complaints.
Monitoring and oversight

The CCG received weekly updates on referral activity during the first few weeks of the service. This was used to identify over/under referring practices and resulted in additional practice bulletin items to promote the service and also promotion at cluster meetings.
Overall, the scheme was far more straightforward to commission, oversee and deliver compared to previous schemes that were developed and implemented at later notice and involved a more significant change in pathways.

Overall, did the scheme achieve its aims?
The service achieved its aims only in part. It was used by some practices far more than others, suggesting that pressure to meet the demand for home visits was not relieved for some practices.
A&E attendances have decreased slightly when compared to the previous year. This will continue to be monitored throughout the winter as it could be a consequence of the various community admission avoidance pathways such as the integrated care networks proactive care pathway.

Main learnings and recommendations for future winter resilience schemes
1) Where funding commitments and strategic priorities permit, it is preferable to plan for winter resilience additionality sufficiently in advance (by August latest) so that additional staff known to the organisation can be recruited via the bank. In addition, a more realistic approach needs to be taken by commissioner and provider with regard to staff recruitment requirements.

2) The principle of increasing capacity within existing services to support smooth implementation and higher 'uptake' has been shown to be sensible.
3) The new Primary Care Networks will offer an opportunity to commission winter resilience schemes differently and in a way that is more focused on the needs of different practices. However, given the need for long lead in times, the 2019/20 may be too soon for this.